THE NEWSLETTER
OF THE AMERICAN ACADEMY OF
EMERGENCY MEDICINE

COMMONSENSE

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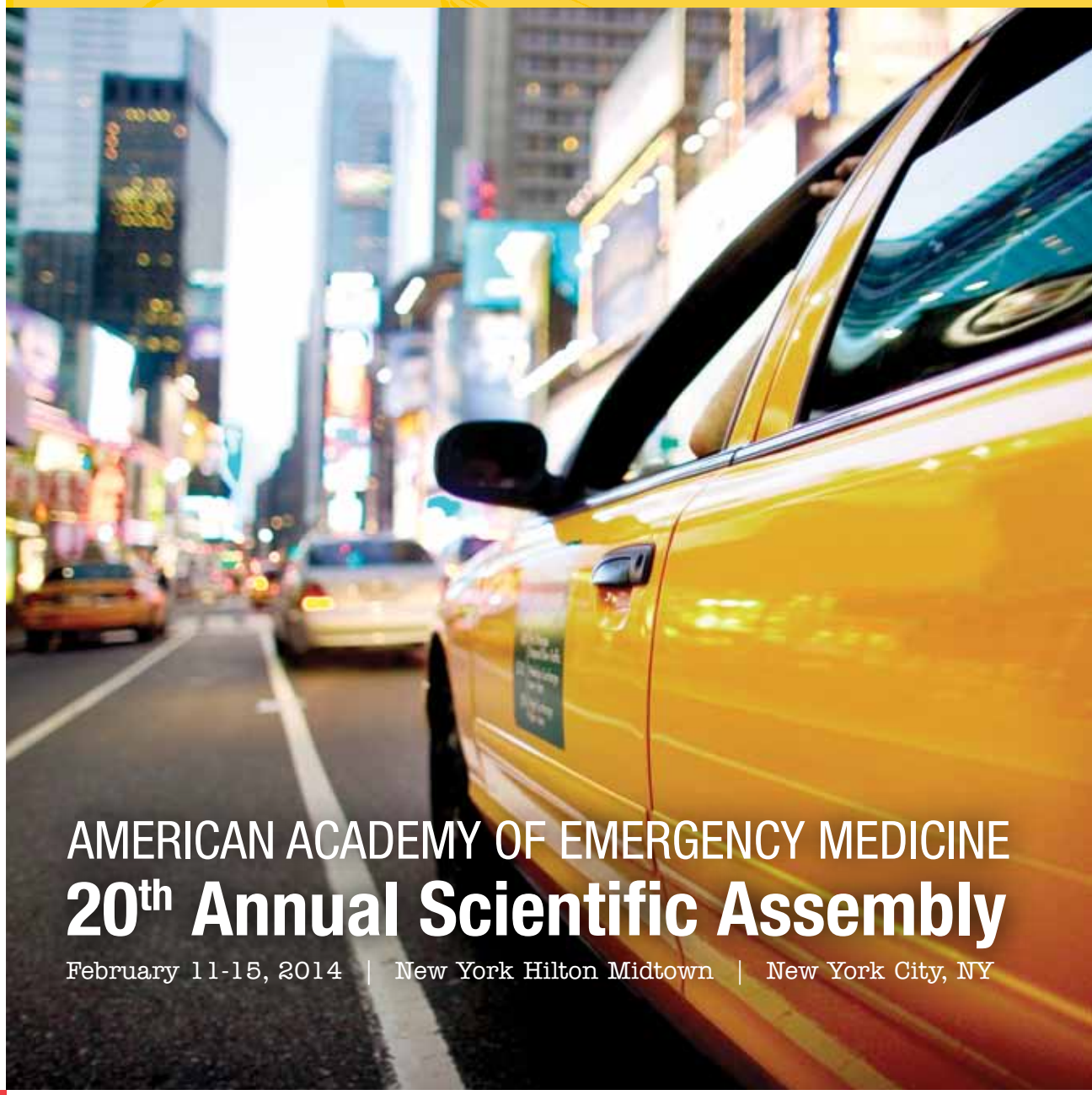
INSIDE



AMERICAN ACADEMY OF EMERGENCY MEDICINE

20th Annual Scientific Assembly

February 11-15, 2014 | New York Hilton Midtown | New York City, NY

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AAEM Mission Statement

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

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

Membership Information

Fellow and Full Voting Member: $425 (Must be ABEM or AOBEM certified, or have recertified for 25 years or more in EM or Pediatric EM)
Affiliate Member: $365 (Non-voting status; must have been, but is no longer ABEM or AOBEM certified in EM)
Associate Member: $250 (Limited to graduates of an ACGME or AOA approved Emergency Medicine Program)
*Fellows-in-Training Member: $75 (Must be graduates of an ACGME or AOA approved EM Program and be enrolled in a fellowship)
Emeritus Member: $250 (Must be 65 years old and a full voting member in good standing for 3 years)
International Member: $150 (Non-voting status)
Resident Member: $55 (voting in AAEM/RSA elections only)
Transitional Member: $55 (voting in AAEM/RSA elections only)
International Resident Member: $25 (voting in AAEM/RSA elections only)
Student Member: $25 or $55 (voting in AAEM/RSA elections only)
International Student Member: $25 (voting in AAEM/RSA elections only)
*Fellows-in-Training membership includes Young Physicians Section (YPS) membership.

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

President's Message

A Call to Serve

William T. Durkin, Jr., MD MBA FAAEM

"Bad men need nothing more to compass their ends, than that good men should look on and do nothing."

— John Stuart Mill

The Academy has now called for nominations for its board of directors (BOD) and Executive Committee. No doubt you have seen these announcements before, and may have thought of running for office. Not sure of what was involved or the time commitment, you hesitated. Others have thought to themselves, "Yes, it would be good to give back to the specialty someday," but then moved on. Well, it is time to take action, my friends. In order to accomplish our mission we need leaders — people who are dedicated and willing to do the work, not just burnish a resume.

The BOD and Executive Committee set the agenda for the Academy. A member of the board of directors serves a two-year term. During this time, it is expected that he/she attend an in-person business meeting each quarter, including one just before the Scientific Assembly and another on the last day of the SA, where the time and place of board meetings for the rest of the year are decided. Email is the primary method of communication between board meetings. The expectation is that emails will be answered within 24 hours. Email traffic tends to be busiest in the few weeks ahead of the in-person meetings. As the board takes on new projects or activities, a subgroup is generally assigned the task and then reports back to the full board. Each member also serves as liaison to one of the Academy's standing committees. That means attending committee conference calls, held quarterly by most committees, assisting the committee chair when needed, and reporting committee activities back to the BOD. All told, it will take you two to four hours per week on average.

Members of the executive committee are the officers of the organization. They are primarily responsible for the day-to-day activities of the Academy. In addition to attendance at all board meetings, there is a phone conference mid-way between the quarterly board meetings. They also assist in making residency visits. The secretary-treasurer is responsible for keeping track of our financial state. Don't worry, you do not need an MBA or degree in accounting, I can tell you from personal experience that our staff provides excellent support, and shortly after your election you spend a day at AAEM's headquarters learning about our finances. With the assistance of staff, each fall you present the budget for the coming year to the board. While serving in this position, one gets a good perspective on how the business end of the organization runs. The time commitment here is about five hours a week; a bit more before the conference calls.

Tom Scaletta once told me that the job of the vice president is to make the president look good. He/she helps with special projects and member requests, and travels to some residency programs. Specific duties depend on the president and the opportunities that come along. The time required for this job varies, but should be about five to six hours per week. A flexible schedule is helpful, to allow for travel and for standing in for the president.

The president's job requires about 20-30 hours/week, depending on travel requirements, activities of the Academy, and member requests. It is the most demanding but, in my opinion, also the most rewarding job. There is always something to do. Ideally, those holding this office should have a flexible schedule without many collateral duties or demands from their main job.

AAEM is also in need of dedicated committee members. Serving on a committee is a good way to get an idea how the Academy works, get experience creating policy, help other physicians, and add value to membership. We want people who are willing to make suggestions and do the work. There is a special need on the Practice Management Committee for those of you who have experience managing and maintaining independent, democratic groups. Take a look at our list of committees and see where you might have something to offer. Have an interest but don't see a committee to match it? Not a problem: submit a proposal to the board and become the chair of a new committee! I promise you my full support.

The Academy has also called for nominations for annual awards. Please take a moment to look at the criteria for each award on our website. We would like much more input from members on these. In some years nominations have been a function of the executive committee, and I very much want to get away from that. I call your attention to a new award, Administrator of the Year. This is for a hospital administrator who has been supportive of an EM group and the specialty as a whole. If your CEO or COO has been helpful and supportive of your group, submit his/her name. This brings publicity to your group, your hospital, and the specialty organization for CEOs — the American College of Healthcare Executives — showing them that we provide recognition to deserving hospital administrators and realize that we are partners with them in providing the best care to our communities.

Like most professional societies, we use our annual awards to recognize those who have gone "above and beyond the call of duty" for us. In too many years it has been the executive committee that has chosen the slate of nominees. Please take some time to think about an appropriate

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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.

nominee. Whether it's an exceptional teacher or someone from the Academy who has exemplified what an EP should be and served the EM community well. Please think of those who you feel deserve recognition.

The success of the Academy very much depends on the participation of its members. Please consider serving in some capacity. When you make your nomination or cast your vote, be sure those people have the energy and ability to make the commitment.

AAEM Advocacy Day

"The penalty good men pay for indifference to public affairs is to be ruled by evil men."

— Plato

October 9th 2013, is our next day on Capitol Hill. Seriously consider taking advantage of this opportunity to come lobby for a day. Our lobbyists, Williams and Jensen (W&J), provide a teaching and briefing session in the morning, and then we head to the halls of Congress. You will meet in small groups with members of Congress and senior staff. A representative from W&J will accompany each group, so you need not worry about being alone or uncomfortable during the meetings. Lunch will be provided and a member of Congress has been invited to attend and have an informal session with the group.

This is a wonderful opportunity to influence law and policy as well as a chance to interact with other members of the Academy and our lobbyists. I hope to see many of you there. If circumstances prevent you from making it this time, please consider a donation to our PAC instead. ■

NEW: AAEM PODCASTS

AAEM is proud to unveil three new podcast series:

Emergency Physician Advocates: Medical-Legal Issues in Emergency Medicine

Newest Episode: The Liability Crisis

Larry Weiss, MD JD FAAEM, addresses the following questions: Do we have a liability crisis? If so, why? And what can we do about this problem?

Critical Care in Emergency Medicine

Newest Episode: ScvO2 vs Lactate Clearance in Early Goal Directed Therapy

David Farcy, MD FAAEM FCCM, speaks with Michael Winters, MD FAAEM. The discussion covers a review of landmark articles as well as recent literature.

Emergency Medicine Operations Management

Newest Episode: Problems and Solutions in ED Throughput

Mark Graban, MS MBA, interviews Joseph Guarisco, MD FAAEM. In parts 1 & 2 of this episode, Mr. Graban and Dr. Guarisco discuss reasons for emergency department difficulties with throughput & patient flow and outline the critical drivers for improving the ED. They highlight a conceptual breakdown of the ED, creating an agenda for change and solutions for this difficult management area.

AAEM podcasts are available on the AAEM website and on iTunes. Visit the AAEM blog, part of AAEM Connect, to leave comments and engage in a conversation around the issues discussed in these episodes.

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Participation

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

Compared to some medical societies, the American Academy of Emergency Medicine is small, with just over 8,000 members — including residents and students. The Academy, however, has influence far greater than its numbers would indicate. There are two reasons for this. First, our principles and the steadfast vigor with which we defend them have given AAEM a well-deserved reputation for occupying the moral high ground in our specialty. Even our opponents admire us for never selling out, the same way a mobster admires a cop who won't take a bribe — although he may see that cop as an obstacle at the same time. Second, many Academy members are active participants in the organization, taking practical action to promote the interests of our specialty, our patients, and individual emergency physicians. They do more than just renew their memberships and pay their dues on time, although those things are important. They also serve on AAEM committees, as committee chairs, on the board of directors, and as officers — or they write articles for *Common Sense*!

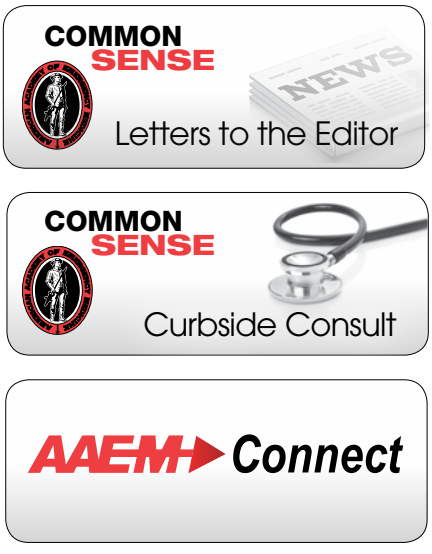
Less obvious forms of participation are also important: attending the annual Scientific Assembly or one of the several international meetings AAEM co-sponsors, such as the Mediterranean Emergency Medicine Congress in Marseille, France, September 8-11, 2013; recruiting new members for the Academy; calling legislators or other leaders about medical issues when asked; or even something as simple as writing a letter to the editor of *Common Sense* to voice your opinion on an issue or something we have published.

It is on *Common Sense* that I want to focus. It has been just over a year since we changed the format of the newsletter, going to multicolored, glossy paper. The professional staff and I also tightened up the production process, shortening the time between article submission and publication. In addition, the average size of each print issue has increased, with content that I hope you find valuable, and we have started new features such as Letters to the Editor and Curbside Consult. With the help of AAEM/RSA and the Social Media Committee, we have enhanced our online and social media offerings. All this is directed to making *Common Sense* more interactive, more timely, and more interesting to read.

I want *Common Sense* to be such an accurate reflection of AAEM and its members that, when you give a copy to a colleague who is not a member of the Academy, he or she reads it and comes back to you wanting to join. For that goal to become reality, I need your help. **I need your participation.** Some of you have experience or expertise that would be valuable or interesting to other emergency physicians, or have faced a problem that many other emergency physicians must overcome too. Write an article about it and send it to me. I am always looking for good material to publish, especially on things like the intersection of emergency medicine and business, economics, regulation, law, politics, and ethics. If you have something to say but don't think it worthy of an entire article, write a letter to the editor. If you read something in *Common Sense* that makes you mad and you think I'm an idiot, write a letter to the editor. If you read something you love and you think I'm a genius, write a letter to the editor. If you are having a problem of some kind at work, especially if it's not a clinical issue, write to Curbside Consult and ask for advice. If practicing emergency medicine is creating a personal problem of some kind for you, write to Curbside Consult. In both cases the odds are good that other emergency physicians are having similar problems and will benefit from the answer to your question. Both the Letters to the Editor and Curbside Consult features can be accessed via the AAEM website, and answers will be posted quickly online too, so you don't have to wait for the next print edition of *Common Sense* to get a response. Whether you are authoring an article, going to Curbside Consult for advice, or writing a letter to the editor — I need to hear from you in order to make our newsletter a good read — and this is an easy but meaningful way to participate in the life of AAEM.

If you want to do more than that, then serve on a committee; join your AAEM state chapter or found one in your state (AAEM's staff makes that easy); run for office or for the board of directors (fall is nominating time); or come to D.C. during the next fly-in and meet with the Academy's lobbyists, followed by a trip to Capitol Hill to meet with legislators and their staffers. AAEM is only as strong as its members choose to make it. The Academy needs your participation! ■

We're listening, send us your thoughts!



Congress Faces Key Deadlines Following Recess

Williams & Jensen, PLLC

The House and Senate worked on several major bills over the summer months, but failed to make substantial progress on any of the major debt and government funding issues that must be addressed in the remaining months of 2013. When Congress returns on September 9th, the fall legislative agenda will be dominated by three major efforts: (1) legislation to continue funding the government past the end of fiscal year (FY) 2013; (2) Congressional action to raise the debt ceiling after the Treasury has exhausted "extraordinary measures" to continue paying the nation's bills; and (3) an attempt led by House Ways and Means Committee Chairman, Dave Camp (R-MI), and Senate Finance Committee Chairman, Max Baucus (D-MT), to comprehensively reform the U.S. tax code.

Thus far, the House has opted to pass government funding bills at sequestration levels, while the Senate is proceeding to mark up bills at higher levels. Given these funding disparities, chances for a compromise on government spending appear remote. Congress has the option to pass short-term legislation continuing to fund the government at current levels, which would give negotiators additional time to work on a compromise.

Sequestration, including the two percent across-the-board cut to Medicare providers, has remained in place since April 1. Congress has provided some relief to certain programs that have been particularly impacted by sequestration, but the Medicare cut is not likely to be addressed except in the context of a larger deal that replaces the sequester with other spending reductions or revenue increases.

The other major issue that Congress must contend with in 2013 is the debt ceiling. At present, estimates have the U.S. government reaching its borrowing limit around November. Due to the proximity of this debate to the government funding negotiations, it is possible that Congress and the Administration will approach these issues together, and attempt to construct a deal that would continue to fund the government and raise the debt ceiling at the same time. This debate may play out similarly to earlier budget debates, with Republicans pushing for spending cuts and Democrats for tax increases. Other major issues, like the elimination of sequestration and funding for Affordable Care Act (ACA) implementation, are also expected to play a prominent role in these discussions.

Following the recess, Congress is set to continue work on a number of health care bills, including: legislation to replace the Medicare Sustainable Growth Rate (SGR) with a new physician payment model; legislation to implement a track and trace system for drugs; a bill providing new regulatory authority for the Food and Drug Administration (FDA) to inspect drug compounding facilities; and possible modifications to the ACA as both sides brace for the parts of the law set to take effect on January 1.

House Continues to Advance SGR Repeal Proposal

In July, the House of Representative's Energy and Commerce Committee convened a markup of legislation to reform the Medicare physician fee schedule payment system. The Committee considered the Medicare Patient Access and Quality Improvement Act of 2013 (H.R. 2810), "a bill to amend title XVIII of the Social Security Act to reform the sustainable growth rate and Medicare payment for physicians' services, and for other purposes."

The legislation was introduced by Rep. Michael Burgess, MD (R-TX), and would repeal and replace the SGR with a new policy to change physician payment in two phases: (1) permanently repeal SGR and replace it with a five-year period of stable physician payments; and (2) create an Update Incentive Program that would link payments to quality of care. The legislation would also allow physicians to opt out of the fee for service (FFS) program and participate in alternative payment models (APMs). AAEM submitted comments to the Committee during the February and July periods in which it accepted input from stakeholder groups, and also weighed in with key members during the June Advocacy Day.

The Committee favorably reported the legislation by a roll call vote, with no members voting in opposition. The bipartisan vote may give Congress momentum to continue negotiations following the August recess, and vindicated the Committee's strategy to focus first on the payment policy issues at hand and then make decisions regarding the difficult matter of offsetting the $139 billion cost of a permanent "doc fix" at a later date. However, after factoring in the other traditional Medicare "extenders" that are generally moved as part of a year-end package, the cost of a full SGR repeal package may rise above $170 billion. In recent years, Congress has enacted provider cuts to pay for a large share of the temporary fixes to SGR, but Congress faces pressure to find revenue in additional places to fund a package of this magnitude.

The issue of paying for the bill has still not been resolved, but Committee leadership has pledged that the legislation will be fully paid for when it comes before the full House for a vote. It is not expected that a bill will come to the floor earlier than October, given Congress' focus on agency funding in advance of the fiscal year's end on September 30. A number of key House and Senate members have signaled they would like to continue working towards SGR repeal because of the discounted cost of a permanent fix, but in the current fiscal environment it will be very challenging to identify offsets that are palatable to both Senate Democrats and House Republicans.

The current "doc fix" expires December 31, 2013. Following this date, physicians would face an approximately 25 percent Medicare reimbursement cut without Congressional intervention. The Senate held hearings this year to examine the physician payment system, but has not yet initiated Committee proceedings on legislation to permanently repeal the SGR.

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House Passes Bills Targeting ACA Health Insurance Mandates; Congress Continues to Monitor Implementation

In July, the House of Representatives passed legislation that would delay two key mandates included in the ACA. By a vote of 264-161, the House approved H.R. 2667, Authority for Mandate Delay Act, a bill authored by Rep. Tim Griffin (R-AR) that would delay until 2015 enforcement of the ACA's requirement that large employers offer full-time employees the opportunity to enroll in minimum essential health care coverage. The legislation also delays the effective date of related reporting requirements. Thirty-five Democrats joined nearly all Republicans in supporting the legislation.

The House considered a second bill, H.R. 2668, Fairness for American Families Act, authored by Rep. Todd Young (R-IN). The legislation would delay the ACA's requirement that individuals maintain minimum essential healthcare coverage until 2015. The House approved the bill by a vote of 251-174, with 22 Democrats voting in the affirmative and one Republican voting in opposition.

Both bills were introduced and brought to the floor following the Department of the Treasury's announcement on July 2nd that the ACA's employer healthcare insurance mandate would be delayed until 2015. The White House issued a veto threat on both bills, and the Senate is not expected to take action on either bill.

Despite the delay of the employer mandate, newly confirmed Centers for Medicare and Medicaid Services (CMS) Administrator, Marilyn Tavenner, told Congress that key ACA deadlines would be met over the next several months. Tavenner said that the final health insurance exchange application will be finished by August 31, and that insurance rates for the Federal exchanges will be published in September. She also indicated that health insurance exchanges will be open for enrollment by the scheduled October 1 deadline. Congressional Republicans have continued to express doubts that components of the law will be implemented on time, and have argued that the decision to delay the employer mandate is evidence that it is behind schedule.

Other provisions of the law, including Medicaid pay parity with Medicare for primary care providers, have also faced delays. CMS issued the Final Rule in November 2012, which outlined the physician groups that are eligible for the pay boost. The two-year pay parity was set to take effect on January 1, 2013, but as of July less than 15 states had implemented the pay increase.

Over one-fourth of Republicans in the House and Senate have written letters urging opposition to any government funding bills that continue to include money for ACA implementation. The Senate effort to deny further funding for the ACA is led by Senators Mike Lee (R-UT), Ted Cruz (R-TX), and Marco Rubio (R-FL). The effort would not impact mandatory spending under the law, such as the Medicaid expansion, but would cut

Continued on next page

off further Federal funding for items such as outreach programs, marketing and promotion of the law, and additional rule-making. Congressional Democratic leadership has said they will block efforts to defund the ACA.

House Passes School Access to Emergency Epinephrine Act

In July, the House passed H.R. 2094, the School Access to Emergency Epinephrine Act. The legislation would encourage states to enact laws that require schools to plan for severe allergic reactions by allowing the Department of Health and Human Services (HHS) to give funding preference to states for asthma-treatment grants if they meet the following requirements: (1) maintain a supply of epinephrine; (2) allow trained school personnel to administer epinephrine; and (3) implement a plan to ensure that trained personnel are available during all hours of the school day. Under the legislation, states must also certify that their laws have been reviewed to ensure that liability protections are afforded to school staff who have been trained to administer epinephrine. Last year, the House Judiciary and House Energy & Commerce Committees advanced a number of medical liability reform bills, which were later approved by the full House. The Senate did not act on any of these bills, as they did not have the support of Senate Democratic leadership. The liability protections included in this bill represent a compromise between House Republicans and Democrats. Once the bill is introduced in the Senate, advocates hope the bill can be passed by a unanimous consent agreement, given the bipartisan support for this legislation in the House. AAEM lobbied for passage of this bill in the House and will continue to do so in the Senate.

CMS Issues Proposed Rule on OPPS and ASC Payment Rates

On July 8, the Centers for Medicare & Medicaid Services (CMS) released the proposed rule for calendar year (CY) 2014 Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System Policy Changes and Payment Rates. According to a CMS press release, the proposed rule would "update Medicare payment policies and rates for hospital outpatient department and ASC services, and update and streamline programs that encourage high-quality care in these outpatient settings consistent with policies included in the Affordable Care Act."

Compared to CY 2013, CMS projected that next year's OPPS payments are projected to increase by $4.37 billion (+9.5%), and Medicare payments to ASCs are projected to rise by approximately $133 million (+3.5%). Broadly, the rule proposes expanding the categories of services packaged into a single payment for primary service under OPPS, and would add seven additional categories of supporting services under the OPPS.

Notably, the rule proposes to replace the five levels of outpatient visit codes with a single Healthcare Common Procedure Coding System (HCPCS) code, which would be applied to outpatient visits — one for clinic visits and one each for 24 hour and non-24 hour emergency department visits. CY 2013 Type A Emergency Department HCPCS codes 99281-99285 would be replaced in CY 2014 by a single code (GXXXA), and Type B Emergency Department HCPCS codes G0380-G0384 would be replaced by one code (GXXXB). CMS offered the following rationale for this proposed change: "CMS believes that by combining the five current levels of codes to one level, it will remove incentives that hospitals may have to provide medically unnecessary services or expend additional, unnecessary resources to achieve a higher level of visit payments under the OPPS. CMS also believes that a single payment code will reduce administrative burden and can be easily adopted by hospitals and will allow for a large universe of claims to be utilized for rate setting." CMS is accepting comments on the proposed rule until September 6, 2013. CMS intends to publish the final rule around November 1, 2013. ■

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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 1-1-13 to 7-16-13.

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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Blast from the Past

Andy Walker, MD FAAEM
Editor, *Common Sense*
AAEM Board Member

As we continue to celebrate 20 years of *Common Sense,* this installment of "Blast from the Past" features highlights from Volume 2 Issue 3 and from Volume 3 Issue 1. ■

EMERGENCY MEDICINE: THE LIVING LAW-San Francisco Jan 27-29 Register now or at the meeting [See UPCOMING CONFERENCES, page 2]

AMERICAN ACADEMY OF EMERGENCY MEDICINE
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COMMON SENSE

WHY DOES ACEP MEMBERSHIP COST SO MUCH?

Scott Plantz, MD FAAEM

ACEP refuses to take a stand on issues that are important for the future of our speciality, such as limiting future voting membership to boarded or residency trained emergency physicians, non-compete clauses, due process, or fee-splitting. It would seem taking a firm stand on these issues would be logical for an organization dedicate to the future of emergency medicine. So why don't they take a stand?

When something just doesn't quite make logical sense, I have always been told to look for the dollar sign. ACEP is a very large and expensive organization to operate. In 1993, annual membership dues generated $5,955,759 dollars. Unfortunately, in the same year, compensation to officers, salaries, pension plan contributions, employee benefits, and payroll taxes cost the organization $6,203,474. Colin Rorrie's salary and benefits alone were over $350,000. To cover the cost of their employee benefits, ACEP generated another $6,702,477 dollars through service revenue, such as charges for courses, books, conferences, etc. This is why even though many speakers donate their time for lectures, the course, and the ACEP category I credit, still costs you a large amount of money.

Given such large costs, ACEP must be very careful not to propose any policy that might jeopardize membership. As a result, it is small wonder it is difficult to get ACEP to take a stand on issues which might aggravate a few large companies that encourage their "independent contractors" to maintain ACEP membership or establish policy that restricts voting membership to individuals that have actually trained or are boarded in the specialty.

LAST CHANCE FOR ACEP?

Scott H. Plantz, MD FAAEM

At times we are criticized for being critical of ACEP. Why don't we work within the college? Why not change from within? Reality is that many members of AAEM have made several attempts to reform ACEP. The 1995 ACEP Scientific Assembly brings yet another chance for reform.

For those of you who are still loyal ACEP followers, I invite your participation in support of the following resolutions:

RESOLUTION ONE — That ACEP board members shall be required to disclose, and publish annually in ACEP News, any personal business investments in emergency medicine related companies.

RESOLUTION TWO — That ACEP's top ten executives shall not have any financial arrangement and /or direct affiliation with any corporate or private organization that financially profits from the field of emergency medicine.

RESOLUTION THREE — That ACEP NEMPAC officers shall be required to report and publish annually the ACEP News any business investments in emergency medicine related companies.

RESOLUTION FOUR — That a separate educational track should be established during the Annual Management Academy conference, with speakers from democratic groups and other institutions dedicated to educate emergency physicians in how to obtain, establish, and operate democratic groups.

RESOLUTION FIVE — That the ACEP board seek legal council to incorporate the principles of the Noerr-Pennington Doctrine into the ACEP anti-trust policy.

RESOLUTION SIX — That ACEP News shall be directed to publish an article providing a full discussion of the issues and opinions of both parties of the Coastal Inc. v. Schwartz lawsuit,

CONTINUED ON NEXT PAGE

and that both parties be allowed to include in the article the address of donation funds privately established for the litigation of this case.

RESOLUTION SEVEN — That ACEP should fund a study of its members to determine what type of practice environment they would prefer, and that if members prefer democratic groups, ACEP should provide a strong educational educational effort, including sponsored books, conferences, and lectures on how to establish local democratic groups.

RESOLUTION EIGHT — That the lobbying efforts of ACEP should be directed toward federal and state legislation which would ban peer-review exclusion clauses and due process exclusion clauses from emergency physicians contracts.

RESOLUTION NINE — That the lobbying efforts of ACEP should be directed toward federal and state legislation, which would ban the sale of emergency department contracts.

RESOLUTION TEN — That all candidates for the board of directors and principle council officers shall submit a full disclosure statement specifying their employment as well as any financial interests in any organization affiliated with the medical and business aspects of emergency medicine and this disclosure shall be published to the membership prior to election.

RESOLUTION ELEVEN — That ACEP create a task force in association with AAEM and AEP to establish suggested guidelines for businesses involved in the practice of managing emergency physicians.

RESOLUTION TWELEVE — That ACEP add a fourth category to the Conflict of Interest Disclosure Certificate:

Describe any positions of personal or family material financial interest in any outside concern, which financially profits from the clinical practice of emergency medicine (i.e., ownership or decisions making position in a contact management company, billing company, sole proprietorship, book company, medical supply company, malpractice insurance company, etc.)

RESOLUTION THIRTEEN — That ACEP bylaws, ARTICLE II — PURPOSES AND FUNCTIONS OF COLLEGE, Section 2 — Purposes and Objectives, be amended by the addition of number 14, which will read, "To promote fair and equitable practice environments necessary to allow emergency physicians to deliver the highest quality of patient care. Such a practice environment does not favor the use of restrictive covenants."

RESOLUTION FOURTEEN — That the lobbying efforts of ACEP should be directed toward federal and state legislation, which would ban the non-compete clause from emergency physician contracts.

RESOLUTION FIFTEEN — That the ACEP bylaws, ARTICLE II — PURPOSES AND FUNCTIONS OF COLLEGE, Section 2 — Purposes and Objectives, be amended by the addition of number 15, which will read, "To promote fair and equitable practice environments necessary to allow emergency physicians to deliver the highest quality of patients care. Such a practice environment include the right of due process."

Common Sense
The Newspaper of
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WHY DOES ACEP MEMBERSHIP COST SO MUCH – PART 2

Scott Plantz, MD FAAEM

In the last edition of *Common Sense*, I mentioned that Dr. Colin Rorrie's salary plus benefits was over $350,000. I was in error, according to Colin Rorrie, Ph.D., speaking at the September ACEP Scientific Assembly; his annual salary is only **$240,000**.

In writing the article, I based the $350,000 figure on the 1993 ACEP tax return. It stated Dr. Rorrie's compensation was $270,625.67. Since most companies' non-taxable benefits generally are an additional 30% of the base salary, I estimated his salary plus benefits at over $350,000. I stand corrected and apologize. Apparently, his salary plus benefits in 1993 totaled only $270,625.67. Interestingly, AAEM has recently obtained a copy of the 1995 ACEP tax return, which shows an annual salary including benefits of $319,594.00. This raises two questions:

First, why is it so much? Few individuals with Ph.D.s in education receive salaries over $270,000. Other than a few contract holding chairmen, I know of few managers of large emergency departments that are paid this well. These individuals are responsible for a similar number of employees and their decisions effect 40,000 to 100,000 people, far greater than the 17,000 members of ACEP. Many chairmen have MDs, Ph.D.s, and MBAs.

Second, why was it so difficult to verify this information with ACEP? A letter to Dr. Rorrie resulted in a referral to Dr. Aghababian. A call and letter to Dr. Aghababian resulted in a long awaited "I'll get back to you." As a law student, I found Texas statutory law suggested that nonprofit organizations are obligated to release executive salaries. ACEP's attorney found a loophole. The bylaws of ACEP revealed the "books of account" are open to member inspection. This too was found not be include Dr. Rorrie's salary. Out of frustration, my attorney threatened to sue. Dr. Rorrie responded with the ACEP News article titled "ACEP Staff

CONTINUED ON NEXT PAGE

Salary Structure." At no point would ACEP officially release Dr. Rorrie's salary plus benefits. Finally, several letters to the IRS by one of our members revealed Dr. Rorrie's salary to be $270,625.67 in 1993.

Although I apologize for incorrectly stating Dr. Rorrie's salary, perhaps the most intriguing question is why did I have to go through such extreme measures to find it? Most likely, ACEP's books are probably protected in the same manner as the average dictator, whose books are open … until you ask to see them! "independent contractors" to maintain ACEP membership or establish policy that restricts voting membership to individuals that have actually trained or are boarded in the specialty.

ACEP'S RESPONSE TO RESOLUTIONS

Scott Plantz, MD FAAEM
Robert McNamara, MD FAAEM

Key resolutions were passed by ACEP Scientific Assembly council after introduction and lobbying efforts by Dr. Robert McNamara and Dr. Scott Plantz. Of particular note are resolutions directing ACEP to promote state legislation to eliminate restrictive covenants and to promote peer review and due process for physicians. The Scientific Assembly rejected, however, fourteen resolutions including efforts to ban sale of emergency room contracts, eliminate ACEP's leaders financial ties to corporations, which may represent conflict of interest, to disclose the salaries and benefits of its leaders, and to limit its active voting membership to board certified physicians.

Key Resolutions Passed:

1. That ACEP use its resources to develop and promote model state legislation to eliminate the use of restrictive covenants in emergency medicine.

2. That the ACEP board incorporates principles of the Noerr-Pennington Doctrine into the ACEP anti-trust policy in order to educate members as to what legal issues can be discussed.

3. That ACEP investigate legislation protecting and promoting peer review and due process for emergency physicians.

4. That ACEP amend its Conflict of Interest Certificate by addition of the following language:

> *Describe any positions of personal or family material financial interest in any outside concern, which financially profits from the clinical practice of emergency medicine (i.e., ownership or decisions making position in a contact management company, billing company, sole proprietorship, book company, medical supply company, malpractice insurance company, etc.)*

5. That ACEP study its members to determine what type of practice environment they would prefer.

6. That ACEP News be directed to publish an article providing a full discussion of the issues and opinions of both parties of the Coastal Inc., vs. Schwartz lawsuit. (Still not done as of February 1996).

Key Resolutions Failed:

1. That the lobbying efforts of ACEP should be directed toward federal and state legislation, which would ban the sale of emergency department contract.

2. That ACEP limit its future active (voting) membership as of January 1, 1997, to those physicians certified by ABEM.

3. That ACEP's top ten executive shall not have any financial arrangement and/or direct affiliation with any corporate or private organization that financially profits from the field of emergency medicine.

4. That ACEP make public to the members the exact salary and benefits paid to the top ten staff including the executive director.

5. That ACEP board members shall be required to disclose and publish annually in the ACEP News, any personal business investments in emergency medicine related companies.

6. That all candidates for the board of directors and principal council officers shall submit a full disclosure statement specifying their employment as well as any financial interest in any organization affiliated with the medical and business aspects of emergency medicine and this disclosure shall be published to the membership prior to election.

7. That the ACEP bylaws, ARTICLE II — PURPOSES AND FUNCTIONS OF COLLEGE, Section 2 — Purposes and Objectives, be amended by the addition of number 12, which will read, "To promote fair and equitable practice environments necessary to allow emergency physicians to deliver the highest quality of patient care. Such a practice environment does not favor the use of restrictive covenants."

8. That the ACEP bylaws, ARTICLE II — PURPOSES AND FUNCTIONS OF COLLEGE, Section 2 — Purposes and Objectives, be amended by the addition of number 15, which will read, "To promote fair and equitable practice environments necessary to allow emergency physicians to deliver the highest quality of patients care. Such a practice environment include the right of due process."

9. That the president of ACEP shall be elected from the council rather than from the board of directors.

10. That the councilors shall be elected rather than appointed, from active, life, candidate, or honorary members.

11. That a separate educational track should be established during the Annual Management Academy conference with speakers from democratic groups and other institutions dedicated to educate emergency physicians in how to obtain, establish, and operate democratic groups.

12. That both parties be allowed to include in the article the address of the donation funds privately established for litigation of the Coastal Inc., v. Schwartz lawsuit.

13. That the ACEP state chapters have the opportunity to decide if members are required to also be members of national ACEP.

14. That ACEP create a task force in association with AAEM and AEP to establish guidelines for legislation involved in the practice of managing emergency physicians.

Upcoming Conferences: AAEM Sponsored and Recommended

AAEM is featuring the following upcoming endorsed, sponsored, and recommended conferences and activities for your consideration.

For a complete listing of upcoming endorsed conferences and other meetings, please log onto http://www.aaem.org/education/aaem-recommended-conferences-and-activities.

September 16-20, 2013
- DevelopingEM 2013
  Havana, Cuba
  http://www.developingem.com/

September 18-19, 2013
- AAEM Pearls of Wisdom Oral Board Review Course
  Las Vegas, NV
  http://www.aaem.org/education/oral-board-review-course

September 21-22, 2013
- AAEM Pearls of Wisdom Oral Board Review Course
  Chicago, IL
  Dallas, TX
  Los Angeles, CA
  Orlando, FL
  Philadelphia, PA
  http://www.aaem.org/education/oral-board-review-course

February 11-15, 2014
- 20th Annual Scientific Assembly
  New York, NY
  http://www.aaem.org/education/scientific-assembly

AAEM-RECOMMENDED CONFERENCES

September 27-29, 2013
- The Difficult Airway Course: Emergency™
  Baltimore, MD
  www.theairwaysite.com

October 28-30, 2013
- The Crashing Patient: Resuscitation and Risk Management Conference
  Baltimore, MD
  www.thecrashingpatient.com

November 22-24, 2013
- The Difficult Airway Course: Emergency™
  Las Vegas, NV
  www.theairwaysite.com

March 14-16, 2014
- The Difficult Airway Course: Emergency™
  Orlando, FL
  www.theairwaysite.com

April 4-6, 2014
- The Difficult Airway Course: Emergency™
  Las Vegas, NV
  www.theairwaysite.com

May 2-4, 2014
- The Difficult Airway Course: Emergency™
  Boston, MA
  www.theairwaysite.com

May 30-June 1, 2014
- The Difficult Airway Course: Emergency™
  Dallas, TX
  www.theairwaysite.com

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

November 14-16, 2014
- The Difficult Airway Course: Emergency™
  San Diego, CA
  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 Marcia Blackman to learn more about the AAEM endorsement approval process: mblackman@aaem.org.

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

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The Business of Emergency Medicine

The Benefits of Physician Ownership

Greg Thomson, CPA
Executive Vice President
Medical Management Professionals

When taking over a new ED or making the transition from employees to an independent group, emergency physicians must choose a strategy about how best to organize and staff the enterprise. Most emergency groups today are structured around either independent contractor relationships, physician employees, or owner-partner physicians.

Evaluating the benefits and drawbacks of each approach, within the context of the group's needs and circumstances, is key to selecting the most appropriate business model. That said, emergency groups that follow the physician ownership path typically enjoy the widest range of advantages over the long term.

With a properly structured physician-owned group, individual physician incentives and group mission are aligned, workforce stability is maximized, and continuity in hospital relationships is enhanced. Given the complexities associated with this approach, however, some physicians elect to enlist qualified third-party practice managers and billing vendors to assist in establishing and operating the business.

The Independent Contractor Model

An independent group contracting with sole-proprietor physicians offers perhaps the simplest and fastest way to get a newly independent practice off the ground. On the plus side, contracting eliminates the need for creating payroll and benefits packages and therefore reduces administrative overhead. Paying physicians an hourly rate on a contractual basis also gives practices the flexibility needed to quickly adjust staffing to meet changes in patient volume. In many markets, physicians can be drawn from a large pool of full or part-time contractors.

The downside of using independent contractors is that there are no built-in incentives for motivating physicians to optimize collections through more effective documentation and coding. This presents a significant and chronic impediment to improving financial performance in an increasingly difficult marketplace. In addition, drawing from a large pool of physicians to meet shift requirements may undermine continuity in the emergency department. It can create a perception of instability in the hospital administration and medical staff. A "revolving door" of new or infrequently seen faces through the emergency department may undercut confidence in emergency services.

Employed Physicians

Hiring physicians as employees represents the second common business model for emergency groups. Benefits of this approach include greater workforce stability and improved continuity of care. In this model, group owners are not required to share profits, but can still attract and retain good talent through appropriate compensation and benefits packages. Employed status is attractive to many physicians because it provides a stable work environment with a steady income. It also eliminates the risks and responsibilities associated with ownership.

Unlike contractors, however, employed physicians do not have any inherent incentive to support revenue optimization. And while they may be more receptive to coding and documentation education than contractors, they are nonetheless susceptible to an "hourly worker" mentality that may inhibit a shared and aggressive commitment to organizational goals. In addition, groups that adopt the employed physician model — unlike those who use independent contractors — must support a range of administrative functions that include income tax withholding, Social Security taxes, and benefits administration. This increases practice overhead as well as practice manager responsibilities.

Physician Ownership Model

The most significant benefit for emergency groups that form around a physician ownership model is that individual goals are aligned with practice goals — it's "All for one and one for all." Physicians are more likely to sustain a commitment to optimizing collections and providing outstanding service if they own the practice. Likewise, enlisting physician involvement in hospital-driven initiatives, like practice benchmarking, becomes easier if doctors understand that they'll benefit from the effort.

Because the group's survival and success depends on maintaining the hospital contract, anything that supports a commitment to improving the group's relationship with the hospital and the medical staff is a plus. With equity ownership, physicians are more inclined to take a proactive role in accomplishing this, whether through involvement in hospital committees or by leading quality assurance initiatives. Similarly, an equity ownership structure can promote practice strength by fostering constructive, long-term working relationships between the stable group of owner-physicians and the referring medical staff.

It should be noted that there is a downside to physician ownership, at least in the initial stages. Creating a shareholding organization — be it a partnership, professional corporation (PC), limited liability corporation (LLC), etc. — is a task that requires time and resources. A fair compensation structure that can take into account different levels of productivity, both administrative and clinical, must be developed. In addition, a process for entering and exiting practice ownership must be established. The administrative responsibilities of running an emergency medicine practice must be met.

Qualified Assistance

Many emergency physicians lack the skills, confidence, or inclination to establish and maintain a physician-owned organization. That's why some groups choose to outsource many of the associated duties. Beyond helping with the legal creation of the new entity and the tasks associated with that process — establishing bylaws, setting up compensation mechanisms and benefits, shopping insurance and the like — a

Continued on next page

qualified consultant will provide assistance in negotiating managed care and hospital contracts. In addition, outsourcing the coding and billing process to an experienced billing provider will help ensure optimal reimbursement and consistent cash flow over the long term.

Note how owning your practice and hiring outside help differs from working for a contract management group (CMG), such as Team Health or EmCare, among others. When emergency physicians own the practice they see the books and are aware of revenue and expenses, they decide who to hire as a management consultant and how much to pay that consultant, and they have the power to fire that consultant. They make the decisions about where to purchase malpractice insurance and other benefits. Most importantly, the physician-owners reap the benefits of their practice rather than enriching others before themselves, and are individually invested in the success of the practice — and thus in the prosperity of their hospital.

Improved Income, Stronger Relationships

The physician ownership business model is unquestionably more complex than the alternatives. It nonetheless provides physicians with the greatest potential for income growth and long-term independence and stability. Perhaps most importantly, it fosters an environment conducive to positive, stable hospital relations and gives individual emergency physicians the greatest incentive to perform at the highest level. So remember, if you want to start an independent emergency medicine group there are plenty of places to go for help. AAEM's Practice Management Committee will provide advice, and many private companies (including my own) are available to provide assistance with management, coding and billing, payroll and benefits administration, etc. You are not alone and can be successful without prior business experience.

Greg Thomson, CPA is the executive vice president for Medical Management Professionals, Inc. (MMP). He leads a team of professionals providing practice management services to radiology, anesthesia, and emergency medical practices, bringing more than 20 years of health care experience to the company. ■

Through the Patient's Eyes

Delivering Life-Changing News

Craig Norquist, MD FAAEM
Chair, Practice Management Committee

Through our many years of training in medical school and residency, we learn an incredible amount about physiology, pathophysiology, diagnosis, and interpreting test results. As best I can remember, no one ever taught me how to deliver serious news. It is easy telling a hopeful couple that their attempts at pregnancy have been successful, or that the feared broken bone is just a bruise, but it is not so easy to tell someone very bad news. Telling a loved one that their family member died is never easy, and hopefully it will never get easy. If it does, you might want to consider a break from medicine in order to rediscover your humanity. I have learned a few things in doing this over the last decade. First, ask the family to describe the events that led up to the patient's arrival at the ED. Second, reassure them that they did everything possible and nothing was their fault. Finally, use simple and clear words so there is no misinterpretation. Say "dead" or "died," not "expired" or "passed." Once the news is given, hardly anything else you say will be heard or understood for some time. That is why it is essential to have a case manager or someone with you to take over, so that you can step away. Always offer to return to answer more questions when they arise, no matter how busy the department might be. No matter how busy or stressed you are, this family has suffered a tremendous loss and their lives have changed forever. There is no more important time for a physician to be available.

Telling a patient they have cancer or another life-threatening disease also takes skill and tact. In this situation, the patient and family will most likely be numb once words like "cancer," "tumor," or "life-threatening" are used, so it is crucial to present as much information as possible prior to using such words. Give the patient and his family reasonable hope. Point out that the diagnosis is uncertain and further tests are required to verify your impression, and it is possible that some other process is mimicking the dreadful, worst-case diagnosis. Many times the diagnosis we make in the ED is not the correct one. I remember vividly, even hauntingly, telling a woman that she probably had lung cancer based on the radiologist's read of a spiculated nodule on a chest CT performed to rule out PE. It later turned out to be valley fever, or coccidiomycosis. I learned the value of humility and the danger of premature certainty when a diagnosis carries such incredible weight, and a biopsy or other definitive test result has not yet been obtained.

Give hope that if the diagnosis is cancer, or something equally fearful, there have been and continue to be promising advances in medicine and technology, and this diagnosis might not be as bad as it would have been 20, 10, or even five years ago. Many patients are now cured of their cancers. Giving realistic hope is crucial, but being honest and open with the patient is at least as important. Sitting at the bedside, touching the patient, and giving him time to process the information are all critical parts of delivering bad news. This is no time to seem rushed and eager to leave the room.

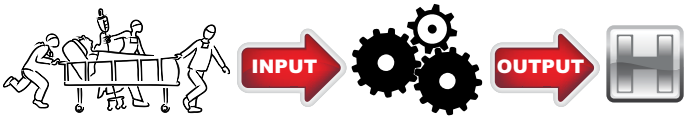
While I personally do not teach courses on delivering bad news, and haven't even taken a formal course on the subject, in May of this year I was diagnosed with lymphoma. In the last several weeks I have gone through almost every emotion possible, and am coming to grips with the diagnosis. I hope to use what I am going through to become a better practitioner and healer. I promise to share any pearls I discover, so that all of us can take better care of our patients. In my next article I will talk about the anxiety associated with waiting for test results, and how we can do a better job of managing that. ■

Cracking the Code: Fixing the Crowded Emergency Department, Part 1 — Building the Burning Platform

Joseph Guarisco, MD FAAEM
Chair, Operations Management Committee

This is the first in a three-part series looking at crowding as a critical ED operations issue. In the submission that follows, we will explore the management failures that lead to this phenomenon. In the final installment, I hope to show that this issue is not without a solution if one understands demand and variance, and applies commonly accepted demand management tools.

The emergency department can be thought of as a factory in which work flow is described as "a patient arrives, stuff happens, and the patient leaves." Of course we all know it's much more complex than that, but it is important that we understand throughput in emergency medicine and break work flow down into three basic components: input, throughput, and output.

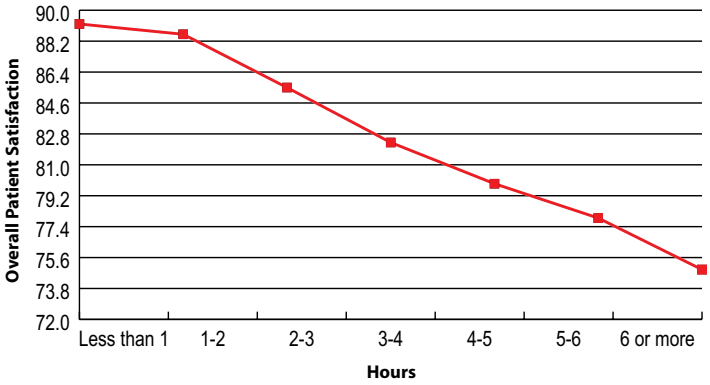


In this series, I will focus on various input models that have been deployed in an attempt to solve the problem of ED crowding, an issue well-known to all of us who practice contemporary emergency medicine. Has the cost of fixing this problem prevented us from successfully addressing it? Have we priced ourselves out of good care, good service, and good quality? Are capital and labor costs simply too high to meet the demands of the ED without going broke? The answer that we must face: if we continue to design operations using traditional staffing and work flow models, then we have indeed priced ourselves out of business from a service and quality perspective. I include quality in that equation, because I will show that meeting the time demands of our patients is part of quality. Because of cost, the traditional operations model does not allow for adequate resources to meet the goal of providing care on demand. This means "no waiting" for emergency services — regardless of acuity. It is imperative that we take a totally new approach to the way we process patients in the emergency department, and this will require adopting new models of care related to how we manage demand. Specifically, how we deploy and utilize space and staff in our departments.

To understand the solution that I will propose in a later part of this series, change management must be understood. The proposed solution will require significant change in how we practice emergency medicine. As Joseph Kotter wrote in his work on managing change, the first step is creating urgency — a "burning platform" for identifying common goals and fostering a sense of shared purpose among stakeholders. In the case of health care, this means we must first create "a sense of need ... a sense of importance to the matter and come to an understanding that it is the right thing to do for our patients … thus 'the burning platform.'"

Let's start with patient satisfaction and the well-known fact that the patient experience is tightly linked to wait times. The graph below shows the predictable linear relationship between waiting and patient satisfaction in the ED.

Patient Satisfaction by Time Spent in ED



Health Leaders Media surveyed hospital leaders in 2011, asking them to rank clinical areas in terms of difficulty in achieving improved efficiency and cost reduction. The top-ranked "most difficult" clinical area in that survey was the emergency department, as voted by 65% of respondents. A follow-up question asked for the greatest strategic challenge for the ED, and the number one challenge — ranked by 43% of respondents — was "patient flow." Putting all this together, it is clear that hospital leaders consider throughput in their EDs to be their number one management problem.

Please rate the following clinical areas on the difficulty of achieving results in improved efficiency and cost reduction.

	Very difficult 1	2	3	4	Not at all difficult 5
Emergency department	30%	35%	23%	10%	1%
Surgery	19%	29%	30%	19%	3%
Inpatient/med-surg/critical care	13%	37%	33%	14%	2%
Imaging	8%	20%	39%	28%	6%
Pharmacy	6%	25%	34%	28%	8%
Lab	4%	19%	42%	28%	6%
Outpatient/ ambulatory	4%	21%	40%	28%	6%

Base = 250

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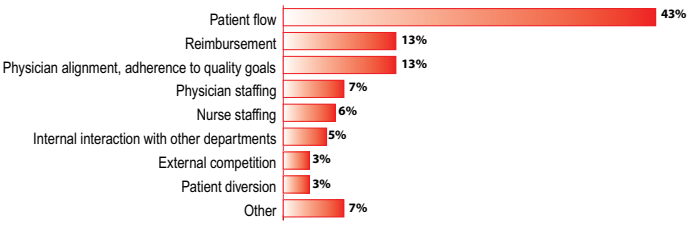
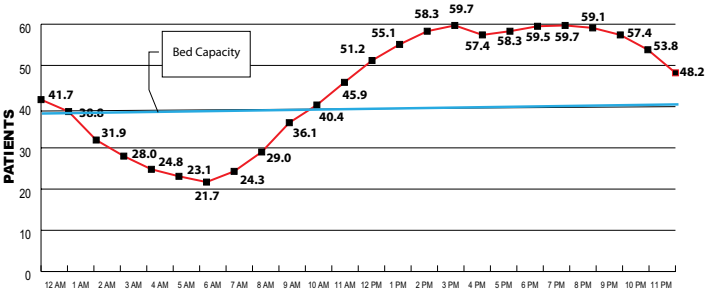
What is the greatest strategic challenge regarding your ED?



Base = 250

This has huge implications for physician groups, both corporate mega-groups and independent democratic groups that want to remain competitive. Solving this problem requires visualizing that burning platform for change.

First we must understand the capacity constraint, classically represented by the graph below.



On any given day in most EDs, the actual census (defined as patients "between the front door and the back door," or between arrival and discharge) can be 50 to 100% larger than capacity (defined as the number of physical beds). The graph above shows an actual ED with a bed capacity of 40 and nearly 60 patients at peak census. Where are those extra 20 patients? The waiting room, of course. The objective is to create more space for patient encounters without going broke, or better yet without any additional cost at all. But creating additional physical capacity at little or no cost is only part of the solution. Just as important is creating a staffing model (labor capacity) that can take advantage of the extra physical capacity, resulting in improved service to patients. That means a bed utilization and staffing plan that can adapt to a highly variable but still predictable service demand environment, an environment that exists in other industries besides our own.

How urgent is this? In 2012 the *Annals of Emergency Medicine* published "Impact of Emergency Department Crowding on Outcomes of Admitted Patients," an article that confirmed that overcrowding was growing at a significant rate across the United States, in that the number of EDs reporting this problem had grown twice as fast as ED volume. This means that something in the way we practice emergency medicine has changed and is aggravating ED crowding. The authors of that article also noted that mortality in EDs identified as being crowded was moderately higher than in those that were not identified as being crowded.

Last year two high-profile stories were published, one in the *New England Journal of Medicine* and the other in *The New York Times*. The first, by Dr. John Maa, details the death of his mother due to delays in care in the emergency department. Dr. Maa says that we must confront our "unwillingness, not inability, to reduce the waits and delays that bedevil emergency care that are harming and even killing our patients."

The second tells the story of Sabrina Seelig, who died of an overdose in a New York hospital. Seelig's mother frames it in a way just as poignant as Dr. Maa, saying, "No one should go to a hospital without someone with you. Don't go unless someone at least knows you're there." How telling is that statement about the perception of care in our emergency departments?

Dr. Maa's and Ms. Gibson's statements were published in two of the most influential publications in our country. We must do something to improve both the reality and the perception of care in crowded emergency departments in the United States.

Dropping this emotional angle, let's look at another issue: money, and the cost of doing nothing. The chart below shows that in an ED with 50,000 visits per year and an average payer mix, the net revenue loss for every 1% of patients who leave without being seen (LWBS) is about $450,000 per year. Considering that crowded EDs can have LWBS rates in the range of 3 to 5%, the amount of lost revenue in just one such ED is measured in millions of dollars.

- Net revenue (actual LWBS payor mix)
  - Outpatient facility net revenue @ **$300/visit discharge** (90% of visits)
  - Inpatient facility net revenue @ **$5,000/visit admission** (10% of visits)
  - Professional provider net revenue @ **$125/visit** all (100% of visits)
- 1% LWBS @ 50,000 visits **= 500 visits**
- Lost opportunity net dollars for every 500 visits LWBS
  - **$135,000** facility outpatient revenue (450 pts x $300)
  - **$250,000** facility inpatient revenue (500 pts x $5,000)
  - **$62,500** professional revenue (500 pts x $125)
- Cost of 1% LWBS AT 50,000 volume = **$447,500**

Another factor to consider: at 50,000 visits per year, with an average visit lasting three hours, a one-hour improvement in length of stay creates the capacity for 20,000 more patients per year and results in $10 million in additional net revenue.

- 60.000 ED Visits x 1 Hr LOS reduction = 60,000 hrs bed capacity
- 2 Hours/Visit = 30,000 potential new visits
- 3 Hours/Visit = 20,000 potential new visits
- 20,000 new visiits x $100/Visit = $2,00,000 pro fees
- 20,000 new visits x $400/Visit/Facility = $8,000,000 facility fees

In addition, the city of New York has decided to create 13 performance indicators for its public hospitals, one of which links reimbursement to how quickly patients get from triage to the ED bed. That puts more money on the line.

Further linking pay to performance, CMS will look at throughput efficiency as part of its performance incentive package. Specific factors include LWBS percentage, elapsed time from arrival to the decision to admit, and elapsed time from that decision to actual admission. The point is that there is more than one way to lose money from poor throughput. Payers are beginning to pay less based on the failure to meet emergency department service metrics.

Finally, the Studer Group published an interesting analysis showing that malpractice risk is four times greater in emergency departments with an

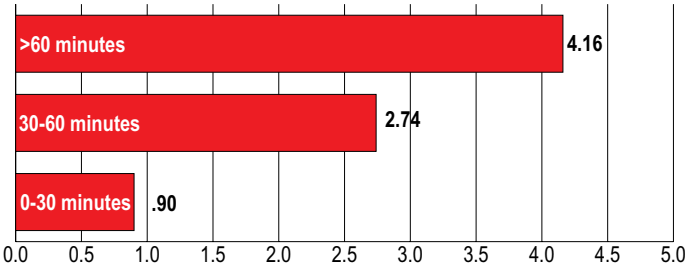
Continued on next page

average wait greater than 60 minutes, compared to EDs with an average wait of less than 30 minutes.

Shorter ED Wait Times Reduce Malpractice Claims

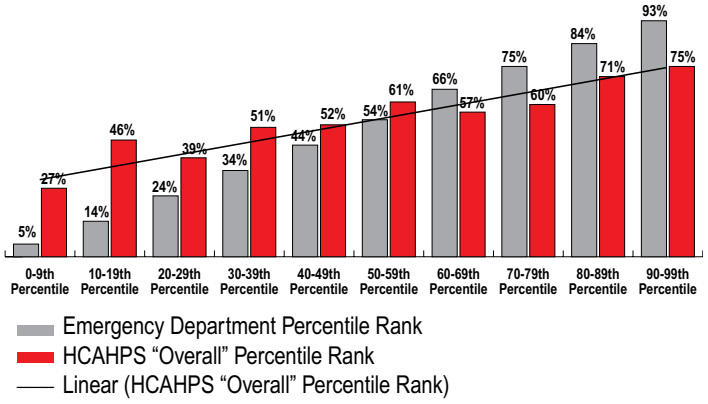
Patients at emergency departments with an average wait time of more than 60 minutes were more than four times as likely to file a malpractice claim than patients at emergency departments who waited less tha 30 minutes. *Courtesy of CEP America Physician Partners, Emeryville, CA, 2006*

Claims per 25,000 patient visits



Not only is poor throughput linked to morbidity and mortality; to direct financial risk from LWBS patients; to indirect financial risk through pay for performance; and to higher malpractice risk; it is also linked to low patient satisfaction, as shown in the graph below, and to lower overall organizational and hospital satisfaction, as well as lower HCAHPS percentile ranks. The HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) survey is a standardized survey instrument and data collection methodology, that has been in use since 2006 to measure patients' perspectives on hospital care.

Relationship: ED And HCAHPS "Overall" Percentile Rankings



The bottom line: a hospital cannot do well financially — or from a credibility and reputation standpoint — without a well-run, highly efficient emergency department.

Understanding this reality should create a sense of shared purpose between hospital administrators, emergency physicians, hospital employees, and the entire medical staff in addressing this critical issue.

In part two of this series on improving ED operations, we will look at defining emergency medicine based on clinical data. This will lead to an understanding of the fundamental flaw in demand management that creates crowding. In part three we will look at a solution to the crowding that endlessly befuddles ED managers and administrators. See you next time. ■

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Anesthesiology Critical Care Medicine Certification Approved for Emergency Physicians

American Board of Emergency Medicine (ABEM)

On June 26, 2013, the board of directors of the American Board of Medical Specialties (ABMS) unanimously approved certification in Anesthesiology Critical Care Medicine (ACCM) through a joint sponsorship of the American Board of Anesthesiology (ABA) and the American Board of Emergency Medicine (ABEM). This co-sponsorship arrangement provides an opportunity for emergency medicine residency graduates to pursue a unique two-year ACCM fellowship training pathway. Upon successful completion of that training, qualified physicians will be able to seek ACCM subspecialty certification.

Any Accreditation Council for Graduate Medical Education (ACGME)-accredited ACCM fellowship program that wishes to offer a two-year fellowship must first apply to the ABA for approval. The eligibility criteria, timeline, and administrative process for emergency physicians to access the ABA Critical Care Medicine Certification Examination, as well as the application process for ACCM fellowship programs are available on the ABA and ABEM websites (www.theABA.org and www.ABEM.org).

ABA President, Douglas B. Coursin, MD, stated that "ABA is pleased to see the culmination of the many efforts of members of the anesthesiology and emergency medicine communities in helping to create this new CCM pathway founded on an interdisciplinary and multi-professional approach to the care of critically ill surgical and medical patients."

ABEM President, John C. Moorhead, MD, stated that, "ABEM appreciates the collaboration with the American Board of Anesthesiology to develop this opportunity, which further recognizes the significant interest in critical care medicine within the emergency medicine education community."

ACCM becomes the eighth subspecialty available to ABEM-certified physicians along with Emergency Medical Services, Hospice and Palliative Medicine, Internal Medicine-Critical Care Medicine, Medical Toxicology, Pediatric Emergency Medicine, Sports Medicine, and Undersea and Hyperbaric Medicine. ■

Exhibiting at American Hospital Association

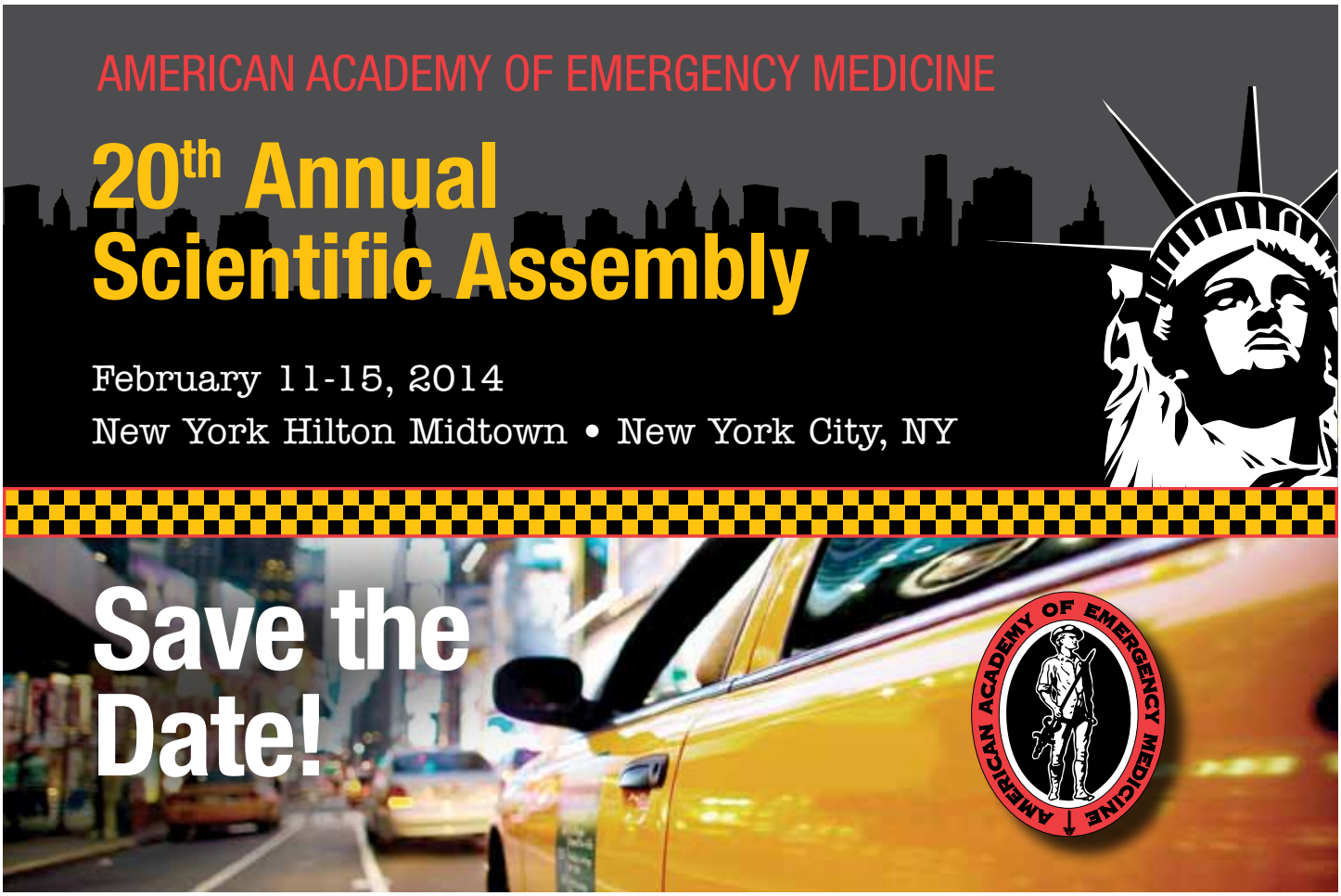
Leslie Zun, MD MBA FAAEM
AAEM Board of Directors

AAEM's president, Dr. Bill Durkin, and I staffed the Academy's exhibit at the American Hospital Association Leadership meeting in San Diego in July. The meeting was attended by a record number of approximately 1,900 attendees. Representatives from surgery and pathology organizations were also at the meeting. EmCare and Team Health had exhibit booths as well, making AAEM's booth a refreshing change for some attendees.

The Academy's exhibit booth has been redesigned to better address the audience of hospital CEOs, CNOs, CMOs, and related hospital leaders. Our message at the meeting was clear: independent, democratic groups with board-certified emergency physicians are the best way to staff your emergency department. We also promoted AAEM's consulting services for hospital administrators and groups.

A record number of individuals stopped by the booth to hear our message. Many were confused about the difference between ACEP and AAEM. At least one administrator who currently uses a contract management group now thinks there is a better way to staff his ED. When the time comes, AAEM stands ready to assist him in changing to an equitable, democratic group.

The primary goal of exhibiting at this meeting, getting our message out to hospital administrators, was clearly met. However, it takes time and repetition for our message to reach everyone in our target audience and sink in. This and similar activities must continue. ■



See you in New York!

AAEM's Annual Scientific Assembly — perpetually advancing emergency medicine for the clinician and proudly the premiere clinical conference in emergency medicine.

Scientific Assembly Highlights

- FREE registration for members, with refundable deposit
- 18 different tracks and 11 plenary sessions
- Convenient mobile app featuring the program, exhibitors, and important updates
- "Passport to Prizes" in the Exhibit Hall
- Open Mic Sessions
- AAEM/JEM Abstract Competition and Diagnostic Case Competition
- Focus on prehospital care with the EMS Track
- Learn how to plan ahead with "Lessons Learned from Unforeseen Tragedies"
- Network with emergency physicians from the U.S. and around the globe!

Invite a Friend

If you're a 20 year veteran of Scientific Assembly, or if you are planning on attending for the first time in 2014, 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 clinical-educators in emergency medicine.

Travel to New York

The bright lights of Times Square, the world-famous art institutions, the green expanse of Central Park and exciting annual events all beckon visitors from around the world to New York City each year.

In addition to attending the premiere clinical conference in emergency medicine, take advantage of all the city has to offer. NYC features world-renown dining, sightseeing, shopping, and museums. Check in regularly for up-to-the-minute discounts & offers and free NYC events at www.nycgo.com.

If you're visiting New York City from outside the United States, you may need a visa to enter the country. Visa requirements for entering the United States can be found at: www.aaem.org/education/ scientific-assembly/travel.

Register

Registration for Scientific Assembly will open in the fall of 2013. For up-to-the-minute information about registration and Scientific Assembly — follow AAEM on social media. Visit our new interactive dashboard, AAEM Connect, to view updates from Facebook, Twitter, LinkedIn, the AAEM blog, and podcasts www.aaem.org/connect. Look for hashtag #AAEM14 on Twitter. ■

Nominations Sought for AAEM and AAEM/RSA Awards

Deadline: November 14, 2013 — Midnight CST

AAEM is pleased to announce that we are currently accepting nominations for its annual awards. Individuals can be nominated for the following awards:

New! Administrator fo 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.

Peter Rosen 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 midnight CST, November 14, 2013. The AAEM Executive Committee will review the nominees and select recipients for all awards except the EM Program Director of the Year Award, which will be selected by the AAEM Resident and Student Association.

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.

Award presentations will be made to the recipients at the 20th Annual Scientific Assembly to be held February 11-15, 2014, in New York City, NY.

Complete nomination criteria and the required online nomination form are found at www.aaem.org/about-aaem/awards. Self-nominations are not accepted. ■

American Academy of Emergency Medicine 2014 Elections

Nomination Deadline: November 14, 2013

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

The president, vice president, secretary-treasurer, and three At-Large positions on the AAEM board of directors are open as well as the Young Physicians Section (YPS) director position. 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.

Elections for these positions will be held at AAEM's 20th Annual Scientific Assembly, February 11-15, 2014, in New York City, NY. Although 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.

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.

In order to nominate yourself or another full voting member for a board position, please complete the nomination form and attestation statement found at: **www.aaem.org/about-aaem/elections**

Then send the information listed below to the AAEM office before midnight CST, on November 14, 2013. Any YPS member can be nominated and elected to the YPS director position. The nomination form and required information is the same as that for a board position.

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 candidate statements from all those running for the board will be featured in the November/December issue of *Common Sense* and will be sent to each full voting and YPS member along with the ballot.

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. ■

Advocacy Day 2013

On June 26, 2013, AAEM members spent a day on Capitol Hill discussing the repeal of the Medicare Sustainable Growth Rate and CME prohibition for federal employees with targeted congressional leaders.

(L-R) Dr. Mark Foppe, Rep. Joe Heck (R, NV-3), Dr. William Durkin, and Dr. Andy Walker

William Durkin, AAEM President, speaks with Rep. Steve Scalise (R, LA-1) (Chairman, Republican Study Committee)

Dr. Michael Ybarra (left) and Dr. Alexander Kheradi (right) meet with Rep. Diane Black (R, TN-6) (center)

Dr. Michael Ybarra (right) and Dr. Alexander Kheradi (left) meet with Senator Tim Scott (R-SC) (center)

Current news and updates

can now be found on the AAEM website

www.aaem.org

Advocacy Day

October 9, 2013 | Washington, D.C.

Visit www.aaemrsa.org for more information and to register!

Be a Voice for Emergency Medicine — Join AAEM/RSA on Capitol Hill!

AAEM/RSA invites you to travel to Capitol Hill to meet with congressional members and discuss important health policy issues. We are looking for a group of passionate AAEM members, residents, and medical students to join us for targeted meetings with congressional leaders to discuss medical student debt reform, GME funding, and more. Fly in or drive in for a day of learning about lobbying and putting those skills to immediate use.

No prior hill experience necessary — just knowledge of caring for patients and a passion for improving the health care system!

Tentative Schedule of Events – October 9, 2013

7:30am: Meet at the Offices of Williams & Jensen.
Williams & Jensen, PLLC
701 8th Street NW, Suite 500
Washington, DC 20001

7:30am: Introduction to lobbying led by the Williams & Jensen staff. The training will cover how to work with congress and their staff. Breakfast will be served — be sure to take advantage of this great opportunity!

9:30am: Educational panel discussion about the topics we will be addressing on the hill.

11:45am-12:30pm: Private lunch for Advocacy Day participants with Representative Raul Ruiz, MD. Rep. Ruiz is both an EM trained physician and Congressman representing California's 36th District. Visit the AAEM/RSA website to read Rep. Ruiz's biography.

1:00pm-5:00pm: Scheduled Capitol Hill visits. Members of the Williams & Jensen staff will accompany you on these scheduled visits with congressional leaders. If you need to leave early for a flight, we will be happy to accommodate you. Additionally, if you have a connection or a relationship with a member of congress, Williams & Jensen can work on setting a meeting for you.

Register Today!

There is no cost to register for Advocacy Day, but registration is required so meetings on Capitol Hill can be scheduled. Advocacy Day attendees should make their own travel arrangements.

Visit www.aaemrsa.org/events/aaemrsa-advocacy-day to register. ■

COMMITTEE UPDATE: Academic Affairs

The Academic Affairs Committee would like to provide an update on the projects the committee has been working this past year. Members of the committee have researched emergency medicine journal articles for ABEM's 2015 Lifelong Learning Self-Assessment (LLSA) test. Approximately 60 journal articles were sent to ABEM in May for their consideration.

Finally, with the assistance of the board of directors the committee is studying or working on these projects:

- A White Paper on the *Use of Scribes in the Emergency Department in Academic and Community Settings*
- Proactive advocacy for board certification
- Funding issues for academic emergency medicine
- Resident moonlighting
- ACGME accreditation of osteopathic emergency medicine residency programs

If you are interested in academic emergency medicine issues, please join the Academic Affairs Committee. Submit a brief online application at http://www.aaem.org/about-aaem/leadership/committees. Thank you.

Heatherlee Bailey, MD FAAEM
Chair, Academic Affairs Committee ■

COMMITTEE UPDATE: Finance

Recent Finance Committee activity has focused on our fiduciary duty to protect and grow AAEM's investments. Specifically, developing a long term investment strategy and securing professional oversight by a fund manager. In April, the committee interviewed five investment companies/managers. During conference call interview sessions, each representative proposed specific investment strategies for AAEM, followed by a Q&A session. The Finance Committee reviewed the pros and cons of each proposal and narrowed the selection down to two fund managers. Both were experienced in financial management for non-profit organizations, had well-developed long-term strategies specific to AAEM, and low fees. After further discussion the committee settled on a final recommendation, and a written report was presented to AAEM's board of directors at its May meeting. The board approved the Finance Committee's recommendation of the Churchill Management Group, which has now assumed oversight of AAEM's investments. Thanks to the members of the Finance Committee for their efforts in this important endeavor: Drs. John Christensen, Bill Durkin, Dave Pillus, Mark Reiter, James Wilson, Les Zun, and Chairman Kevin Rodgers.

Kevin Rodgers, MD FAAEM
AAEM Secretary-Treasurer ■

COMMITTEE UPDATE: Operations Management

It's a pleasure to provide a midyear update on the activities of AAEM's Operations Management Committee.

At the 2013 Scientific Assembly in Las Vegas, the committee delivered on one of its key objectives: organizing and delivering a workshop focused on best practices in managing patient arrival and throughput challenges. Attendance was on target with about 40 Academy members. Going forward, the committee plans to develop and execute a second workshop for the February 2014 Scientific Assembly in New York City. This workshop will focus on the impact of the Affordable Care Act and accountable care initiatives on emergency medicine, as they relate to operations in our EDs. It will address what we need to do differently in the future to ensure success. Speakers are being secured for this event now, and it should be an excellent intro to Scientific Assembly.

In the first half of 2013, *Common Sense* published Dr. Frank Gaudio's article on the impact of burnout on physician productivity. This was in follow-up to Dr. Tom Scaletta's late 2012 article on patient satisfaction. These are planned to be the first and second in a continuing series on ED operations.

A third initiative in progress is a podcast series showcasing experts on ED operations. Two podcasts have been produced so far, with the help of AAEM Communications Manager, Laura Burns, and are now available online. These focus on the importance of valuing and improving the patient experience. They are hosted by Dr. Joe Guarisco, with guest expert Dr. Tom Scaletta. Take a listen at aaem.org/publications/podcasts. The series continues in mid-July, in an interview with the widely published LEAN writer Mark Graban, as he discusses hot topics in operations management and current activities of this committee leading into the 2014 Scientific Assembly in New York City.

The committee wants to do more and be more. More helpful, more educational, more of a resource, and more accessible to Academy members looking for solutions to operational problems. And we want more involvement from you! I know this gets harder everyday, as work and life consume more and more of our time and attention. We are working on some projects that will help us do a better job of connecting and communicating. We will keep you posted.

Joseph Guarisco, MD FAAEM
Chair, Operations Management Committee ■

Continued on next page

COMMITTEE UPDATE: Membership

The Founders Circle of AAEM

AAEM is interested in encouraging our members' support for emergency medicine residents and residency programs. Many emergency medicine programs have not been exposed to our mission or values. The future of our specialty and society are in our future emergency physicians. With this goal in mind, the Academy has created the FOUNDERS CIRCLE. This section would serve a dual role of collecting member donations directed to the sponsorship of resident memberships in the Academy. The second purpose would be to direct these donations to specific residency programs which we are encouraging to hear our message. Currently, members of our board of directors visit residencies throughout the country to introduce them to what we stand for and want to pass on to the next generation of emergency physician.

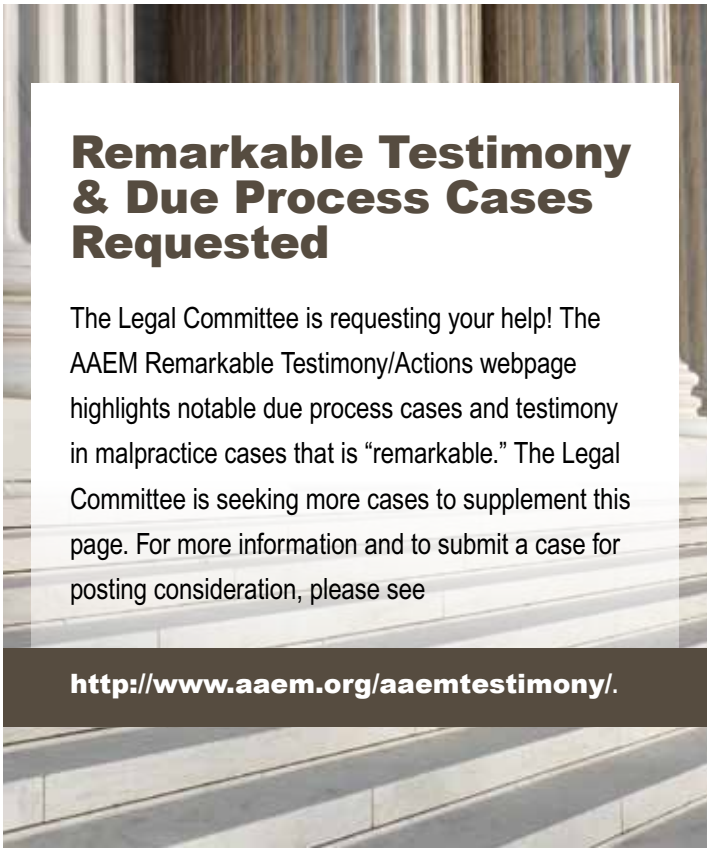
The point of the Founders Circle would be to increase our support for resident membership in AAEM. A member could help support a specific local residency of his/her choosing. We would also hope that this member would be able to become a mentor to this residency and be able to speak to the EM residents if they so decided. In the past, we have had individual members or state chapters donate funds to enroll an entire residency in AAEM for a year. Our increased focus would be to have the donating member or a member of the board speak at the residency program for this donation. This has been well received and appreciated.

Individual emergency medicine groups would also be encouraged to participate in this activity by donating to the Founders Circle or by sponsoring a local residency program. Another idea, which has been very well received, is a group sponsoring a residency's journal club in a more relaxed social setting to expose EM residents to a practice model supported by our mission statement and to see AAEM's ideals in action and practice.

The costs of a resident membership are as follows:
1 year - $55.00 (100% program discount = $50 per Resident)
2 years - $90.00 (100% program discount = $81 per Resident)
3 years - $135.00 (100% program discount = $121.50 per Resident)
4 years - $180.00 (100% program discount = $162 per Resident)
5 years - $225.00 (100% program discount = $202.50 per Resident)

Please consider a donation to the Founders Circle. The residents are our future!

Andrew Mayer, MD FAAEM
Chair, Membership Committee ■



Remarkable Testimony & Due Process Cases Requested

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

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

JOIN A Committee!

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

Subcommittee activities include:

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

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

CHAPTER UPDATE: Great Lakes AAEM

Join the newly formed Great Lakes Chapter of the American Academy of Emergency Medicine (GL/AAEM)! Emergency physicians in Minnesota, Wisconsin, Iowa, Illinois, Indiana, Ohio, and Michigan are eligible to join. GL/AAEM will represent a region with the highest concentration of emergency medicine residencies in the country. Joining GL/AAEM supports the growth and sustainability of emergency medicine residency programs and medical education. GL/AAEM will focus on this region's local issues and promote access to board certified emergency physicians for all. In addition, GL/AAEM will address specific issues facing practitioners in the inner city and in rural areas. Consistent with AAEM's mission, GL/AAEM seeks to promote fair and equitable practice environments throughout the Great Lakes region. Initiated by Dr. Michael Walters, MD FAAEM, and representatives from the Great Lakes area, this chapter is still in its infancy and hopes to hold its first face-to-face meeting in New York, at AAEM's Scientific Assembly in February 2014.

GL/AAEM needs you! We are looking for members from each of the represented states, resident members, and members willing to serve on our board of directors. Please contact info@aaem.org if you are interested in representing your state, serving on the board, or becoming an associate member.

Ronny M. Otero, MD FAAEM ■

CHAPTER UPDATE: Uniformed Services AAEM

The Uniformed Services Chapter of the American Academy of Emergency Medicine (USAAEM) had another successful year that was highlighted by a great pre-conference course in Las Vegas last February, "Introduction to Wilderness and Operational Medicine," led by Dr. Sean Keenan and Dr. Travis Deaton. There was a wonderful turnout at our chapter reception where members had the opportunity to meet and socialize with one another. We look forward to seeing you at our preconference course at the 2014 AAEM Scientific Assembly in New York next February. Please see the AAEM website this fall for details, www.aaem.org/scientific-assembly.

The chapter also launched an interactive Facebook page, AAEM - Uniformed Services Chapter to serve as an open forum where members can express their views, and residents and recent graduates can seek advice from some of their more experienced colleagues. Total USAAEM membership is currently at 178. Chapter members continue to enjoy a free subscription to *West*JEM, as a benefit of chapter membership.

The chapter recently completed an election of the board of directors. We welcome new board members Drs. Brian Hall and Patrick Magajna. Our thanks go to outgoing board members Drs. Robert Thaxton, Cord Cunningham, and Peter Mishky. Below is the current USAAEM board of directors:

President - David Tanen, MD FAAEM
Immediate Past President - Sean Keenan, MD FAAEM
Vice President - David Bruner, MD FAAEM
Navy Representative - Michael Matteucci, MD FAAEM
Army Representative - Brian Hall, MD FAAEM
Resident Representative - Patrick Magajna, MD
Student Representative - Devin Keefe

Thank you,

David Tanen MD FAAEM
President, USAAEM
Capt (ret), United States Navy
Professor of Clinical Medicine
David Geffen School of Medicine at U.C.L.A.
Department of Emergency Medicine
Harbor-UCLA Medical Center ■

JOIN THE NEWLY FORMED
Great Lakes Chapter of AAEM!

This chapter represents emergency physicians from:

- Minnesota
- Wisconsin
- Iowa
- Illinois
- Indiana
- Ohio
- Michigan

Please contact AAEM at
info@aaem.org or 800-884-2236 to join!

IMAGINE YOUR ARTICLE HERE!

YPS is actively seeking new authors to publish articles in *Common Sense.*

If your submitted article is selected for publication, you will receive a $25.00 Visa gift card*, along with a complimentary 1 year YPS membership*.

Need a topic?

Topics listed below have been requested by our members and would be a great place to start. Original topics are still welcomed and encouraged.

- BP Management in Stroke
- Dermatologic Emergencies
- Hand Trauma
- Clinical Decision Rules for Pulmonary Embolism
- Low Risk Chest Pain Protocols
- Pediatric Conscious Sedation
- Updated Toxicology (ex: THC derivatives, bath salts)
- Vertigo
- Billing and Coding Tips
- Managing High Malpractice Risk Scenarios
- How to Deal with Difficult Consultants

Articles should be a maximum of 800 words and cannot have been previously published.

Please submit all articles to info@ypsaaem.org.

** Limit of one*

Attention YPS and Graduating Resident Members

CV & Cover Letter Review

Are you ready?

Enhance your credentials.
Increase your job opportunities.

The AAEM Young Physicians Section (YPS) is excited to offer a new curriculum vitae review service to YPS members and graduating residents.

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For graduating residents, a $25 Service Fee is required, which will be applied to your YPS dues if you join AAEM as an Associate or Full Voting Member. This offer is only valid for the year following your residency graduation.

For more information about YPS or the CV Review service, please visit us at www.ypsaaem.org or contact us at info@ypsaaem.org.

The Art of Decision-Making

Meaghan Mercer, DO
AAEM/RSA President

Medical school teaches an algorithmic approach to decision-making and stresses the importance of corroborating evidence in choosing a final diagnosis or treatment plan. However, emergency medicine is a fantastic swirling pot of people and split-second interactions. In this fast-paced world you have to learn to make decisions quickly. Emergency medicine means using your education, experience, and intuition to make hundreds of decisions every day.

As residents, we seek the key that will unlock the door to excellence in EM. The art of this specialty lies in cultivating rapid cognition and learning to trust your ability to make a decision quickly under stress. You must be able to select a course of action, but at the same time be adaptable, given the bombardment of new data to be processed. Initially we are taught the simple choice of "sick or not sick" when evaluating a patient. This is often not a long, drawn out process — or even one that requires conscious analysis. It is rapid cognition and one of the fundamental skills of our specialty. From there we advance, learning to gather the data we need to make a disposition and plan. As we progress through our training and careers, this skill becomes fine-tuned into the ability to walk into a room and predict the ED course of a patient in the blink of an eye.

Residency is the time to nurture and cultivate this talent. Early in our training we are open, without significant bias or experience in medical care. This is the time to immerse ourselves in every opportunity and see every patient, to gather as much information and experience as we can. We have to be aggressive learners, proactive in getting anyone and everyone we can to teach us. Develop your rapid thinking skills and your intuition, because those connections are formed during residency, and develop good habits and a strong base for your assessments to stand on.

Malcom Gladwell, in his book *Blink*, lays it out perfectly. When arriving at nearly instant conclusions our mind rapidly bounces around, and in those seconds the decisions we reach can be really powerful and important. When aware of this we can fine-tune these skills. We can start to refine the "gut instinct" that is actually the amazing power of our brains, rapidly sorting all our experiences to give us an answer. Listen to your instinct, it is one of the most powerful skills you have.

Residency is also the time to challenge and test that inner voice. You have to evaluate all your decisions while the safety net is there. This process should not be molding yourself to each attending's personal style, but learning your own. You have to integrate many practice characteristics, so that you can develop the critical thinking skills you will need to survive when you are out of training.

As a young resident, I really appreciate the growth my intern year gave me. I watched my colleagues develop the ability to reach sophisticated solutions rapidly. This is a skill that comes naturally to us all. With the new academic year, remain vigilant in this process and be a passionate learner. As a good friend of mine often says, "Stand on your laurels but don't rest on them." ■

Helpful Documents to Navigate Your Career!

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

Helpful Documents for Students

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

Helpful Documents for Residents

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

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

Lessons from a Previous Life

Edward Sigel, MD
AAEM/RSA Publications Committee Chair

I am a late entrant to the world of medicine, having spent 15 years in the world of finance where I worked as a stock and bond trader, venture capitalist, and investment banker. And to answer the question I get from most of my current colleagues: yes, those are actually different things.

On one recent overnight shift, we had a patient brought in by police on "wet" — marijuana laced with PCP — which is a particularly popular drug in Philadelphia these days. After an hour or so of howling like a werewolf from the stretcher, where he was in four-point restraints, the patient calmed down enough to ask for water. Unfortunately he asked the way a three-year-old asks for something, repeating the words "Can I have water?" in such a rapid and repetitive fashion that the words quickly lost all recognizable form, and he even began to get them in the wrong order. In hopes of calming, and more importantly quieting down the patient, I got a cup of water and held it while he drank. As I returned to the nurses' station, one of my fellow residents laughed and asked how I came from flying around the world in business class and arranging billion dollar deals to holding a Dixie cup while some knucklehead on PCP drank from it.

The truth is that the gaps between my old world and my new one are not all that wide. There are a few truisms that have held through all my careers.

1) Everybody Lies

Earlier this year, a study conducted by General Electric with the Cleveland Clinic and Ochsner Health System found its way into the mainstream press, in which 28% of surveyed patients reported that they have lied to their doctors at some point.

Many laypeople and physicians were shocked by this figure. Doctors are supposed to be the one group of people to whom you don't lie. After all, HIPAA and the doctor-patient confidentiality covenant prohibit us from repeating anything that we are told. Furthermore, it seems as counterproductive for someone seeking help with a medical complaint to tell a lie, and thereby risk the possibility of receiving insufficient or inappropriate treatment. (Though to be fair, one can understand a patient's reluctance to tell the truth for fear of embarrassment or in an attempt to please his doctor.)

I read this a different way. Having spent years negotiating over the prices of stocks, bonds, companies, and virtually anything upon which a price tag can be attached, I've learned that every statement must be taken with a degree of skepticism. I would never start a business negotiation with the truth of what I could or would pay. In business school classes on negotiation we're taught to make an opening offer that is "unacceptable but not unreasonable." In other words, we are told to open with a lie. Since I know the person across the negotiating table likely took the same classes and is also opening with a lie, there is nothing immoral or objectionable about the practice — it is simply the way things are done, and both sides of the table are fully aware of the landscape in which we are operating.

After reading the GE-Cleveland Clinic-Ochsner study, I reasoned that it was safe to assume there was a large segment of the remaining 72% who lied to the survey-taker about lying to their doctors, making them not just double-liars but also raising the true figure of those telling mistruths to greater than one-third of all of our patients.

Just as a lie didn't shock me when I was working in finance, neither should it when I'm working in the ED. Of course I'm not advocating that we ignore what our patients tell us. Rather, I'm advising that we avoid falling into traps by limiting our examinations and differential diagnoses based solely on the word of our patients — after all, a third of them may be lying to us.

2) Hindsight is 20/20

I spent several years as a stock and bond trader in Asia, working for an American company. This meant I would be left an order by my America-based colleagues, which I would work on during my day, which was their night. My America-based colleagues would then come to work in their morning, after the Asian markets had closed. Invariably, some of my America-based colleagues would criticize me for not buying their stock/bond at the lowest price of the day, or not selling their stock/bond at the highest price of the day.

Unless you're the Duke Brothers from "Trading Places" and have some insider knowledge about the Florida orange harvest, it is simply impossible to always buy at the bottom and sell at the top. (For anyone who has never seen "Trading Places," I highly recommend it. It will remind you of the days when Dan Aykroyd was skinny and Eddie Murphy was funny … but I digress).

Medicine has its share of those with perfect hindsight. I recently completed my off-service rotation on the internal medicine floors. At one conference, a group of internal medicine residents were presenting an interesting case to an attending nephrologist. They started by saying, "The patient was admitted by the ER because of pneumonia, but that turned out not to be the patient's major problem." Before they could say another word, the attending said, "Of course the ER got it wrong … they always do." The fact that the patient DID in fact have pneumonia, and that it took her own internal medicine residents more than one week to diagnose the patient with diabetes insipidus secondary to long-term lithium use — when the patient denied any past medical history or prescribed medications to the ED team — didn't let our specialty off the hook.

So how do you deal with the colleague who won't take off those 20/20 hindsight goggles? My advice is simple: don't. Those that use the protection of hindsight to make claims which cannot be proven don't deserve our concern. If this nephrologist had the clairvoyance to diagnose

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the patient with diabetes insipidus upon his arrival in the ED, with all the (mis)information available at that time, then I'm guessing she would be lying on the beach of the private island she bought with her lottery winnings, rather than sitting in a poorly lit conference room in the basement of our hospital second-guessing the emergency department.

3) Playing Nice in the Sandbox

In my last job prior to enrolling in medical school, I was in charge of the Mergers & Acquisitions Department of the medical division of a large multinational company. When an acquisition arose, I would assemble a large team of lawyers, engineers, salespeople, accountants, etc., and it was my job to manage and assimilate the work they did. Though all these groups were looking at the same acquisition target, they all assessed the target company differently, focusing on their areas of expertise and interest.

Similarly, in the ED we often find ourselves relying on consultants who will look at the same patient that we are caring for, but focus on their specific areas of expertise and interest.

As it was in a multi-disciplinary team in business, so is it in the hospital — each specialty believes that its realm is the most important and should garner the most attention and resources. As we were about to close one acquisition, I remember getting a panicked call from a patent lawyer on our team telling me the deal had to be canceled because one of the patents of the target company was likely unenforceable. I reviewed these findings and found that the patent in question was not being used by the target company, and was not something that my company had any intention of using. While I expressed my gratitude to the patent lawyer for his diligence, I explained that the patent in question had no binding on the totality of the target company or our interest in buying them. The patent lawyer just repeated, "But the patent is no good."

Just as it was my job as leader of the project to see the forest for the trees, so must we be the ones who treat the totality of the patient, and not just the area of interest of our respective (and respected) specialists.

In a two-part series on conflicts within the emergency department, printed in the journal *ED Management*, several recommendations are given for dealing with conflicts that arise with specialists. For example, if the specialist tells you a patient should be admitted/discharged when you believe the opposite, it is recommended that you listen to the consultant's points but bear in mind that the final decision on such matters is yours. If the specialist says they will not come see a patient who you believe requires urgent attention, suggest that your departments have a discussion about valid reasons for consultation, but such a discussion should be held in the FUTURE. They still need to come now. That way you show that you accept a difference of opinion and are willing to discuss it in a proper forum, but at the same time convey the need for the consultant to see the patient now.

While dealing with the conflicting interests and demanding personalities in medicine can be daunting, it should be of some comfort that similar struggles take place in other professions. Learning to deal with such challenges, whether they be over large financial transactions or life-and-death medical issues, requires a similar level of tact, tenacity, and training.

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Resident Journal Review

Resident Journal Review: Management Strategies for Acute Atrial Fibrillation in the Emergency Department

Authors: Eli Brown, MD; Allison Regan, MD; Kaycie Corburn, MD; Jacqueline Shibata, MD
Edited by: Jay Khadpe, MD FAAEM; Michael C. Bond, MD FAAEM

A more detailed review of the articles can be found online at Medscape.com.

Introduction

Atrial fibrillation (AF) and atrial flutter (AFL) are the most commonly occurring arrhythmias in the United States. Management strategies for AF and ALF emphasize ventricular rate control, cardioversion to normal sinus rhythm, and long-term interventions such as anticoagulation to reduce the risk of stroke. In patients for whom cardioversion is an option, either pharmacological or electrical cardioversion may be considered. While there is a significant amount of literature comparing the effectiveness and safety of pharmacologic versus electrical cardioversion in acute AF, studies which analyze discharge rates and hospital length of stays are becoming more frequent due to concerns over rising health care costs and emergency department (ED) overcrowding. This review focuses on treatment strategies for patients presenting to the ED with acute atrial fibrillation; in particular, rate control versus cardioversion, options for cardioversion (chemical versus electrical), and the safety of these strategies when used in the ED.

Cohn BG, Keim SM, Yearly DM. Is emergency department cardioversion of recent-onset atrial fibrillation safe and effective? *J Emerg Med.* 2013 Apr 30.

This review includes five observational studies totaling 1,593 ED patients with atrial fibrillation, treated by either rate control or cardioversion. The authors sought to determine whether treatment of patients presenting to the ED with recent-onset (less than 48 hours) AF or AFL with direct-current cardioversion (DCC), followed by discharge home, is safe and effective. Potential benefits of this approach include decreased length of stay, decreased cost, and improved patient satisfaction.

Success rates ranged from 85.5% to 97%, with only one (0.06%) thromboembolic complication reported. The one observed stroke occurred within 48 hours of visiting the hospital, in a patient who was not on anticoagulation post DCC.

Unfortunately, none of the studies compared complication rates to a control group of patients treated with alternative strategies. Furthermore, patient satisfaction rates with DCC were not adequately assessed or compared to alternative treatment regiments. Only one article addressed the potential cost benefit of rapid cardioversion, and found no significant cost difference.

Based on this review, DCC should be offered as a safe and effective treatment for patients presenting with new-onset AF or AFL, with success rates ranging from 85.5-97% and the risk of thromboembolic phenomena being as low as 0.06%.

Vinson DR, Hoehn T, Graber DJ, Williams TM. Managing emergency department patients with recent-onset atrial fibbrillation. *J Emerg Med.* 2012; 42: 139-48.

This is a prospective cohort, multicenter study of 206 patients with AF or AFL presenting to the emergency department within 48 hours of symptom onset. Of note, this study is one of the included trials in the review by Cohn et al., discussed above. Cardioversion, whether chemical or electrical, was attempted in 115 patients (56.3%) and was successful in 110 (95.7%). Of these, chemical cardioversion was attempted in 52 patients and was successful in 31 (60%). DCC with procedural sedation was attempted in 83 patients and was successful in 80 (96%).

Of the 206 patients enrolled in the study, 183 (88.8%) were discharged from the ED. Six adverse events in the ED were recorded that required intervention: vomiting, hypotension, ventricular tachycardia, and hypotension. Only four of these events led to admission for observation and no patient died or developed a more severe dysrhythmia. At 45 days after the initial visit, no patient had died and thromboembolic events had occurred in two patients, both of whom developed expressive aphasia within 48 hours of their ED visit. Neither patient was receiving anticoagulation at the time of their thromboembolic event.

Based on their results, the authors conclude that DCC for AF or AFL is highly successful and carries a low risk for adverse events.

Coll-Vinent B, Fuenzalida C, Garcia A, Martin A, Miro O. Management of acute atrial fibrillation in the emergency department: a systematic review of recent studies. *European Journal of Emergency Medicine.* 2013 Jun;20(3): 151-9.

This review includes 14 studies with a total of 2,765 patients who presented to the ED with acute AF. It includes the study by Vinson et al., which is discussed individually above. Measured outcomes include hospital length of stay, discharge rates, effectiveness of DCC versus pharmacological cardioversion, readmission rates, and recurrence rates.

In four articles (Cristoni et al.,[1] Bellone et al.,[2] Vinson et al.,[3] and Dankner et al.,[4]) DCC was compared with pharmacologic cardioversion or with a conservative option, and in all four articles DCC was found to have superior efficacy for conversion to NSR. In the study by Cristoni et al., DCC was compared to pharmacologic cardioversion with amiodarone or class IC antiarrhythmics. Restoration of NSR occurred in 93% of patients in the DCC group versus 51% of those in the pharmacologic cardioversion group (P< 0.001). In the study by Bellone et al., in which DCC was compared with intravenous propafenone, 89.3% of patients treated with DCC had conversion to NSR compared with 73.8% of patients treated with propafenone (P= 0.02). The third study, by Vinson et al., is discussed separately above. The fourth and final trial by Dankner

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et al., is a retrospective study comparing DCC, chemical cardioversion (with propafenone, procainamide, or amiodarone), and rate control (with digoxin, verapamil, or beta-blockers) combined with observation for spontaneous conversion. The DCC group again had the highest rate of restoration of NSR at 78.2% (P< 0.001).

DCC was also found to be associated with higher discharge rates and shorter lengths of stay. Based on their results, the authors conclude that amiodarone is inferior to both class IC antiarrhythmics and ibutilide for chemical cardioversion. Furthermore, in patients with AF sustained for longer than 48 hours, combined DCC and chemical cardioversion was highly successful for conversion to NSR.

In the 13 trials that reported adverse events or complications, there were five early embolic events (0.1% of all patients from all trials), two of which occurred in patients who were cardioverted (one after DCC and one after chemical cardioversion), with the other three in patients being rate-controlled. This suggests that the embolic events may not have been associated with cardioversion itself. Serious adverse events such as hypotension and arrhythmias were infrequent, and no deaths were reported.

Stiell IG, Clement CM, Perry JJ, Vaillancourt C, Symington C, Dickinson G, Birnie D, Green MS. Association of the Ottawa Aggressive Protocol with rapid discharge of emergency department patients with recent-onset atrial fibrillation or flutter. *CJEM*. 2010 May;12(3):181-191.

The Ottawa Aggressive Protocol for cardioversion of patients with AF or AFL in the ED includes eight clinical steps: assessment, rate control, pharmacologic cardioversion, electrical cardioversion, anticoagulation, disposition, plans for patients not treated with cardioversion, and recommended additions to the protocol. The study enrolled 660 ED patients with the primary diagnosis of new-onset atrial fibrillation or atrial flutter, and applied the Ottawa Aggressive Protocol. Pharmacologic cardioversion is first attempted with procainamide, then electrical cardioversion is attempted if pharmacologic intervention was not successful. Patients who undergo successful cardioversion are discharged home within one hour without additional medications.

There were 1,057 ED visits for AF or AFL. Six hundred sixty subjects had the aggressive protocol applied. Of the included patients, 39.6% received rate-controlling medications, 100% received IV procainamide, and 36.8% received subsequent electrical cardioversion. The conversion rates for AF and AFL with procainamide were 59.9% and 28.1%, respectively. The conversion rates for atrial fibrillation and atrial flutter for electrical cardioversion were 91% and 100%, respectively. The rate of

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adverse events was 7.6%, with 3.2% of the patients requiring admission. The most common adverse event was hypotension. No patient suffered stroke or death. Length of ED stay for AF and AFL were 4.8 hours and 6.3 hours, respectively.

This study demonstrates one safe, effective, and time-saving protocol to follow for these patients, using chemical and DCC.

Bickford, CL; Agarwal R; Urbauer DL; Durand JB; Lenihan DJ. Efficacy and safety of ibutilide for chemical cardioversion of atrial fibrillation and atrial flutter in cancer patients. *Am J Med Sci.* 2013 Apr 12.

One of the agents that can be used for pharmacological cardioversion is ibutilide, a class III antiarrhythmic which acts by activation of a slow inward sodium current, thereby prolonging the action potential. While it has been found safe in most instances, ibutilide carries a small risk for induction of torsades de pointes.

This study is a retrospective chart review to assess the efficacy and safety of using ibutilide for cardioversion of atrial fibrillation or atrial flutter in 81 cancer patients. Ibutilide was infused, and if the arrhythmia persisted 10 minutes after the end of the initial infusion, a second infusion of ibutilide was given. Cardioversion was considered successful if conversion to NSR was accomplished during drug administration or up to four hours after the end of drug infusion.

Successful cardioversion with intravenous ibutilide was achieved in 75% of patients, and only five patients (6%) required a second dose of ibutilide. Sixty-eight (84%) patients were taking at least one other medication with the potential for QT prolongation. Although patients who were concomitantly taking amiodarone (47% of study population) were found to have a significant change (mean of 37 milliseconds) in QT interval after ibutilide administration, no adverse cardiovascular events occurred.

The authors conclude that ibutilide is a safe and effective agent for pharmacologic cardioversion of patients with AF and AFL. The two major limitations of this study are its retrospective design and small sample size. The latter raises doubt that the results are sufficiently powered to support the authors' conclusions. In addition, there was no follow-up to assess maintenance of NSR beyond 24 hours.

Biecher GE, Stiell IG, Rowe BH, Lang E, Brison RJ, Perry JJ, Clement CM, Borgundvaag B, Langhan T, Magee K, Stenstrom R, Birnie D, Wells GA. Use of rate control medication before cardioversion of recent-onset atrial fibrillation or flutter in the emergency department is associated with reduced success rates. *CJEM.* 2012 May;14(3):169-77.

In this study researchers reviewed medical records from 1,068 ED patients with AF or AFL of recent onset, to see which variables were associated with successful conversion to sinus rhythm. Six hundred thirty-four patients underwent cardioversion (428 electrical, 354 chemical, and 148 both).

Continued on next page

The researchers calculated that rate and rhythm controlling medications were associated with a reduction in the success rate of subsequent attempts at electrical cardioversion (OR 0.39 [95% CI 0.21-0.74] and 0.28 [95% CI 0.15-0.53] respectively, with both p values <0.001). However, the use of procainamide was associated with an increased success rate for chemical cardioversion (OR 2.32 [95% CI 1.43-3.74] with p value of 0.0002). Notably, only 37% of the chemical group converted, requiring 32.8% of patients in the chemical group to undergo electrical cardioversion.

Based on their results, Biecher et al., recommend not attempting to slow the ventricular response prior to cardioversion in patients presenting with acute AF or AFL. This study is limited by its design as an observational, non-randomized trial.

Conclusion

Atrial fibrillation and atrial flutter are encountered commonly by emergency physicians. While the management of unstable AF or AFL is unambiguous, there are several potential treatment modalities for stable but symptomatic AF or AFL.

Direct current cardioversion appears to be more effective than chemical cardioversion and carries a low risk for adverse effects. Ideally, ventricular rate control should not be attempted prior to cardioversion, as this may be associated with a decreased rate of successful conversion to NSR.

Chemical cardioversion's advantage over DCC is that it does not require procedural sedation. If this is chosen over DCC, procainamide, ibutilide, or a class IC antiarrhythmic should be used. If chemical cardioversion is unsuccessful, DCC should be considered if there are no contraindications.

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Medical Student Council President's Message

Following Up and Following Through

Mary Calderone, MS4
AAEM/RSA Medical Student Council President

"If you have ADD, you're a good fit for emergency medicine." That's the running joke, at least. However, after working my first few shifts in the ED, I've realized that the skill required to effectively manage multiple patients in the ED requires a lot more than a short attention span.

Perhaps observations of the hectic ED environment generated the old adage. After all, it's not unusual to witness an emergency physician answering the phone of a consultant for room 3, while putting in an order for the patient in room 5, while looking at an X-ray for the patient in room 10. This EP may even be simultaneously teaching you, the trusty and eager medical student, as you admire his or her ability to juggle all of the above.

It's one thing to realize that you enjoy the fast paced ED environment that keeps you on your feet and is constantly intellectually stimulating. However, it 's important to remember that such an environment carries with it the responsibility of constantly following up, following through, and tying up loose ends. Avoid the pitfall of minimizing the importance of being focused and goal-directed. The ED environment does indeed require focus on multiple patients and tasks at once, despite an overabundance of distracting and unpredictable stimuli.

Not only must we remember this advice as we reflect on ourselves and what does or does not make us a great fit for emergency medicine, we must employ it during our clerkships and ultimate career as we develop into the best EPs possible. Constantly strive to take full ownership of your patients. Several key pearls for success follow directly from this concept.

For one, frequently reassess your patients. Unlike other outpatient settings, where patients come in for a 15-minute visit and subsequently return home, a patient may remain in the emergency room for hours with an uncertain disposition. Of course efficiency is important in the ED, and no patient desires to wait around needlessly, but time can be a valuable, non-invasive, and cost-effective diagnostic tool. Is your patient who initially presented with chest pain having chest pain now? Is your patient with abdominal pain now demonstrating peritoneal signs despite a dose of Dilaudid? Another key piece of advice is to know what lab and imaging results you're waiting for and check for them frequently. The results can often change your impression of a patient's clinical picture — after all, their purpose is to narrow the differential diagnosis generated by your initial history and physical and ultimately guide your decision-making regarding management and appropriate disposition. Perhaps the patient who presented with a cough, which you initially chalked up to a viral URI, has an obvious infiltrate on the chest X-ray and an impressively elevated lactate. Communicate such updates to your attending. Take it a step farther and think critically about how such findings affect your assessment and plan.

Don't forget to additionally apply "following up" to your interactions with patients at the bedside. Share results with your patients. Thank them for their patience, reassure them that you are actively watching for new results and analyzing how to best care for them. Let them know that a CT scan came back normal, or that an abnormal lab result might signify an underlying process that warrants admission. Ask about their pain and ways in which you can make them more comfortable. Find an appropriate balance of knowing when and how to communicate information without overstepping your boundaries as a student.

When you strive to constantly follow up and follow through, you will actively demonstrate your desire to serve as a team-player as well as a leader. Through taking initiative in this manner you will accomplish more than just learning for the sake of your medical school education. You will contribute to patient care in a meaningful way and leave better prepared to take on the role of resident and ultimately attending emergency physician. On the topic of short attention spans — wait, look, a squirrel! ■

Italian Emergency Medicine: The Fight for Recognition

Michael Wilk, MS2

While in Rome in August 2009, I found myself in one of the busiest emergency departments in the city, watching a young resident treat patients with problems ranging from broken bones to chest pain in a language I could barely understand. As an undergraduate, I participated in grant program called the Ricci Scholarship that afforded me the opportunity to study in Rome and research the topic of my choice: the development of emergency medicine (EM) in Italy. My mentor in Rome was an Italian emergency physician, Gemma Morabito, MD, who connected me with emergency departments (EDs) and ambulance ride-alongs in many Italian cities so I could better understand the past, present, and future of Italian emergency medicine.

Watching TV dramas like *ER* as a child, I always dreamed of one day working in the ED of a hospital like Chicago's County General. The show portrayed the doctors in the ED as some of the most talented and skilled in the entire hospital. Now, as a medical student, I can see for myself just how competitive EM residencies are. Having always thought highly of the specialty and knowing how respected EM is in the U.S., I had no idea of the challenges American physicians faced in establishing EM as a legitimate specialty until I began my project. Arriving in Italy I found an ongoing struggle for EM specialty recognition, strangely similar to the one that occurred in the U.S. three decades ago. When shadowing the young resident in Rome, I realized I was watching history unfold when I learned he was in the country's first-ever class of EM residents.

Much like the U.S. prior to the 1970s, until recently, there were few Italian physicians who wanted to work in EDs. One physician in Venice explained, "Up to about 15 years ago, the idea that the doctors had was that the doctor working in the emergency room was the most incompetent or the youngest in the hospital, who would be sent there just to gain experience." The medical profession in Italy did not recognize EM as a specialty until 2006, and the first residency programs were not established until 2010. Even today over 25 different specialists, from obstetricians to surgeons, are permitted to work in Italian EDs. This causes huge variability in the quality of care. Although Italy is a relatively small country, in terms of land mass, the development and quality of EM training varies significantly by region. In the north and central areas of the country, programs are progressing much more rapidly than in the south. Before 2006, efforts were made to introduce EM courses as components of other medical specialties. For example, a new specialty was developed called emergency surgery, and another emergency subspecialty was created within internal medicine. This approach quickly disappeared.

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Some of the strongest opposition to the new specialty came from anesthesiologists and their associated academic societies. They even went as far as a one day strike in 2006, to shut down operating rooms across the country in protest of this new, "useless" specialty. During an interview with me, an anesthesiologist in Turin insisted that an EM specialty was a waste of training and would be of no benefit in improving patient care. Later I learned that some, particularly anesthesiologists and a few surgical specialists, feared that emergency physicians would not be able to diagnose or perform procedures at the same level as these specialists. Moreover, some feared financial losses from staffing EDs with specialty-trained emergency physicians.

My mentor, Dr. Morabito, is a well-known Italian physician who committed much of her career to disseminating the best practice of EM. As she found her training in internal medicine inadequate to handle the broad range of acute pathology found in the ED, in the 1990s she began searching online for information about EM, as the internet became accessible in Italy. She learned about the rigorous and standardized residency training that EM physicians in the U.S. and other countries are required to complete. In the early 2000s she created an online newsletter, which was expanded into a website in 2009 (medicinaurgenza.org), to help educate and organize thousands of emergency physicians and nurses throughout Italy. Perhaps my generation takes for granted the power of the internet as a gateway to knowledge and advocacy? The enormous success of this website, with countless contributions from international EM societies and other experts, reveals just how big the demand for improving the field was from Italian EM professionals.

In 2003 the region of Tuscany recognized the need to standardize its EM practices, and signed a contract with Harvard University to create the *Tuscany Emergency Medicine Initiative*. A new training program began at the University of Careggi Hospital with three goals: 1) create a group of physicians who would become EM educators, 2) train all Tuscany physicians working in EDs and pre-hospital care systems, and 3) start an EM master's program to bridge physicians into EM specialty training. This international collaboration ultimately trained hundreds of physicians.

Finally, in 2009 the first 26 EM residency programs in Italian history were approved. They accepted their first residents in 2010, who will graduate in 2015. Since Italy follows the European model of medical education, students enter a six-year course of study at a medical college immediately after high school, and residencies are typically five to six years long. EM residents are required to perform a number of clinical procedures such as intubations, central venous catheter insertions, and trauma management. When I asked one of the residents why he had chosen this field, his answer was simple but honest, "I love emergencies." I couldn't help but laugh as I said, "Me too."

On my last day in Italy I hurried to the train station to catch a ride to Florence. Finally making it to the hospital, I walked into a dark, crowded basement room packed with residents and attending physicians, trying to get a glimpse of the man everyone seemed to be so interested in hearing. I felt the hair stand up on my neck as I listened to him speak of his struggles in establishing EM as a specialty in his own country. He lauded the people in the room for standing up for what they believed in, as they forged a path so many groups were intent on destroying. The man was Dr. Peter Rosen. Nearly 40 years after founding one of the first EM residency programs in the U.S., here he was fighting for the same principles halfway around the world. Despite the challenges that remain, Italy has finally established one of the most vital missing links in its health care system, and EM continues to emerge as an important specialty around the world.

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