common SENSE

VOLUME 18, ISSUE 1
SPRING 2011

THE NEWSLETTER OF THE AMERICAN ACADEMY OF EMERGENCY MEDICINE

FAAEM
always means
board certified

PRESIDENT'S MESSAGE
What About ABEM?

Howard Blumstein, MD FAAEM

I have never been involved with a survey that created such a response or caused such a stir.

Last year, AAEM sent out a survey to full voting members asking about the impact of the American Board of Emergency Medicine's (ABEM) Emergency Medicine Continuous Certification process (EMCC). At a retreat held as part of a board of directors meeting, there was broad agreement that the EMCC was a source of frustration for our members. Because the board is always striving to represent the interests of our members accurately, we felt the need to define exactly what our members were thinking. Hence the survey.

(Important note – although I write exclusively about the allopathic boards, my understanding is that the same basic events are unfolding in the osteopathic world.)

The response was surprising. The survey was sent to about 3,000 emergency physicians, 1,151 of whom responded. That is a response rate of 38%, which is a remarkable number given that most surveys struggle to achieve a response rate of 20-25%.

Here is just a brief summary of what we learned. In response to the query "How likely is it that you will allow your board certification to expire at some point in your career before you retire from clinical medicine rather than pursue the MOC process," 52% of respondents indicated that they were likely or highly likely to do so.

With regard to the various components of the EMCC, 65% rated the ConCert component (the test taken every 10 years) as beneficial. However, the Lifelong Learning and Self Assessment (LLSA) and Assessment of Practice Performance components fared less well (47.8% and 6.4%, respectively).

More revealing were the written comments, of which there were 387. Here the unhappiness was palpable. So were the misunderstandings. And so I write this column, in which I wish to make five important points.

First, I want to make absolutely clear that AAEM sees ABEM as its most valuable partner in ensuring quality emergency medical care. Board certification is not a guarantee of high quality care, but we believe the available research clearly shows that board certified physicians outperform non-boarded physicians. AAEM is the only EM organization in the United States that, since its inception, has required board certification for full membership and fellowship. We are proud of that history, and nobody should interpret the survey as an indication that our commitment to ABEM is slipping.

Secondly, the EMCC is not a scheme dreamed up by ABEM. Far from it. The whole concept of continuous certification comes from the American Board of Medical Specialties (ABMS). The ABMS has also defined the various components of the process. Further, state medical boards across the country have been making similar demands for a more rigorous continuous certification process. Simple tallying up a certain amount of CME each year is no longer enough. The state medical boards and the ABMS have been moving their processes ever closer together. I expect that their requirements will become identical (this has already happened in many instances). The only control left to specialty boards like ABEM is to define the details and work out the process.

Third, this is not a giant money making scheme. Yes, it costs a great deal to take all these tests and maintain your certification. But, it also costs a great deal to develop, maintain and administer the tests. ABEM volunteers (examiners and writers) put in a great deal of personal time, as does ABEM leadership. Those who see this as a great conspiracy to reap huge profits from the sweat of the brow of the emergency physician across the nation are just being unrealistic.

However, as my fourth point, ABEM would do well to be more open about its finances. ABEM is not a member organization. It serves the public, not emergency docs. But, it has a significant public relations issue within our community. Finances are a big part of the public relations issue. ABEM should be transparent about where the money is being spent. It should stress what is being done to make sure members get their full money's worth. No reasonable person would begrudge ABEM and its volunteers a comfortable and appropriate working environment and top quality support. Just, please, assure us that money isn't being spent extravagantly.

continued on page 7

INSIDE THIS ISSUE

EDITOR'S Letter

Editor's Letter

David D. Vega, MD FAAEM

Another Great Scientific Assembly

It's hard to believe that Scientific Assembly 2011 has already come and gone. As in past years, the meeting was an overwhelming success. The educational offerings were of the highest quality, with lecturers including some of the finest in our specialty. The record number of poster submissions allowed for an impressive array of abstracts and interesting photo presentations. All of this, and much more, is made available without the major support of Big Pharma and corporate mega groups that plagues other conferences. Combine all of this with the fact that this conference remains free for members, and I have no qualms about calling Scientific Assembly the best conference series in emergency medicine.

Attendance at Scientific Assembly continues to increase in a time when many organizations are seeing much more modest increases in any sort of member involvement. The enthusiasm of our members at this meeting was extraordinary. In talking with other members and in attending committee and section meetings, I heard some great ideas to advance the organization and its mission. Each of us needs to maintain that enthusiasm from Scientific Assembly and decide how we are going to contribute to the continued growth and success of AAEM. Serving on one of AAEM's committees is a great place to increase your involvement with the organization and give back to your specialty. A list of AAEM's committees can be found online at http://www.aaem.org/committees. We all have to remember that inaction is our adversary and will lead to the erosion of our rights as specialists in emergency medicine and lessen our ability to effectively care for our patients in the emergency department. If we do not take action, others will act on our behalf, often not having our best interests in mind.

continued on page 11

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: $365 (Must be ABEM or AOBEM certified in EM or Pediatric EM)
*Associate Member: $250
Emeritus Member: $250 (Must be 65 years old and a full voting member in good standing for 3 years)
Affiliate Member: $365 (Non-voting status; must have been, but are no longer ABEM or AOBEM certified in EM)
International Member: $150 (Non-voting status)
AAEM/RSA Member: $50 (voting in AAEM/RSA elections only)
Student Member: $20 or $50 (voting in AAEM/RSA elections only)
*Associate membership is limited to graduates of an ACGME or AOA approved Emergency Medicine Program.

Send check or money order to : AAEM, 555 East Wells Street, Suite 1100, Milwaukee, WI 53202

Tel: (800) 884-2236, Fax (414) 276-3349, Email: info@aaem.org.
AAEM is a non-profit, professional organization. Our mailing list is private.

Supreme Court Upholds Treasury Rule on Resident Employment Taxes

Kathleen Ream, Director of Government Affairs

On January 11, 2011, the United States Supreme Court unanimously held that the Treasury Department acted reasonably in promulgating a rule that says medical residents are not exempt from paying employment taxes under the Federal Insurance Contributions Act (Mayo Foundation for Medical Education and Research v. United States, U.S., No. 09-837). The case is considered to be the highest profile health care matter before the court this term, affecting most hospitals and involving an estimated $700 million in employment taxes annually.

In an opinion by Chief Justice John G. Roberts, Jr., the high court found the regulations, which say that medical residents who work more than 40 hours per week do not qualify for the student exception under Section 3121(b)(10) of the Internal Revenue Code, address an area "to which Congress has not directly spoken" and that, because the regulations were "a reasonable construction of what Congress has said," they had to be upheld.

The ruling affirms a June 2009 decision by the U.S. Court of Appeals for the Eighth Circuit and is consistent with views of oral argument attendees who in November said the majority of the sitting justices appeared poised to uphold the regulations. Justice Elena Kagan recused herself from the case.

AHRQ Reports Rising ED Visits, Overcrowding

In a statistical brief (#100) released by the Agency for Healthcare Research and Quality (AHRQ), the growing numbers of ED visits are cited as cause for concern. In the report, AHRQ states, "As visits to the ED rise, policymakers are increasingly concerned about potential cost, quality and long-term health and health care system consequences of ED overcrowding, overuse and inappropriate use."

Some of the significant findings in the report are:

- Of the 124.9 million ED visits in 2008, 98.5 million (or three in four) were for adults age 18 or older needing care.
- Four out of five were treated and released, while 18.5% had illnesses serious enough to warrant admission. Of those released, 93.7% were discharged home and 1.7% left against medical advice. Another 1.7% were transferred to another acute care facility, and 1.6% went to a long-term or intermediate care facility (nursing home or psychiatric treatment facility).
- Women had 26% higher ED utilization rates than men.
- Rates of ED visits were 90% higher for those from the lowest incomes areas than for those from the highest income areas.
- Rates of ED use were 39% higher for people from rural areas than for those from urban areas.
- Injuries accounted for 22.7% of all adult visits.
- More than nine in ten ED visits were for acute conditions, half of which were also associated with chronic conditions.

The complete brief is available at www.hcup-us.ahrq.gov/reports/statbriefs/sb100.pdf.

Census Bureau Reports Highest Number of Uninsured to Date

The Census Bureau Report, *Income, Poverty, and Health Insurance Coverage in the United States: 2009,* states that the number of people without health insurance in 2009 was 50.7 million, up from 46.3 million in 2008. That is the highest number of uninsured people since the government began collecting data on health insurance in 1987. Percentage-wise, people without health insurance increased to 16.7% in 2009 from 15.4% in 2008. The decrease in the number of people with health insurance – 253.6 million in 2009 from 255.2 million in 2008 – also set a record for being the first year since the Census Bureau began collecting health insurance data that the number of people with coverage decreased.

Other significant decreases were seen in the number of people with private health insurance (194.5 million in 2009 from 201 million in 2008) and the percentages of people covered by private health insurance and by employment-based health insurance (respectively, 63.9% in 2009 from 66.7% in 2008, and 55.8% in 2009 from 58.5% in 2008). In commenting on this data, David Johnson, chief of the Census Bureau's Housing and Household Economic Division, said, "The rates of coverage for both private and employment-based coverage have shown a downward trend for the last nine years." In contrast, the percentage of people covered by government health insurance programs, including Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and military coverage has increased for the third consecutive year to 30.6% in 2009.

Johnson also noted some demographics related to the uninsured rates. The rates for children younger than age 18 (10%) and those age 65 and older (1.8%) were not statistically different from 2008, but for adults age 18-64 the uninsured rate increased by two percentage points to 22.3% in 2009. With respect to income, Johnson said that, while the 2009 uninsured rate for people in households with incomes between $25,000 and $50,000 was not statistically different from 2008, the uninsured rate for other income groups increased. For people living in households with incomes less than $25,000, nearly 27% were uninsured, and for people in households with incomes greater than $75,000, 9.1% were uninsured.

Full-time workers had a 0.6 percentage point increase in their uninsured rate between 2008 and 2009, but the number of full-time, year-round workers decreased by five million between those years, and, for people that were not full-time, year-round workers, the uninsured rate went up by 2.7 percentage points. Johnson suggested that the rise in the number of uninsured was due to the changes in employment status experienced by many workers.

In commenting on the Census Bureau's data, Robert Zirkelbach, spokesperson for America's Health Insurance Plans, blamed the economy and medical costs for the rise in uninsured people. "Families and employers are struggling to cope with a slow economy and continually rising medical costs. The new Census numbers confirm the trend that we have been seeing over the past couple of years of younger and healthier people dropping their insurance because of the weak economy. This results in an older and sicker risk pool and higher costs for people with insurance. In order to make it easier for people to get and maintain health care coverage, far more needs to be done to address [the] rising cost of medical care," Zirkelbach wrote.

continued on page 11

17TH ANNUAL AAEM SCIENTIFIC ASSEMBLY HELD FEBRUARY 28 – MARCH 2, IN ORLANDO.

Hands-on instruction during the Simulation Course. Pre-Conference courses were held February 26 and February 27.

Howard Blumstein, AAEM president, welcomed attendees to the Scientific Assembly on Monday, February 28, 2011.

AAEM president, Howard Blumstein, presenting the James Keaney Leadership Award to Howard Roemer, MD FAAEM, on February 28, 2011.

Howard Blumstein, AAEM president, presenting Heather K. Jiménez, MD, with the Resident of the Year Award.

Stephen Hayden, MD FAAEM (right), editor-in-chief of the *Journal of Emergency Medicine*, with the winners of the AAEM/*JEM* Resident and Student Research Competition, from left, Alexander Garcia, DO, Michael Pelster and Steve Aguilar, MD.

Seung Ho Kim, MD, past president, Korean Society of Emergency Medicine, invites AAEM attendees to the Pan-Pacific Emergency Medicine Congress (PEMC), Oct. 24-26, 2012.

Attendees walking through the exhibit hall during the Opening Reception on February 28, 2011.

Lisa Sanders, MD, was the keynote speaker on Monday, February 28, 2011.

Standing room only during the Plenary sessions.

American Board of Emergency Medicine

3000 Coolidge Road
East Lansing, Michigan 48823-6319

517.332.4800
fax 517.332.2234
www.abem.org

News Release

Contact: Frances M. Spring, Administrative Coordinator, Communications
Phone: 517.332.4800 ext. 345
Email: fspring@abem.org

FOR IMMEDIATE RELEASE

INCREASED NUMBER OF CME CREDITS AVAILABLE FOR ACHIEVING OR MAINTAINING ABEM CERTIFICATION

East Lansing, Michigan, March 23, 2011—Effective September 1, 2010, the American Medical Association (AMA) approved increasing the number of *AMA PRA Category 1 Credits*™ for diplomates who successfully attain certification (by passing the Oral Examination) or renew certification (by passing the Continuous Certification Examination) through the American Board of Emergency Medicine (ABEM). Diplomates may now apply for 60 CME credits for attaining or renewing certification. Prior to September 1, 2010, diplomates could apply for only 25 credits. The cost of continuing medical education (CME) credits remains at $30 for AMA members and $75 for non-members. Diplomates may apply for CME credits for up to six years from the effective date on their certificate.

ABEM feels that this information could be helpful to some ABEM-certified physicians. ABEM President Mark T. Steele, M.D., states that, "The CME credit that is being offered by the AMA recognizes the educational value of board certification preparation and provides added worth to the certification process." Because of this potential benefit, ABEM has decided to spread this news to the Emergency Medicine community. ABEM is providing this notification for informational purposes only and has no financial interest in or gain from this voluntary activity.

Sixty-two medical boards in the United States and its territories require physicians to earn CME credits to renew their medical licenses.[1] Many of these governmental medical boards also require a certain percentage of the CME credits to be *AMA PRA Category 1 Credits*™ or an equivalent. The increase in the number of credits diplomates may receive further elevates the value of ABEM certification.

Additional information about the credits, including a link to the appropriate form, can be found on the AMA Direct Credit page of their website www.ama-assn.org/go/directcredit.

###

[1] American Medical Association, "Continuing Medical Education for Licensure Reregistration," *State Medical Licensure Requirements and Statistics, 2010*, American Medical Association Press, pp. 53-56, http://www.ama-assn.org/ama1/pub/upload/mm/40/table16.pdf.

New Board of Directors

President
Howard Blumstein, MD – 2012

Vice President
William T. Durkin, Jr., MD MBA – 2012

Secretary-Treasurer
Mark Reiter, MD MBA – 2012

Immediate Past President
Larry D. Weiss, MD JD – 2012

Past Presidents Council Representative
Robert M. McNamara, MD – 2012

At-Large Board Members:
Michael Epter, DO – 2013
Andrew P. Mayer, MD – 2012
Kevin Rodgers, MD – 2013
Joel M. Schofer, MD RDMS – 2012
Robert Suter, DO MHA – 2013
Andy Walker, MD – 2013
Joanne Williams, MD – 2012
Leslie Zun, MD MBA – 2013

YPS Representative
Brian Potts, MD MBA – 2012

AAEM/RSA President
Ryan Shanahan, MD – 2010-2011

Editor, *JEM* – Ex-Officio Board Member
Stephen R. Hayden, MD

Editor, *Common Sense* – Ex-Officio Board Member
David D. Vega, MD

Welcome to our Newest 100% ED Groups

Campbell County Memorial Hospital – WY

Eastern Carolina Emergency Physicians (ECEP) – NC

Fort Atkinson Emergency Physicians (FAEP) – WI

Northeast Emergency Associates – MA

Physician Now, LLC – VA

Space Coast Emergency Physicians – FL

Temple University – PA

To view a complete list of all 100% ED Groups please visit www.aaem.org/membership/100_ed_programs.php

2011 AAEM Awards

David K. Wagner Award
Leslie S. Zun, MD FAAEM

Young Educator Award
Joel M. Schofer, MD RDMS FAAEM

Resident of the Year Award
Heather K. Jiménez, MD

James Keaney Leadership Award
Howard Roemer, MD FAAEM

Peter Rosen Award
Stephen R. Hayden, MD FAAEM

Joe Lex Educator of the Year Award
Ghazala Q. Sharieff, MD FAAEM

Program Director of the Year
Jonathan E. Davis, MD FAAEM

Resident Research Forum
Michael Pelster
Steve Aguilar, MD
Alexander Garcia, DO

Departing Board Members
Kevin Beier, MD FAAEM
Christopher C. Lee, MD FAAEM
Lisa D. Mills, MD FAAEM

Mitchell Goldman Service Awards

25 SESSIONS:
Bill Gossman, MD FAAEM
Bruce Lobitz, MD FAAEM

20 SESSIONS:
David W. Dabell, MD FAAEM

15 SESSIONS:
Alexandre F. Migala, DO FAAEM

10 SESSIONS:
Paul E. Kleinschmidt, MD FAAEM
Michael J. Matteucci, MD FAAEM
Matthew J. Vreeland, MD FAAEM
Benjamin Wedro, MD FAAEM

5 SESSIONS:
Sudhir Baliga, MD FAAEM
Ross P. Berkeley, MD FAAEM
William S. Boston, MD FAAEM
Riemke M. Brakema, MD FAAEM
Francis X. Chuidian, MD FAAEM
Albert L. Gest, DO FAAEM
Gregory H. Gilbert, MD FAAEM
Monica Johnson, MD FAAEM
Michael I. Omori, MD FAAEM
James W. Small, MD FAAEM
Matthew W. Turney, MD FAAEM
Robert R. Westermeyer, MD FAAEM

Written Board Course Awards

5 YEARS:
Michael E. Silverman, MD FAAEM
Kenneth Kwon, MD FAAEM

Written Board Top Speaker:
James E. Colletti, MD FAAEM

Member Feedback

The following is a portion of an email sent in by a Common Sense *reader in response to our previous issue and particularly the President's Message by Howard Blumstein:*

Dear Editor,

I cannot tell you how pleased I am with AAEM's stance. I'm glad you are out there and calling the issues exactly like they are, without any spin or softening of your opinion, no matter who might not like it. When there's clearly right and wrong, there's no need to backpeddle [sic] and play it soft.

I did three years of another residency before I found my true love, EM. So guess what? I bit the bullet, moved halfway across the country, and did an EM residency. Why? Because that's the right way. If all these others want to call themselves EPs, go get trained. Period. Don't... make excuses or try to do an end-around the process.

Most of us could learn to takeoff and land a small aircraft in a couple hours, but does that make you a pilot? I get so tired of hearing that being good at [emergency medicine] is only a matter of doing shifts. The problem is that they don't know what they don't know, and so are quintessential back seat drivers.

It's ridiculous that if you clearly don't qualify for board certification, you just invent a new board that will certify you. Might as well just put degrees, residencies and board certifications in Cracker Jack boxes.

I'm sure most are well-intentioned, decent people, doing the best they can, and trying to fill a need, but if they left it at that, they'd be more appreciated for being honest with themselves and others.

I have joined and maintain many organizations in my life. Prior to AAEM, absolutely none have deserved or earned my 100% support. As long as AAEM stays hardcore, true to principle, and upfront, it will be the most relevant and representative organization in all of emergency medicine, maybe all of medicine. But be vigilant---the other medical organizations probably started out on the right track too. Someone from the outside or the inside WILL try to buy you or bend you, I GUARANTEE it.

Anonymous

President's Message - continued from page 1

Finally, many survey respondents were quite vocal about the LLSA. I agree that some of the articles selected have been less than ideal. If you feel they are lacking, consider impacting the issue by submitting articles for consideration. The process for doing so is clearly described on the ABEM website. Or, volunteer to serve as an item writer or perhaps an examiner. Don't gripe about the problem; become part of the solution.

For AAEM's part, we have shared the survey results with ABEM. We have been working with ACEP and ABEM to create the opportunity for our members to earn CME for their LLSA activities at low cost. The idea is to extract extra benefit for members – and added value.

CLINICAL PRACTICE STATEMENT:

Is an Unenhanced CT Scan of the Abdomen and Pelvis Accurate in Diagnosing Acute Appendicitis in Adults? (6/1/10)

Reviewed and approved by the AAEM Clinical Practice Committee.
Chair: Steven Rosenbaum, MD FAAEM
Authors: Julie Gorchynski, MD FAAEM, Lisa D. Mills, MD FAAEM
Reviewers: Sean Fox, MD FAAEM, Robert Meurer, MD, Jack Perkins, MD, Richard Shih, MD FAAEM, Michael Winters, MD FAAEM
Reviewed and approved by the AAEM Board of Directors 6/1/2010.
Authors Who Disclosed No Conflict of Interest: Julie Gorchynski, MD FAAEM, Lisa D. Mills, MD FAAEM

With the advent of more sophisticated CT scanners, imaging without contrast (unenhanced) is increasingly utilized in the evaluation of adults with suspected acute appendicitis. Oral contrast presents a significant delay to imaging. Intravenous contrast presents the small, but real risks of allergic reaction and contrast nephropathy. There is sufficient literature to support the use of unenhanced CT of the abdomen and pelvis (CT AP) to evaluate adults for acute appendicitis.

There are no large, prospective, randomized studies directly comparing the diagnostic accuracy of CT AP with contrast and unenhanced CT in the setting of acute appendicitis. However there are separate studies that address the accuracy of CT AP with IV and/or oral contrast or unenhanced CT AP, separately.

Three studies were of sufficient quality (all Grade C) to address the question of accuracy of unenhanced CT AP. One study of 300 patients by Lane MJ, et al found non-contrast CT had an accuracy of 94% (sensitivity 90%; specificity 97%).[4] Another study by MacKersie AB, et al. revealed an accuracy of 95.6% (sensitivity 98%; specificity 95.1%).[6] Ege G, et al, studied 91 patients with suspected appendicitis and found an accuracy of 97% (sensitivity of 96%; specificity of 98).[22]

CT AP with IV and/or oral contrast is generally cited to be 94-97% accurate in the diagnosis of acute appendicitis.[9,10, 14,15]

Given that the reported accuracy of enhanced and unenhanced CT AP for the diagnosis of acute appendicitis in adults are both in the high 90th percentile, unenhanced CT AP is an accurate imaging modality in the diagnosis of acute appendicitis in adults. However, if the emergency physician has a radiology consultant who is not comfortable reading an unenhanced CT for this indication, the emergency physician may find it necessary to administer contrast to facilitate care of the patient.

References:

1. Gaitini D, et al. *AJR*. 2009;190(5):1300-6. Diagnosing acute appendicitis in adults: accuracy of color Doppler sonography and MDCT compared with surgery and clinical follow-up. Grade D
2. Raman SS, et al. *AJR*. 2002;178(6):1319-25. Accuracy of nonfocused helical CT diagnosis of actue appendicitis: a 5-year review. Grade D
3. Leite N P, et al. *AJR*. 2005;185(2):406-17. CT evaluation of appendicitis and its complications: imaging techniques and key diagnostic findings. Grade F
4. Lane MJ, et al. *AJR*. 1997;168(2):405-9. Unenhanced helical CT for suspected acute appendicitis. Grade C
5. Moteki T and Horikoshi H. *AJR*. 2007;188(5):1313-9. New CT criterion for acute appendicitis: maximum depth of intraluminal appendiceal fluid. Grade C
6. MacKersie AB, et al. *Radiology.* 2005;237(1):114-22. Nontraumatic acute abdominal pain: unenhanced helical CT compared to three view acute abdominal series. Grade C
7. Jacobs JE, et al. *Radiology*. 2001;220(3):683-90. Acute appnedicitis: comparison of helical CT diagnosis focused technique with oral contrast material versus nonfocused technique with oral and intravenous contrast material. Grade A
8. Bixby SD, et al. *Radiology*. 2006;241(3):780-6. Perforated versus nonperforated acute appendicitis: accuracy of multidetector CT detection. Grade D
9. Neville AM, Paulson EK. *Abdom Imaging*. 2009;34(1):42-8. MDCT ofa cute appendicitis: value of coronal reformations. Grade D
10. Karam AR, et al. *Clin Imaging*. 2007;31(2):77-86. Alternative diagnoses of acute appendicitis on helical CT with intravenous and rectal contrast. Grade D
11. Urban BA, Fishman EK. *Semin Ultrasound CT MR*. 2000;21(1):20-39. Targeted helical CT of the acute abdomen: appendicitis, diverticulitis, and small bowel obstruction. Grade D
12. Ives EP, et al. *Acad Radiol*. 2008;15(8):996-1103. Independent predictors of acute appendicitis on CT with pathologic correlation. Grade D
13. Rao PM, Rhea JT, Movelline RA. *J Comput Assist Tomogr*. 1997;21(5):686-92. Sensitivity and specificity of the individual CT signs of appendicitis: experience with 200 helical CT examinations. Grade C
14. Raman SS, et al. *J compute Assist Tomogr*. 2003;27(4):583-9. Patient gender-related performance of nonfocused helical computed tomography in teh diagnosis of acute appendicitis. Grade C
15. Yeung KW, hang MS, Hsiao CP. *Clin Imaging*. 2004;28(6):422-7. Evaluation of perforated and nonperforated appendicitis with CT. Grade E
16. Choi D, et al. *Acta Radiol*. 2003;44(6):574-82. The mot useful findings for diagnosing acute appendicitis on contrast-enhanced helical CT. Grade D
17. Terasawa T, Blackmore CC, Bent S, Kohlwes RJ. *Ann Intern Med*. 2004;141(7):537-46. Systematic review: computed tomography and ultrasonography to detect acute appendicitis in adults and adolescents. Grade B
18. Neumayer L, Kennedy A. *Obstet Gynedol*. 2003;102(6):1404-9. Imaging in appendicitis with special emphasis on the treatment of women. Grade B
19. Poh AC, Lin M, Teh HS, tan AG. *Singapore Med J*. 2004;45(8):379-84. The role of copmuted tomography in clinically-suspected but equivocal acute appendicitis. Grade D
20. Diagnostic Accuracy of Noncontrast CT for Appy in Adults; *Systematic Reivew Annal EM* Jan 2006. Grade B
21. Christopher, FL et al. *JEM*. 2002; 23(1):1–7. Unenhanced Helical CT scanning of the abdomen and pelvis changes disposition of patients presenting to the Emergency Department with Possible Acute Appendicitis. Grade A
22. Ege G, Akman H, Sahin A, Bugra D, Kuzucu K. Diagnostic value of unenhanced helical CT in adult patients with suspected acute appendicitis. *Br J Radiol* 2002; 75:721–725. Grade C

February 14, 2011

Sallie Debolt, Esq.
General Counsel
State Medical Board of Ohio
30 E. Broad Street, 3rd Floor
Columbus, Ohio 43215-6127

Re: Fee-splitting arrangements in ED contracts in Ohio

Dear Ms. Debolt,

Dr. Carol Cunningham is a member of the American Academy of Emergency Medicine and a member of Lake Health Emergency Services, Inc., which until recently held the contract for emergency services at Lake Health hospitals. She shared with us your letter of 12/27/2010 regarding the corporate practice of medicine in the State of Ohio wherein you stated the following "moreover, compensation packages must be structured to prevent fee-splitting." In the case of a for profit corporate entity employing emergency physicians in the State of Ohio the fee-splitting aspect requires examination. The specific areas of concern include:

1) Whether emergency physicians are required to give a portion of their fee which is above fair market value for the services the corporation provides to the physician
2) Whether the arrangement creates inducements to increase referrals
3) Whether the arrangement creates inducements for overutilization
4) Whether the arrangement creates/includes financial incentives that increase the risk of abusive billing practices

In the case of an emergency physician working for an entity such as EmCare at Lake Health Hospitals, the ability of that physician to engage in patient care (receive referrals) is predicated upon the signing of an employment contract with EmCare. EmCare holds the exclusive contract for emergency services and a physician cannot see patients in that ED without a contractual relationship with EmCare. The emergency physicians at Lake Health who work for EmCare contractually give up a portion of their fee in return for the right to see patients. The amount of the professional fee that is given to EmCare is solely determined by EmCare and not the physician. Given the profit motive of the company, it is likely that the four items listed above would be of concern.

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

The US Office of the Inspector General in its Advisory Report OEI-09-89-00330 specifically details the prohibition on hospitals taking a portion of a hospital-based physician's fee beyond fair market value for the services provided to the physician. This report recognizes the hospital's power in controlling the awarding of the exclusive contract for hospital-based physician services. It would seem logical to expect that a for-profit corporation that holds similar power by owning the exclusive contract for emergency services would likewise be held to that standard.

Upon investigation of the financial relationship of EmCare with its employed physicians at Lake Health (and other hospitals in Ohio) we are confident that you will discover that the physicians are not given access to what is billed or remitted in their name. They therefore have no basis on which to gauge whether the services EmCare is providing to them are at fair market value. By analyzing publicly reported data by entities engaged in similar arrangements, it is clear that the cost to the physicians above and beyond the practice expenses (management, coding, billing, malpractice insurance) can be quite high, approximating $75,000 per year per physician.(1) The services provided in return for this large sum by EmCare do not include much more than a scheduling function. This is, as you have pointed out in your letter to Dr. Cunningham, because a corporation cannot legally direct a physician's care of a patient.

In order to ensure that the relationship between Ohio emergency physicians and an entity such as EmCare do not constitute payments for referrals beyond fair market value one would need to analyze the exchange of dollars in this arrangement. The physicians and regulatory bodies would have to be aware of what amount of the physician fee is being taken by the corporation and the value of the services in return for that. At the very least the State Medical Board of Ohio should ensure that the emergency physicians in these relationships are given access to what is billed and remitted in their name. The American Medical Association believes this is essential (AMA Policy H 190.971).

More concerning is the potential for abuse in an arrangement where the corporation's profits are primarily determined by the corporation. The primary reason prohibitions on fee-splitting exist is to prevent financial abuses in health care. The more patients an emergency physician sees in this arrangement the higher the potential profit for the corporation. The higher the charges generated for a specific patient (ex., overutilization of testing) the higher will be the corporate profits. Emergency physicians in such arrangements are typically tracked using the metric of patients seen per clinical hour as well as relative value units (RVUs) generated per clinical hour. Finally, the profit structure creates a direct incentive for abusive billing practices. It is of note that EmCare paid a large fine for billing fraud in the past. (DOJ CIV press release 97-214)

We call to your attention these issues regarding your concern that "compensation packages must be structured to prevent fee-splitting." We believe that an investigation into the structure of the relationship between the emergency physicians at Lake Health and EmCare is warranted including an examination of the actual contracts between the physicians and EmCare and an assessment as to how the physicians are provided information on what is billed and remitted in their name.

Please contact us if we can be of further assistance. Robert McNamara, MD will be the primary contact for the AAEM on this matter. His contact information is on the following page:

Robert M. McNamara, MD FAAEM
Department of Emergency Medicine
Temple University School of Medicine
3401 North Broad Street
Philadelphia, PA 19140
Office: 215-707-5030
Mobile: 215-370-9033
E-mail: Robert.McNamara@tuhs.temple.edu

Thank you for your attention to this important matter.

Sincerely,

Howard Blumstein, MD, FAAEM
President, AAEM

(1) http://www.aaem.org/commonsense/commonsense0110.pdf (page 8)

Enclosures

Washington Watch - continued from page 3

But Senate Finance Committee Chair Max Baucus (D-MT) issued a release saying that the increase in the number of Americans without health insurance is due to "egregious insurance company abuses." The increase in uninsured people "is clear evidence of how critical it was to take action to protect patients, and that's exactly what the [Patient Protection and Affordable Care Act (PPACA, Pub. L. No. 111-148)] will do," he said.

Robert Greenstein, executive director of the Center on Budget and Policy Priorities, also issued a statement. Greenstein said the Census data "show a striking divergence between declines in private insurance and expanded coverage through federally supported programs." He added, "Without the expansion the increase in the number and percentage of people who are uninsured would have been much larger." Both Greenstein and Ron Pollack, executive director of Families USA, credited government programs such as Medicaid, CHIP, and Medicare with preventing an even greater increase in the ranks of the uninsured; and they cited the further help coming from the new requirements of PPACA that will take effect soon.

The Census Bureau report is available at http://www.census.gov/prod/2010pubs/p60-238.pdf.

Editor's Letter - continued from page 2

One cannot overestimate the value of the social interactions and networking that comes as a result of meetings like Scientific Assembly. Besides meeting with peers and former residents, I've always enjoyed the opportunity to rub elbows with some of the "big names" in emergency medicine and talk with various experts after their lectures. In addition, every single member has easy access to AAEM's leaders and can have their voice heard on any aspect of the organization's activities. Meetings of the board of directors are open to all members, who can learn about and influence the direction of the Academy. Unlike some other organizations, the board is elected through a completely democratic process involving board certified emergency physicians.

As a democratic organization, your thoughts and ideas are highly valued by AAEM. If you have something to say to your fellow members of AAEM, you may want to start by sending some comments to us here at *Common Sense* as a letter to the editor or by submitting an original article for publication. Feel free to contact me directly at cseditor@aaem.org with your opinions about anything you read in *Common Sense*. In addition, direct communication with the leadership of AAEM is merely an email away (http://www.aaem.org/boardofdirectors/boardlisting.php). Through my own service on the board of directors, I can say that the board is completely dedicated to the promotion of AAEM's mission and willing to go far beyond what is necessary to respond to the needs of individual members.

Start planning now to attend next year's Scientific Assembly, February 8-10, at the Hotel Del Coronado in San Diego. This beachfront resort, designated as a National Historic Landmark, is sure to be a great location for the best conference in emergency medicine. And while you're looking at your schedule, don't forget that the Sixth Mediterranean Emergency Medicine Congress (MEMC VI) will be held September 10-14 this year in Kos, Greece. Co-sponsored by AAEM, this meeting is expected to see nearly 2,000 emergency medicine specialists from more than 75 countries converge on the island of Kos to share in academic and scientific exchange.

AAEM Announces New Honorary "Master" Designation

Larry D. Weiss, MD JD FAAEM
AAEM Immediate Past President

The AAEM board of directors recently approved the creation of its Master of the American Academy of Emergency Medicine (MAAEM) designation. This honorary title recognizes a small number of extraordinary senior AAEM fellows who demonstrated a career of (1) service to AAEM, (2) service as an exemplary clinician and/or teacher of emergency medicine, (3) service to emergency medicine in the area of research and/or published works, (4) service as a leader in the hospital, the community or organized medicine, (5) service in the areas of health policy and advocacy, (6) volunteerism, or (7) other activities or high honors that distinguished the physician as preeminent in the field of emergency medicine.

Nominees are expected to meet most, but not necessarily all of the above criteria. *However, with rare exception, nominees must meet the first criterion, extraordinary service to AAEM.* Current members of the board of directors may not receive a nomination, but will become eligible for a nomination two years after completion of their service as members of the board. AAEM authorizes Masters to use the title MAAEM as long as their AAEM membership remains current. AAEM plans to announce the first recipients of this high honor at its annual Scientific Assembly in February 2012 in San Diego.

The executive committee of AAEM will submit Master nominations to the board of directors. Active full voting members of AAEM may also submit nominations to the executive committee. Regardless of the source of nomination, a nominator shall recruit three other full voting members to write letters of reference for the nominee. The nominator shall also provide the nominee's current curriculum vitae to the executive committee. Individuals shall not self-nominate. If a nominee does not successfully receive the MAAEM designation, that individual may receive up to three subsequent nominations. Completed nominations, including all letters of reference, received by the AAEM home office by November 15 of each calendar year, will receive consideration by the executive committee for approval and submission to the board of directors. Those nominees who receive approval from the board of directors shall receive their awards at the next Scientific Assembly.

Our board did not approve the MAAEM award as an empty gesture to recognize senior members. We anticipate that only a small number of very dedicated AAEM fellows will qualify for this award. The award will remain distinct from all other honorary designations in emergency medicine because it will recognize those who dedicated their careers to serving their colleagues and their specialty through extraordinary service to AAEM and our Mission. We eagerly look forward to naming our first Masters in February 2012 at our Scientific Assembly at the magnificent Hotel Del Coronado in San Diego. You may initiate the nomination process by contacting our home office at info@aaem.org. We look forward to hearing from you!

AAEM ED Group Membership

NEW AND IMPROVED!

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

- 100% ED Group Membership - receives a 10% discount on membership dues. All board certified and board eligible physicians at your hospital/group must be members.
- ED Group Membership - receives a 5% discount on membership dues. 2/3 of all board certified and board eligible physicians at your hospital/group must be members.

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

2011 Membership Applications Now Being Accepted!

NEW THIS YEAR: MULTI-YEAR MEMBERSHIPS NOW AVAILABLE!

Plan ahead for your future. Secure your AAEM membership at the price of $365 per year. Full voting multi-year memberships now available for up to 10 years.

Have You Set Up Your Member's Login Account?

- Check your membership status or payment history
- Update your contact information
- Pay your membership dues
- Register for a conference or other educational opportunities
- Browse the member's only publications
- Perform a job search with our job bank services
- Participate in AAEM Career Network

To set up your initial login account, **please visit http://aaem.execinc.com/edibo/LoginHelp**.
Please contact info@aaem.org or 800-884-2236 with any questions.

View from the Fishbowl

Joel M. Schofer, MD RDMS FAAEM
Member, AAEM Board of Directors
Lieutenant Commander, Medical Corps, US Navy
Emergency Ultrasound Director, Emergency Department
Naval Medical Center Portsmouth, Portsmouth, Virginia

One of the biggest benefits of being in the U.S. Navy is the potential for travel and exposure to other cultures. In my 10 years of Naval service, I've been to Japan, Thailand, China, Hong Kong, Indonesia, Kuwait, Iraq, Sri Lanka, Bahrain, Kenya and Australia. Our final stop on the way home from my current seven-month deployment aboard the USS Pearl Harbor was Singapore, where we were forbidden from participating in "kangaroo boxing or crocodile wrestling." Bummer.

The Republic of Singapore is a city-state at the tip of Malaysia. It is relatively small, only 724 square miles, and has a population of five million people. It is one of the world's leading financial and business centers and has a reputation as a clean, safe, modern city, and that's exactly what it was.

One of the main reasons Singapore is so safe is its unique and unforgiving justice system. Singapore prevents the importation of any weapons, including toy guns, empty shell casings, pocketknives, lighters that resemble weapons, handcuffs (including plastic ones), and other seemingly safe and non-threatening objects. We were told that someone was arrested for wearing a necklace with a handgun on it.

Drugs exist in Singapore, but the penalties are severe. If you possess any drugs, you are looking at 10 years in prison. If you are convicted of drug trafficking, you are looking at 20 years…and 15 strokes with a cane! Yes, caning is an acceptable form of punishment. Possession of more than 15 grams of heroin, 30 grams of cocaine, 500 grams of marijuana, or 250 grams of methamphetamines yield a mandatory death sentence by hanging.

Any vandalism results in a caning.

Pornography of any kind is forbidden.

Proselytizing, or attempting to change someone's religious beliefs, could result in deportation. I guess they don't have many door-to-door missionaries.

One of my buddies witnessed the Singapore version of a bar fight, which consisted of two grown men getting very angry at each other, shouting but never even touching each other during what was apparently a very prolonged altercation. They probably cane you if you assault someone, so I guess these are what their fights are like.

In addition to an absence of crime, one of the other major differences you will note from a city in the United States is the amazing cleanliness. It was difficult to find any stray pieces of trash, and that is probably because littering, and even spitting on a sidewalk, results in large fines up to about $750. You can't eat, drink, or even chew gum on the mass transit trains, and there are attendants there to enforce this rule.

Police are universally present throughout the city, although you would never know it because the majority are not in uniform, but disguised in plain clothes. In addition, they can search you for any reason without probable cause or a warrant.

Finally, a near universal difference in all of my travel throughout Asia that remained true in Singapore is the marked absence of anyone who is obese. As we were boarding the train, my friends and I tried to find someone in the terminal that was obese and we couldn't.

Singapore may sound like a crime-free utopia where everyone is thin, but like any place it had its black marks. Prostitution is legal and rampant.

There is also a well established system of pick pocketing teams, electronics stores that overcharge your credit cards, and clubs that will steal your identity if they can get your military ID card and the full name, birth date and social security number it contains.

After seeing all of the pluses and minuses of this truly impressive city, I have to say that there appear to be many more positives than negatives. It makes you wonder how much potential exists in our cities.

How clean would the streets in the U.S. be if there were undercover police all over the place ready to fine you $750 if you littered or spit on the street?

How many drug dealers would there be if you'd get caned or even hung for larger quantities?

How many shootings would there be if there were no guns allowed, not even toy guns?

And how many emergency department visits would result if bar fights were nothing more than prolonged, glorified arguments?

How much fun would it be to kangaroo box or wrestle a crocodile?

I guess I'll never know…

(Contact Dr. Schofer with any comments at jschofer@gmail.com.)

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

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.

Recognition Given to Foundation Donors

Levels of recognition to those who donate to the AAEM Foundation have been established. The information below includes a list of the different levels of contributions. The Foundation would like to thank the individuals below that contributed from 12/15/2010 to 3/27/2011.

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.

MEMBER

Kevin Beier, MD FAAEM
Crystal Cassidy, MD FAAEM
Jerris R. Hedges, MD FAAEM

DONOR

William T. Durkin, Jr., MD MBA FAAEM
Mark Reiter, MD MBA FAAEM
Joel M. Schofer, MD RDMS FAAEM

CONTRIBUTOR

Bobby Abrams, MD FAAEM
Jaime J. Aleman, MD FAAEM
Leonardo L. Alonso, DO FAAEM
Susan M. Ambrose, MD FAAEM
Jonathan D. Apfelbaum, MD FAAEM
Elizabeth S. Atkinson, MD FAAEM
W. Lynn Augenstein, MD FAAEM
Jennifer Bahr, MD
Garo Balkian, MD FAAEM
William M. Barnett, MD FAAEM
Andrew H. Bauer, MD FAAEM
John W. Becher, DO FAAEM
Marc Belrose, MD FAAEM
Michael L. Blakesley, MD FAAEM
Leo R. Boggs, Jr., MD FAAEM
Michael A. Bohrn, MD FAAEM
Michael A. Borunda, MD FAAEM
William S. Boston, MD FAAEM
Eric W. Brader, MD FAAEM
Riemke M. Brakema, MD FAAEM
Antonio L. Brandt, MD FAAEM
Richard D. Brantner, MD FAAEM
J. Allen Britvan, MD FAAEM
Kevin Robert Brown, MD FAAEM
David P. Bryant, DO FAAEM
Colin M. Bucks, MD FAAEM
Daniel Burian, MD FAAEM
Leo W. Burns, MD FAAEM
Bruce R. Bush, MD FAAEM
Thomas P. Campbell, MD FAAEM
John W. Cartier, MD FAAEM
Carlos H. Castellon, MD FAAEM FACEP
Jeffrey J. Chambers, MD FAAEM
Vijai V. Chauhan, MD FAAEM
Frank L. Christopher, MD FAAEM
Mark C. Clark, MD FAAEM
Joseph E. Clinton, MD FAAEM
Robert Lee Clodfelter, Jr., MD FAAEM
Jordan Yechiel Cohen, MD FAAEM
Domenic F. Coletta, Jr., MD FAAEM
Thomas R. Coomes, MD FAAEM
Gaston A. Costa, MD
Steven K. Costalas, DO FAAEM
David C. Crutchfield, MD FAAEM
Patrick W. Daly, MD FAAEM
Doreen M. Dargon, MD FAAEM
Jonathan E. Davis, MD, FAAEM
Justin B. Davis, MD
Francis X. Del Vecchio, MD FAAEM
Bronson Delasobera, MD
Jonethan P. DeLaughter, DO
Anthony B. DeMond, MD
Cheryl L. Dickason, MD FAAEM
Robert L. Dickson, MD FAAEM
John Timothy DiPasquale, MD FAAEM
Lala M. Dunbar, MD PhD FAAEM
Michael L. Epter, DO FAAEM
Richard G. Faller, MD FAAEM
David A. Farcy, MD FAAEM
Michael J. Federline, MD FAAEM
Clifford J. Fields, DO FAAEM
David M. Fisher, MD FAAEM
Sean Fleming, MD FAAEM
Mark A. Foppe, DO FAAEM
Robert A. Frolichstein, MD FAAEM
Paul W. Gabriel, MD FAAEM
Steven H. Gartzman, MD FAAEM
Kathryn Getzewich, MD FAAEM
Richard Russell Gill, MD FAAEM
Steven R. Ginder, MD FAAEM
Bell Girma, MD FAAEM
Samuel H. Glassner, MD FAAEM
Steven D. Goodfriend, MD FAAEM
Richard Oren Gray, MD FAAEM
Robert E. Gruner, MD FAAEM
Theresa Gunnarson, MD FAAEM
Michael N. Habibe, MD FAAEM
William L. Haith, Jr., DO FAAEM
Elizabeth C. Hall, MD FAAEM
Dennis P. Hanlon, MD FAAEM
Mark J. Harrell, MD FAAEM
Benjamin P. Harrison, MD FAAEM
Geoffrey E. Hayden, MD FAAEM
Ross A. Heller, MD FAAEM
Ronald G. Himmelman, MD FAAEM
Victor S. Ho, MD FAAEM
Joel S. Holger, MD FAAEM
Mark Hoornstra, MD FAAEM
Joseph C. Howton, MD FAAEM
David R. Hoyer, Jr., MD FAAEM
Timothy J. Huschke, DO FAAEM
Matt K. Hysell, MD FAAEM
Leland J. Irwin, MD FAAEM
Jacqueline A. Jeffery, MD FAAEM
Carroll Don Johnson, MD FAAEM
P. Scott Johnston, MD FAAEM
Gregory C. Jones, MD FAAEM
Jonathan S. Jones, MD FAAEM
Shammi R. Kataria, MD, FAAEM
John Kelsch, MD FAAEM
Eric M. Ketcham, MD FAAEM
Jonathan Kim, MD
Scott K. C. King, MD FAAEM
Michael Klein, MD FAAEM
Paul E. Kleinschmidt, MD FAAEM
Christopher L. Klingenberg, MD FAAEM
Frederick Kotalik, MD FAAEM
Ron Koury, DO FAAEM
Pamela J. Krol, MD FAAEM
Erik Kulstad, MD FAAEM
Roger C. Lai, MD FAAEM
David W. Lawhorn, MD FAAEM
Liza Le, MD FAAEM
Douglas S. Lee, MD FAAEM
Benjamin Lerman, MD FAAEM
Michael Kevin Levy, MD FAAEM
Michael H. LeWitt, MD MPH FAAEM
Donald J. Linder, DO FAAEM
Shahram Lotfipour, MD MPH FAAEM
Ann Loudermilk, MD FAAEM
Daniel R. Martin, MD FAAEM
Maurice W. Mascoe, MD FAAEM
Keith L. Mausner, MD FAAEM
Andrew P. Mayer, MD FAAEM
Brian P. McColgan, DO
Adrienne McFadden, MD JD FAAEM
Edgar McPherson, MD FAAEM
Marc S. McSherry, MD FAAEM
Russell H. McUne, MD FAAEM
David E. Meacher, MD FAAEM
Chris A. Meeker, MD FAAEM
James J. Mensching, DO FAAEM
Graham Scott Meyer, MD FACEP FAAEM
Trevor Mills, MD FAAEM
Peter B. Mishky, MD FAAEM
Siamak Moayedi, MD FAAEM
Raquel A. Mora, MD FAAEM
Usamah Mossallam, MD FAAEM
Michael Paul Moulton, MD FAAEM
Elizabeth A. Moy, MD FAAEM
Michael P. Murphy, MD FAAEM
Heather M. Murphy-Lavoie, MD FAAEM
Melissa Natale, MD FAAEM
My-Huong Nguyen, MD FAAEM
Paul D. O'Brien, MD FAAEM
Michael P. O'Connell, MD
Bertram I. Okorie, MD FAAEM
Louis D. Orosz, MD FAAEM
Stephanie S. Ortega, MD FAAEM
Lillian Oshva, MD FAAEM
Alonso J. Osorio-Giraldo, MD
Ramon J. Pabalan, MD FAAEM
Pamela S. Parks, MD FAAEM
Hector L. Peniston-Feliciano, MD FAAEM
Christopher W. Pergrem, MD FAAEM
Jeffrey S. Peterson, MD FAAEM
Prakash Phulwani, MD FAAEM
Jeffery M. Pinnow, MD
Michael S. Pulia, MD FAAEM
Vitaut N. Ragula, MD FAAEM
Laurence H. Raney, MD FAAEM
Jeffrey A. Rey, MD FAAEM
Jaime A. Reyes, MD FAAEM
Alberto R. Rivera, MD FACEP FAAEM
Edgardo M. Rodriguez, MD FAAEM
Brad L. Sandleback, MD FAAEM
Dorcas J. Sandness, MD FAAEM
Victor Andres Sasson, MD FAAEM
Kenneth A. Scheppke, MD FAAEM
Sachin J. Shah, MD FAAEM
Richard D. Shih, MD FAAEM
Lee W. Shockley, MD MBA FAAEM
Paul R. Sierzenski, MD RDMS FAAEM
Michael E. Silverman, MD FAAEM FACEP
P. John Simic, MD FAAEM
Karen A. Siren, MD, MPH
John Sisson, MD FAAEM
Edward P. Sloan, MD MPH FAAEM
Brendon J. Smith, MBBS FACEM
Donald L. Snyder, MD FAAEM
Matthew T. Spencer, MD FAAEM
Keith D. Stamler, MD FAAEM
Joel B. Stern, MD FAAEM
Robert E. Suter, DO MHA FAAEM
James K. Takayesu, MD FAAEM
Yeshvant T. Talati, MD FAAEM
Mary Ann Hanes Trephan, MD FAAEM
Philip F. Troiano, MD FAAEM
Alan T. Uyeno, MD FAAEM
Arlene M. Vernon, MD FAAEM
Matthew J. Vreeland, MD FAAEM
Roland S. Waguespack, III, MD FAAEM
William A. Walters, III, MD FAAEM
Kenneth J. Wedig, MD FAAEM
Benjamin Wedro, MD FAAEM
Peter Weimersheimer, MD FAAEM
Ellen J. Westdorp, MD FAAEM
Robert R. Westermeyer, MD FAAEM
Kay Whalen
Ellen W. White, MD FAAEM
Brian J. Wieczorek, MD FAAEM
William David Wilcox, MD FAAEM
Michael Robert Williams, MD FAAEM
Scott E. Williams, MD FAAEM
Janet Wilson
Richard Clarke Winters, MD FAAEM
Andrea L. Wolff, MD FAAEM
Emily Wolff, MD FAAEM
Patrick G. Woods, MD FAAEM
George Robert Woodward, DO FAAEM
Edwin Yaeger, DO FAAEM
Jorge M. Zeballos, MD FAAEM
Anita M. Ziemak, MD FAAEM

WARNING

Is Your Financial Advisor RIPPING YOU OFF?

DOWNLOAD **FREE** REPORT AT
LOTUSWEALTHSOLUTIONS.COM:

"HOW FINANCIAL ADVISORS RIP OFF DOCTORS"

This is the report NO financial advisor wants you to read!

SAY GOODBYE TO HIGH FEES!

WELCOME TO LOW FEES!

Lotus Wealth Solutions has one of the LOWEST advisor fees in the country. That means more money in YOUR pocket and for your retirement.

Take control of your financial life and make smarter financial decisions.
*Call **404.816.9555** for your **FREE consultation**.*

404.816.9555
SETU MAZUMDAR, MD
PRESIDENT
Board Certified Emergency Medicine Physician
LOTUSWEALTHSOLUTIONS.COM

LOTUS
WEALTH SOLUTIONS

Upcoming AAEM–Sponsored and Recommended Conferences for 2011

AAEM is featuring the following upcoming 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/conferences.php

AAEM–Sponsored Conferences

April 16-17, 2011
AAEM Pearls of Wisdom Oral Board Review Course
Chicago, Dallas, Los Angeles, Orlando, Philadelphia
www.aaem.org

August 24-25, 2011
AAEM Pearls of Wisdom Oral Board Review Course
Las Vegas, NV
www.aaem.org

August 25-28, 2011
AAEM Written Board Review Course
Newark, NJ
www.aaem.org

September 10-14, 2011
The Sixth Mediterranean Emergency Medicine Congress (MEMC VI)
Kos, Greece
http://www.emcongress.org/2011/

September 17-18, 2011
AAEM Pearls of Wisdom Oral Board Review Course
Chicago, Dallas, Los Angeles, Orlando Philadelphia
www.aaem.org

AAEM–Recommended Conferences

May 5-6, 2011
Practical Emergency Airway Management
Baltimore, MD
http://jeffline.jefferson.edu/jeffcme/airway/

May 13-15, 2011
The Difficult Airway Course-Emergency™
Boston, MA
www.theairwaysite.com

May 15-18, 2011
Heart Course: Cardiac Emergency and Resuscitation
Boston, MA
www.theheartcourse.com

May 25-27, 2011
High Risk Emergency Medicine
San Francisco, CA
www.highriskem.com

June 2-3, 2011
Practical Emergency Airway Management
Baltimore, MD
http://jeffline.jefferson.edu/jeffcme/airway/

June 10-12, 2011
The Difficult Airway Course-Emergency™
Chicago, IL
www.theairwaysite.com

June 22-25, 2011
Clinical Decision Making in Emergency Medicine
Ponte Vedra Beach, FL
www.clinicaldecisionmaking.com

July 7-8, 2011
Practical Emergency Airway Management
Baltimore, MD
http://jeffline.jefferson.edu/jeffcme/airway/

August 4-5, 2011
Practical Emergency Airway Management
Baltimore, MD
http://jeffline.jefferson.edu/jeffcme/airway/

September 8-9, 2011
Practical Emergency Airway Management
Baltimore, MD
http://jeffline.jefferson.edu/jeffcme/airway/

September 9-15, 2011
Emergency Response Group
Nahariya, Israel
www.jfgi.org/page.aspx?id=203624

September 23-25, 2011
The Difficult Airway Course-Emergency™
Seattle, WA
www.theairwaysite.com

September 26-28, 2011
2nd Up To Date Emergency Medicine Practice Conference
Riyadh, Saudi Arabia
www.kfmced.com/uemp

October 6-7, 2011
Practical Emergency Airway Management
Baltimore, MD
http://jeffline.jefferson.edu/jeffcme/airway/

October 28-30, 2011
The Difficult Airway Course-Emergency™
Atlanta, GA
www.theairwaysite.com

November 3-4, 2011
Practical Emergency Airway Management
Baltimore, MD
http://jeffline.jefferson.edu/jeffcme/airway/

November 13-16, 2011
Heart Course: Cardiac Emergency and Resuscitation
Las Vegas, NV
www.theheartcourse.com

November 18-20, 2011
The Difficult Airway Course-Emergency™
Las Vegas, NV
www.theairwaysite.com

December 1-2, 2011
Practical Emergency Airway Management
Baltimore, MD
http://jeffline.jefferson.edu/jeffcme/airway/

December 2-4, 2011
Critical Points in emergency Medicine
Las Vegas, NV
www.criticalpoints.net

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

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

Simple Tips to Improve Patient Satisfaction

Michael Pulia, MD FAAEM
President, AAEM Young Physicians Section (YPS)

"Welcome to the emergency department. May I take your order?"
"I'll take the chest pain value work-up."
"An EKG with a side of blood work. Any toppings today?"
"Sure how about aspirin, nitroglycerin and dilaudid. Morphine makes me itchy."
"Would you like a CXR with that?"
"No, I want to supersize that to a CT scan."
"That will be an extra $2,000; is that okay?"
"Sure, why not!"
"Okay that will be $50 with your co-pay; anything else?"
"Yes, make it snappy!"

Does this conversation sound even vaguely familiar? If so, it should be easy to convince you that the era of McMedicine has come to an ED near you. Although I used this factitious interaction as hyperbole, it does reflect the daily struggles we face in trying to provide excellent patient care while meeting the expectations of patients who are more informed and demanding than ever. A lack of formalized training in patient satisfaction during residency combined with responsibility for factors beyond our control (e.g., facility quality, boarding patients in the ED) makes this task more than frustrating at times. Regardless of your opinion on these new expectations, it is long past the time for lamenting a bygone era of medicine, when interacting with patients in a paternalistic manner was the norm and patient satisfaction was a foreign concept. Like it or not, to thrive in this new reality, we have to start seeing patients as they see themselves: informed health care consumers. Through education and practice, we can develop the skills needed to meet this challenge head-on.

If you are still resisting jumping on the "service with a smile" bandwagon, it might just run you over. Today, there are online reservations for ED visits, publically broadcasted wait times, patient comfort rounds, drive-through vaccination programs, hospital-employed patient advocates and retail clinics trying to meet these new demands. Meanwhile, as the ED is more frequently the gateway into a health care system, it is important to realize that patients' experiences here can influence decisions about future use and referrals. In order to keep up with the competition, administrators are focusing on patient feedback as a measure of quality care, which ultimately results in greater scrutiny on how you provide care, not just your outcomes. Combine this with trends in pay for performance, and both your job security and bottom line could be affected.

Yet it is not all doom and gloom. The patient satisfaction game does offer a bright side. Success in this area has been shown to reduce malpractice exposure, enhance perceptions of your clinical competence, raise levels of patient compliance and improve job satisfaction and morale.[1-10] Thus, instead of focusing on the negative, it is helpful to look to these positive outcomes as motivation for examining some of the simple steps you can use during your next shift to start improving patient satisfaction.

Before outlining specific techniques to improve patient satisfaction, it is important to understand exactly what patients expect when they arrive at the ED. Thankfully, a significant amount of research has already been conducted to define the physician-related determinants of patient satisfaction in EM. An oversimplified summary of these efforts is that our patients want rapid/efficient care from a physician who is empathetic and communicates well.[10-13] Although it seems like such a simple statement, it is in fact deceptive in that it lists subjective components that vary from patient to patient. Still, keeping this statement in mind, we can use some simple strategies to meet the demands of the majority who have reasonable expectations about their ED experience.

The one factor that seems to rise above the rest for ED patients is wait time. They do not want to wait at any time during the experience, which includes time to registration, time to triage, time to room placement, time to treatment by the physician and time to disposition. Of course, most of this wait time is beyond your immediate control. Aside from getting involved in the process of determining how your ED is run (e.g., bedside triage/registration, physician in triage), there is not much you can do change these built-in times. However, when it comes to wait times, it is crucial to understand that perception is not always reality. It might be surprising to learn that patients' perception of wait time can vary significantly from the actual time elapsed.[14] This disconnect provides the opportunity for us to utilize techniques that can alter perceptions of time and bend the satisfaction curve in our favor. Achieving this goal requires two steps: setting expectations and providing explanations.

Each initial interaction with patients should conclude with an estimated timeline of the encounter. Setting expectations by letting patients know the exact steps and timing of a workup for their particular complaint will ultimately reduce uncertainty, mitigate stress and demonstrate respect for the logistics of their lives. This brief interaction changes their perception of wait times, which has a bigger influence on patient satisfaction than actual wait time.[14,15] When utilizing this technique, it is important to remember the business principle of "under promise, over deliver." By setting the estimated time at a mark you can meet or beat 99% of the time, you are more likely to end up with a pleasantly surprised patient who has waited less time than expected.

Meanwhile, the explanation component of this technique is used in those circumstances when the workup is taking longer than you initially promised. From a patient's perspective, the only thing worse than waiting is waiting without receiving any explanation. If you underestimate the time, you must go see the patient, apologize, explain the exact nature of the delay, and then provide an updated encounter timeline. A similar approach can be used during the initial interaction if the triage-to-physician time takes more than one hour (the average time patients feel they should wait regardless of acuity).[16] In most facilities, it is most likely impossible to ensure that each patient is seen in less than one hour; therefore, this may seem like an unreasonable expectation. Nevertheless, the best approach is to understand the expectation and offer a brief apology and explanation when we fail to meet it. Doing so will typically diffuse

continued on page 19

Simple Tips to Improve Patient Satisfaction - continued from page 18

any anger and frustration that the patient has built up while allowing you to move forward with the encounter.

In addition to wait times, patients seem to place significant value on physician empathy when considering satisfaction. Empathy is a decidedly subjective factor, but it is not exclusively personality driven. A few specific actions could make a significant difference between being perceived as warm and kind or cold and callous. For instance, sitting down during the encounter has been shown to increase the perceived physician bedside time.[17] Undoubtedly, if patients feel that you spend a sufficient amount of time listening to all their concerns, they will perceive you as caring. In the time crunch inherent in EM, anything we can do to enhance the time we spend with the patient (whether real or perceived) is of tremendous value.[18] Furthermore, research on physicians' body language in the clinic setting suggests that a seated position with your torso and legs facing the patient is important for establishing collaborative interaction and demonstrating active listening. Sitting down is especially important in the ED because, as opposed to a traditional office visit where both physician and patient are seated, our patients are typically in the more vulnerable prone position with us standing over them. Therefore, whenever possible, we should try to recreate the framework that people are accustomed to when they interact with a physician to relay a complaint. This not only creates a familiar dynamic, but also lets patients know that we are fully engaged with what they have to tell us.[19] Although perceived empathy is subjective, simple actions like sitting down can influence patient perception and significantly improve your effectiveness in this area.

These simple techniques merely scratch the surface of what you can do to improve your patient satisfaction scores. Each clinical scenario presents unique challenges in terms of patient expectations, so use your best judgment when developing a plan to win patients over. Patient satisfaction will only become more important in the future. Improving our efforts in this area will benefit us and our patients in numerous ways, which should be enough to convince everyone to get on board. By continuing to educate ourselves and practice new methods, we can integrate these skills into our clinical practice and use them as another tool in our arsenal of excellent patient care.

1. Vaccarino J. Malpractice. The problem in perspective. *JAMA*. 1977 Aug 22;238(8):861-3.
2. Kaplan S, Greenfield S, Ware JE Jr. Assessing the effects of physician-patient interactions on the outcomes of chronic disease. [Erratum appears in Med Care. 1989 Jul;27(7):679]. *Medical Care*. 1989 Mar:110-27.
3. Evans B, Stanley R, Mestrovic R, Rose L. Effects of communication skills training on students' diagnostic efficiency. *Medical Education*. 1991 Nov;25(6):517-26.
4. Hickson G, Clayton E, Entman S, Miller C, Githens P, Whetten-Goldstein K, et al. Obstetricians' prior malpractice experience and patients' satisfaction with care. *JAMA*. 1994 Nov 23;272(20):1583-7.
5. McLeod P, Tamblyn R, Benaroya S, Snell L. Faculty ratings of resident humanism predict patient satisfaction ratings in ambulatory medical clinics. *Journal of General Internal Medicine*. 1994 Jun;9(6):321-6.
6. Hall JA, Roter DL, Katz NR. Meta-Analysis of Correlates of Provider Behavior in Medical Encounters. *Medical Care*. 1988 Jul;26(7):657-75.
7. Roter DL, Hall JA, Katz NR. Relations between Physicians' Behaviors and Analogue Patients' Satisfaction, Recall, and Impressions. *Medical Care*. 1987 May;25(5):437-51.
8. Rydman RJ, Roberts RR, Albrecht GL, Zalenski RJ, McDermott M. Patient Satisfaction with an Emergency Department Asthma Observation Unit. *Academic Emergency Medicine*. 1999;6(3):178-83.
9. Taylor C, Benger JR. Patient satisfaction in emergency medicine. *Emergency Medicine Journal*. 2004;21(5):528-32.
10. Trout A, Magnusson AR, Hedges JR. Patient Satisfaction Investigations and the Emergency Department: What Does the Literature Say? *Academic Emergency Medicine*. 2000;7(6):695-709.
11. Hall M, Press I. Keys to patient satisfaction in the emergency department: results of a multiple facility study. *Hospital & Health Services Administration*. 1996;41(4):515-32.
12. Bursch B, Beezy J, Shaw R. Emergency department satisfaction: What matters most? *Annals of Emergency Medicine*. 1993 Mar;22(3):586-91.
13. Yarnold PR, Michelson EA, Thompson DA, Adams SL. Predicting Patient Satisfaction: A Study of Two Emergency Departments. *Journal of Behavioral Medicine*. 1998 Dec 1;21(6):545-63.
14. Thompson DA, Yarnold PR, Williams DR, Adams SL. Effects of Actual Waiting Time, Perceived Waiting Time, Information Delivery, and Expressive Quality on Patient Satisfaction in the Emergency Department. *Annals of Emergency Medicine*. 1996 Dec;28(6):657-65.
15. Sun B, Adams J, Orav E, Rucker D, Brennan T, Burstin H. Determinants of patient satisfaction and willingness to return with emergency care. *Annals of Emergency Medicine*. 2000 May;35(5):426-34.
16. Monzon J, Friedman SM, Clarke C, Arenovich T. Patients who leave the emergency department without being seen by a physician: a control-matched study. *CJEM*. 2005;7(2):107-13.
17. Johnson RL, Sadosty AT, Weaver AL, Goyal DG. To Sit or Not to Sit? *Annals of Emergency Medicine*. 2008 Feb;51(2):188-193.e2.
18. Bruce T, Bowman J, Brown S. Factors that influence patient satisfaction in the emergency department. *Journal of Nursing Care Quality*. 1998 Dec;13(2):31-7.
19. Robinson JD. Getting Down to Business Talk, Gaze, and Body Orientation During Openings of Doctor-Patient Consultations. *Human Communication Research*. 1998;25(1):97-123.

AAEM Young Physicians Section

The Young Physicians Section (YPS) of AAEM is proud to announce the new 2011 – 2012 Board of Directors:

President – Michael S. Pulia, MD FAAEM

Vice President – Elizabeth C. Hall, MD FAAEM

Secretary-Treasurer – Jennifer Kanapicki, MD

Immediate Past President – Brian Potts, MD MBA FAAEM

At-Large Board Members:

Heather K. Jiménez, MD

Alicia M. Pilarski, DO

Jeffery M. Pinnow, MD

Michael A. Ybarra, MD

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.

The service is complimentary to all YPS members. If you are not a YPS member, visit us at www.ypsaaem.org to join and learn about the additional membership benefits.

FAAEM *always* means board certified

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.

Pan-Pacific Emergency Medicine Congress 2012

PEMC 2012

Hand-in-Hand Across the Pacific

October 23-26, 2012
Coex, Seoul, Korea

For the first time, the American Academy of Emergency Medicine (AAEM) and the Korean Society of Emergency Medicine (KSEM) organize the Pan-Pacific Emergency Medicine Congress 2012 (PEMC 2012), in Seoul, Korea, on October 23-26, 2012. The latest issues and various areas that cover the emergency medicine will be discussed.

Approximately 1,000 attendees will join the congress. Renowned scholars and experts will offer sessions and workshops in areas of interest to those involved in emergency medicine around the world.

PEMC 2012 will provide every participant with an excellent opportunity to exchange ideas, build new networks, strengthen old ones, and keep up with what is happening in the emergency medicine.

Mark your calendar for the PEMC 2012.
For more information, visit at
www.pemc2012.org.

Hosted by

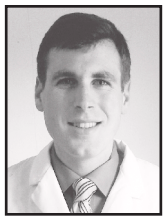
The Korean Society of Emergency Medicine

American Academy of Emergency Medicine

RESIDENT PRESIDENT'S MESSAGE

International Emergency Medicine

Ryan Shanahan, MD
AAEM/RSA President



I recently returned from a trip to Haiti with a group of pediatric residents from Johns Hopkins. The person who runs the trip is a pediatric emergency medicine attending, and she invites the emergency medicine residents along. It was, in short, an eye-opening trip. It also caused me to reflect on the fledgling field of international emergency medicine and, in doing so, I want to highlight some of the efforts of the Academy in this regard.

To say that Haiti has a health care system is to stretch the definition of those words. To say that they have an emergency medical system would simply be false.

Haiti operates as the U.S. did in the 40s and 50s. A hearse doubles as an ambulance in some lucky places; in most others taxi-motorcycle will have to do. Rooms little different from outpatient clinic rooms serve as the "ER," and these are staffed with a random assortment of specialties on a rotating basis. Surgical backup is spotty to nonexistent, and everything shuts down at five or so.

In other parts of the world, however, countries with more resources are making the transition from the "emergency room" to rooms (emphasis on the plural) and departments. Training programs in emergency medicine are opening in places as far flung as Vietnam and Guyana. For these training programs to mature into full-fledged specialties requires support and networking. AAEM has been a growing and active voice in the field of international emergency medicine and is an important partner for this networking.

AAEM has been a partner in the Mediterranean Emergency Medicine Conference, now entering its sixth iteration. We are currently working on plans for a Pan-Pacific conference and are deepening our relationship with the Inter-American Emergency Medicine Conference. AAEM has demonstrated a consistent effort to support the development of our specialty on an international stage. These meetings are important because they provide legitimacy to the specialty and allow countries with weak emergency services to learn from neighbors who are more advanced in their development of the field.

I encourage residents from the United States to look at these conferences as the powerful networking tools they are. There are vast swaths of the world where proper emergency care is a distant dream. To enable the transition will require some internal level of medical structure, but also some help and guidance in the transition. It is an exciting area, and I am pleased that AAEM is so involved in it.

The Third biennial

Emergency Medicine In the Developing World

Conference



Isixeko Sasekapa, uMzantsi Afrika

Cape Town, South Africa

15 to 17 November 2011

Molweni basebenzi becandelo lenkonzo ezingxamisekileyo

Greetings Emergency Medicine Workers

Join us in the Mother City for a truly **African** conference experience

Scientific content Paediatrics to Psychiatry, Toxicology to Trauma

Pre-conference workshops: 14 November 2011 Cardiology, Ultrasound, Airway, Nursing, Disaster and Paediatrics

Venue Cape Town International Convention Centre

Call for Abstracts Abstracts may now be submitted through the website www.emssa2011.co.za. Abstract submission will close on 1 September 2011.

Visit us on **www.emssa2011.co.za** for more details

EMSSA

Emergency Medicine Society of South Africa

RESIDENT EDITOR'S LETTER

The EM Resident as Teacher

Leana S. Wen, MD MSc
AAEM/RSA Board Member

It's the start of your shift, and every bay is full. There are 37 patients in the waiting area. A bright-eyed third year medical student runs up to you and tells you that he has a new patient. "He's a 40-year old with lung cancer with a chief complaint of fever and chills. He says he has a cough and hasn't been eating well at home and also has some abdominal pain after his chemo. On his physical exam, he had some abdominal tenderness and guarding. I think he has some kind of viral syndrome or pneumonia or sepsis. I'm not sure what to do but I think we should get some labs."

Whoa! All kinds of thoughts run through your head. How sick is this guy? Is he neutropenic with a fever? Does he have a surgical abdomen? What kind of differential is that: viral syndrome or sepsis? This patient is too sick, you decide. I need to take over myself. So you thank the med student and go see the patient yourself. The student doesn't know what he's doing, you decide. It's a busy shift, and you don't have time to teach.

As we transition from interns to junior to senior residents, a growing part of our responsibility is leadership and teaching. During residency, all of us teach medical students. Even if we don't stay in academics, teaching is still a critical skill, because we will continue to teach physician extenders, nurses and our patients. Learning how to teach also enables us to become better lifelong learners.

Yet, of all of the skills we learn in residency, learning how to teach is something we are just expected to know how to do. Few programs provide specific training on how to teach—which is unfortunate, because educators know that teaching, like practicing medicine, is a skill that requires training, focus and commitment. This article is by no means sufficient as a guide to teach, but I will provide some tips and a simplified model for you to teach in the ED.

"But I don't have time. The ED is busy enough as it is. It's faster to have a student tag along with me than for the student to see the patient by himself. Besides, I don't know enough to teach."

It's probably true that you can see patients faster on your own. Our attendings can probably see patients faster on their own, too. If everyone thought that way, no one would ever learn! As for knowledge, you will see as we go along that you know far more than you think you do.

Tip #1: Set goals and expectations

Have a quick talk at the start of your shift. Ask them where they are in their clinical training (third vs fourth year, how many rotations they've done, etc.) and what their goals are from this rotation (first rotation of third year vs sub-internship wanting to learn procedures, etc.). Give basic expectations on your end. These might include talking to you before signing up for patients so you can assign them specific people; coming to find you immediately if there are concerning vital signs or any sign of the patient being unstable; and presenting to you within 15 minutes of seeing the patient. Let them know that your first and foremost goal in the ED is patient care, but you are also committed to teaching—and the two can happen together, even in the busy ED setting.

Tip #2: Enforce the three-minute presentation

Before the student presents the patient to you, make sure the student understands that being concise and focused is key. As such, they should aim to give a presentation of no more than three minutes. This three-minute presentation model was adapted for EM by Davenport, et al, as a way to train students to the EM-presentation style and also help teachers provide specific feedback. Let the student know this is your expectation. Keeping the presentation to three minutes allows you more time to teach the student, as well as get on with your work.

Tip #3: Teach by the one-minute preceptor model

Neher and colleagues developed a five-step interactive teaching process called the one-minute preceptor model. Initially designed for the outpatient setting, it works equally well for the ED. I'll show how it applies to the example at the beginning.

Step 1: Get a commitment

"So what do you think is going on? Does the patient look very sick? Viral syndrome is very different from sepsis."

Step 2: Probe for supporting evidence

"What were his vital signs? You said he has a fever, but his heart rate and blood pressure are normal. What do these vital signs tell you about whether he is in sepsis?"

"Where do you think his fever is coming from? What about from the abdomen—tell me about the belly exam again?"

Step 3: Teach a general principle

This could be a good time to talk about fever in cancer patients. You can talk about sepsis and the criteria for sepsis. You can talk about the abdominal exam. If you are strapped for time, choose one teaching point and focus on that.

Step 4: Reinforce what was done

"I'm glad you came to get me as soon as you saw the patient. He could be very sick."

Step 5: Correct learner's errors and make recommendations for improvement

"It's important to include vital signs in your presentation. Saying that someone has guarding is very serious, so make sure to do a thorough abdominal exam and provide an accurate description of it."

Tip #4: Model professionalism

Maybe you're an intern and you don't have formal teaching responsibilities in the department yet. Maybe you're rotating at a hospital without students. No matter what, you are a leader, and

continued on page 29

PeerCharts Online™ is an emergency medicine charting system built to **mirror** your style. Unlike other systems, it **adapts** to you, not the other way around. Describe the encounter your way with complaint-specific content that's **personalized** to your style and **evolves** to enhance performance.

With the live document viewer you'll be confident that the chart **reflects** exactly what you intended because you can **view it as you do it**.

When your patient encounter doesn't fit the mold, **flexibility** is the key. Using content guidance with voice narrative, PeerCharts Online™ offers the perfect **balance** between structure and speed.

Click • Talk • Type™ = Personalized automation + Voice = It's your **choice**.

PeerCharts™ online

See our 3 minute intro!
http://www.peercharts.com/intro

EvolveMed • 175 West 200 South #4004, Salt Lake City, UT 84101 • 800.301.4901 • www.peercharts.com

Resident Journal Review: September – October 2010

Karin Chase, MD; Alena Lira, MD; Christopher Doty, MD FAAEM; and Michael C. Bond, MD FAAEM

This is a continuing column providing a review of journal articles pertinent to emergency medicine (EM) residents. It is not meant to be an extensive review of the articles, nor is it wholly comprehensive of all the literature published. Rather, it is a short list of potentially useful literature that the busy EM resident may have missed. Residents should read the articles themselves to draw their own conclusions. This edition will include articles published in September and October 2010.

Emergency Department Visits For Concussion in Young Child Athletes. Bakhos L, Lockhart G, Myers R, Linakis J. *Pediatrics* **2010; 126:e550-e556.**

The topic of sports related concussion (SRC) has received increasing attention in the media and in clinical practice. Pre-high school-aged children (8-13 years old) are an understudied group who are likely more vulnerable to the sequelae of concussions. These young athletes are at a different developmental stage than older athletes, which has lead to a demand for more research and raises a question whether there should be age-specific guidelines on the management of concussion.

In this retrospective review, the authors focused on emergency depaprtment (ED) visits for SRC in pre-high school versus high school-aged athletes. The National Electronic Injury Surveillance System (NEISS), the NEISS All Injury Program (NEISS-AIP), and the National Sporting Goods Association (NSGA) were the sources of information gathered for the review. All emergency department (ED) visits for concussion were included in the data analysis. These visits were subdivided into all causes, all sports-related, individual and leisure sport-related and organized team sport (OTS)-related. The OTS included the five most common concussion-generating sports: football, basketball, baseball, ice hockey and soccer.

The authors found that between 2001-2005, children aged 8-19 years, had an estimated 502,000 ED visits for all cause concussion and of those, 50% were SRC. Of the SRC, 40% were seen in the 8-13 age group. These percentages correlate to an estimated incidence of ED visits for SRC of roughly 4 in 1,000 U.S. children aged 8-13 and roughly 6 in 1,000 U.S. children aged 14-19 during 2001 to 2005. The authors also examined the trend of ED visits for concussion over time and found that over a 10-year period from 1997 to 2007, ED visits for OTS related concussion in 8-13 year olds doubled. In the older aged group (14-19 years old) the visits increased by more than 200%. These dramatic increases over time were found despite an approximate 13% decrease in overall team sport participation in the same 10 years.

The high incidence of SRC virtually guarantees that any practicing EM physician will need to be up to date on the signs, symptoms, management and appropriate follow up for these patients. This study highlighted the large number of young child athletes that visit the ED with concussion. The source of the data is a limitation. The NEISS included only ED visits; therefore, visits to other health care facilities (urgent care centers or doctor's offices) are not accounted for, as well as concussions that are managed at home or at school. Therefore, the method of data collection likely resulted in an underestimation of the incidence of SRC in these age groups. As clinicians, we must have a heightened awareness when managing these young patients and be cognizant of the fact that this population is likely more vulnerable to the sequelae of concussion. The ED also gives us the opportunity to educate the patient and family about preventive measures which should be taken when participating in sports.

Bedside Ocular Ultrasound for the Detection of Retinal Detachment in the Emergency Department. Yoonessi R, Hussain A, Jang T. *Acad Emerg Med.* **2010; 17:913-917.**

The incorporation of ultrasound into daily EM practice continues to increase. The benefits of this imaging modality include its noninvasive nature and accessibility. Ophthalmologists use ultrasound to diagnose various ocular pathologies, and it is a modality that can be utilized by ED physicians to identify potential ocular emergencies.

The authors looked at the use of bedside ocular ultrasound to identify retinal detachment in ED patients presenting with acute visual changes. The study was a prospective, observational study using a convenience sample in an urban academic ED. The providers that performed the bedside ultrasounds included both attending and resident-level physicians with adequate ultrasound training. Patients were enrolled in the study if they had less than 48 hours of visual changes, an ophthalmology consult was to be obtained, and if the bedside ocular ultrasound could be done prior to the ophthalmology evaluation. The standard for the diagnosis of retinal detachment was that given by the ophthalmologist after their examination.

A total of 48 patients were enrolled in the study, of which 18 had a confirmed diagnosis of retinal detachment. The authors found that beside ocular ultrasound for detection of retinal detachment was 100% sensitive (95% confidence interval (CI) = 78% to 100%) and 83% specific (CI 65% to 94%). There were five patients with vitreous hemorrhage that were misidentified as having retinal detachment. Ultrasound results obtained by more experienced ultrasonographers (physicians with more than 50 prior ultrasounds) were analyzed in a separate subgroup analysis, and the results were similar.

Despite the limitations of this study, which include small sample size and high prevalence of retinal detachment found in the population, these results support using ultrasound as a possible screening tool for retinal detachment. In the current ED environment, which is busy and fast-paced, the use of an accessible, non-invasive imaging modality to evaluate emergent diagnoses is welcome. Given that retinal detachment is an ocular emergency, this study supports that even with minimal training, bedside ocular ultrasound may aid in triaging patients with acute visual changes.

Six Years of Epinephrine Digital Injections: Absence of Significant Local or Systemic Effects. Muck A, Bebarta V, Borys D, Morgan D. *Ann Emerg Med.* **2010; 56:270-274.**

The outpatient treatment of choice for severe allergic reactions and anaphylaxis is epinephrine administered via an autoinjector. One of

continued on page 28

If you have not yet set up your AAEM/RSA members only account, please visit http://aaemrsa.execinc.com/edibo/LoginHelp. In order to authenticate your identity, you will be required to enter your current email address on file with AAEM/RSA. Please contact us at info@aaemrsa.org if you need to update your email address.

AAEM/RSA is Going Green!

The Journal of Emergency Medicine (JEM), *the official journal of the American Academy of Emergency Medicine, is provided in electronic format only. If you prefer to receive* JEM *in both paper and electronic format, a subscription upgrade is available for an additional $20 per year. If you are a current member and would like to upgrade your* JEM *subscription, please log in to your members only account and click on "Publications."*

Now Being Accepted!

2011-2012 AAEM/RSA Membership Applications

Join or renew your membership online at https://aaemrsa.execinc.com/edibo/Signup or call our office at 800-884-2236 to renew over the phone.

Have You Moved?

If you are a graduating resident or medical student and your email address will be changing, we recommend you use an email address outside of your institution once you've logged into the RSA members only section. You may update your email address on file at any time. This will ensure your member benefits will continue without interruption. Please include any changes to

- Last Name (include maiden name if applicable)
- Mailing Address (including city, state and zip)
- Email Address
- Telephone Number

To update your contact information, please login to your members only account at https://aaemrsa.execinc.com/edibo/Login/Default/call or contact us at info@aaemrsa.org or (800) 884-2236.

The Next Generation of Board Review—

"This book is amazing; it's really helping my in-service review."

"AAEM and Dr. Schofer have done an outstanding job preparing a comprehensive and succinct review of emergency medicine designed to prepare you for the qualifying exam in emergency medicine. With the review chapters and test questions, I would not need any other resource to prepare for this exam."

AAEM Resident and Student Association's:

Emergency Medicine: A Focused Review of the Core Curriculum

INTRODUCTORY PRICE:
$49.95 for AAEM members (plus shipping & handling)
$79.95 for non-members (plus shipping & handling)

15% discount for 100% residency programs
Buy a set of board review books for your graduating seniors or incoming interns and save 10%!

Editor-in-Chief: Joel Schofer, MD FAAEM
Senior Associate Editor: Amal Mattu, MD FAAEM
Associate Editors: James Colletti, MD FAAEM
Elizabeth A. Gray, MD
Robert Rogers, MD FAAEM
Richard Shih, MD FAAEM

"A Focused Review of the Core Curriculum has found the perfect balance of depth and brevity to match my test anxiety and short attention span."

This is a 22 chapter text based on the contents of the national AAEM Written Board Review Course, and written to prepare you for the:

- Emergency medicine qualifying exam (formerly the "written boards")
- Emergency medicine annual resident in-service exam
- ConCert Exam
  - 79 color images
  - 225 question practice in-service examination
  - 22 chapters written by experts in the field

This text also serves as a comprehensive review of emergency medicine for the motivated medical student.

To purchase your copy, go to www.aaemrsa.org or call 800-884-2236.

Resident Journal Review - continued from page 26

the inherent risks of the autoinjector is an accidental digital injection and the associated concern for digital ischemia.

In this retrospective review, the authors reviewed cases that were reported to six poison centers in Texas and sought to determine the frequency of digit ischemia after accidental epinephrine injections. Both adult (0.3mg) and junior (0.15mg) autoinjector accidents were included in this study. Secondary outcomes included frequency of digital injections, treatments used, adverse local effects and systemic effects. The chart review identified 365 patients with hand epinephrine injection exposure that had been reported to the six poison centers over six years. Of those patients, 213 had finger injuries. The final analysis consisted of 127 patients with finger injuries who received complete follow up.

The patients ranged in age from 8 months to 69 years. Fifty-four percent of the cases were managed outside the hospital. A majority of the patients (77%) had a minor effect from the digital injection including symptoms such as pain, blanching and discoloration at the injection site. Ten percent of the patients reported no effect from the injection. There were four patients (3.1%) that had a report of an ischemic finger. All patients, including those with ischemia, had complete resolution of their symptoms, most in less than two hours. Regarding medical treatment, 77% received no drug therapy. Of those patients who did receive treatment, the regimens consisted of nitroglycerine paste alone, phentolamine alone, both nitroglycerine paste and phentolamine, or terbutaline alone. All of the patients with reports of an ischemic finger received drug therapy. None of the patients had significant systemic effects, none were admitted, nor had a surgical consult or received surgical care.

This study suggests that digital ischemia after an epinephrine digital injection is a rare event, and if symptoms do occur, they usually resolve in less than two hours. This study does have limitations. It is a retrospective review, and the data set is limited to only those cases reported to the poison centers. Data from the poison center is not based on first hand observation of the clinical picture but relies on physician reporting. In addition, many of the patients with finger injuries had no follow up (86/213) after the initial contact with the poison center.

Despite the limitations, the findings of the current study could be used as a foundation to guide a reasonable observation time in the emergency department before discharge of such patients. This evidence supports previous literature stating that complications associated with local anesthetic digital blocks with lidocaine containing epinephrine are extremely rare. In clinical practice though, there still remains a certain degree of unnecessary hesitancy in utilizing lidocaine with epinephrine when repairing finger injuries that should no longer exist.

Randomized Controlled Trial of Trimethoprim-Sulfamethoxazole for Uncomplicated Skin Abscesses in Patients at Risk for Community-Associated Methicillin-Resistant Staphylococcus Aureus Infections. Schmitz G, Bruner D, Pitotti R, et al. *Ann Emerg Med.* **2010;56:283-287.**

With the increasing prevalence of community-associated Methicillin-Resistant *Staphylococcus aureus* (CA-MRSA) as a cause of skin and soft tissue infections, the question of whether antibiotics are necessary after incision and drainage (I&D) of simple abscesses continues to linger. If the decision is made to prescribe antibiotics, trimethoprim-sulfamethoxazole is commonly used when CA-MRSA coverage is needed.

In this multi-centered, randomized, double-blinded, placebo-controlled trial, the authors evaluated whether a seven-day course of trimethoprim-sulfamethoxazole taken after I&D of a simple abscess reduced treatment failure at seven days. Treatment failure was defined as no improvement after two days, development of a new lesion within seven days, or worsening infection within seven days that prompted more aggressive treatment. Secondary outcome was the development of new lesions at 30 days. A convenience sample of 212 adults were enrolled and randomized to receive either trimethoprim-sulfamethoxazole (160mg/800mg) two pills by mouth twice a day for seven days or placebo after I&D of an abscess performed in the ED. The study had a number of exclusion criteria; most notable was the exclusion of immunocompromised patients (HIV, diabetes and cancer patients). After the initial ED visit and I&D of the abscess, the enrolled patients were asked to return on days two and seven for re-evaluation and appropriate wound care. Telephone calls, return ED visits within 30 days, and review of medical records were used to obtain 30 day follow up for the secondary outcome.

Ninety-six patients were randomized to the trimethoprim-sulfamethoxazole group and 116 patients to the placebo group. Follow up at seven days was obtained for 190/212 (90%) of the patients. The authors found no statistically significant difference in treatment failure at seven days; 17% (15/88) in the trimethoprim-sulfamethoxazole group versus 26% (27/102) in the placebo group ($p = 0.12$). At 30 days, 69% of patients were available for follow up. Nineteen percent fewer lesions were seen in the treatment group 9% (4/46) versus placebo 28% (14/50) which was statistically significant (95% CI 4% to 34%, $p= 0.02$).

In the current era of antibiotic overuse and increasing antibiotic resistance, these findings are important. This study does not support routine use of antibiotics to cover against CA-MRSA after I&D of a simple abscess in an immunocompetent patient. However, the results must be interpreted with some caution given the limitations of the study design. A significant number of patients were lost to follow up, especially at 30 days, which may have affected the secondary outcome analysis. Furthermore, the convenience sample may limit the generalizability of these results.

Accuracy and Quality of Clinical Decision Rules for Syncope in the Emergency Department: A Systematic Review and Meta-Analysis. Serrano LA, Hess EP, Bellolio F, Murad MH, Montori VM, Erwin PJ, Decker WW. *Annals of Emerg Med* **2010; 56(4):362-373.**

The focus of the ED evaluation of an adult with syncope has shifted from diagnosis to risk stratification. Several clinical decision rules that predict adverse outcomes in these patients have been created to aid with clinical decision-making and patient disposition. The goal of this meta-analysis was to evaluate the methodological quality and prognostic accuracy of currently available clinical decision rules.

The authors conducted a comprehensive search of six databases and recent abstracts to identify all relevant studies that derived or

continued on page 29

Resident Journal Review - continued from page 28

validated clinical decision rules or risk scores to predict subsequent adverse outcomes. The quality of the decision rules as well as the quality of the individual studies was assessed by two independent reviewers. Data from studies that used the same clinical decision rule was pooled for the final meta-analysis, and between-study heterogeneity was assessed. Eighteen studies, representing nine clinical decision rules, were identified in the initial search. Of those, only 12 studies, representing five clinical decision rules, had enough quantitative data to undergo full quantitative analysis. Of the five clinical decision rules, only two were validated - the San Francisco Syncope Rule (SFSR) and the Osservatorio Epidemiologico sulla Sincope nel Lazio risk score (OESIL), the others were derived but lacked further validation.

Of the clinical rules, the most studied is the San Francisco Syncope Rule, which was evaluated by nine of the 12 studies included in this meta-analysis. It is the only clinical decision rule that evaluates adverse outcomes within seven days of the initial ED visit. In this meta-analysis, the pooled sensitivity and specificity for the SFSR was lower than in the original study (sensitivity 86% vs 96%; specificity 49% vs 62%, respectively).

The findings of the initial OESIL derivation study showed that abnormal electrocardiogram (ECG), history of cardiovascular disease, lack of prodrome, and age greater than 65 predicted deaths at one year. The results were replicated in the initial validation cohort, but subsequent validation studies did not reproduce this result. Again, sensitivities and specificities differed markedly between the original study and the pooled data (sensitivity 100% versus 95%, specificity 22% versus 33%, respectively).

After evaluating multiple clinical decision rules for syncope, the authors of this meta-analysis concluded that all clinical decision rules need further development prior to being routinely incorporated into clinical practice. Most of these rules have not been validated, and the ones that have show a high degree of variability between the individual studies. In an attempt to explain this variability, the subgroup analysis suggested that differences in study design and differences in ECG interpretation may account for the differences between the studies' outcomes. This is important to note because it bares consequences on how to correctly apply these rules in a wide variety of ED settings.

Clinical decision rules are desirable to assist complex decision-making such as that required in evaluation of patients with syncope. However, the current data warns that they should be applied with caution and should not be substituted for clinical experience and judgment. The methodological quality analysis in the current study suggested that, in order to increase their utility, clinical decision rules must contain clear definitions in order to be interpreted and applied correctly.

Resident Journal Review articles are now being translated to Spanish! AAEM would like to thank Fernando Soto, MD; Roberto Portela, MD FACEP; Cesar Andino, MD; Manuel Colón García de la Noceda, MD FACEP; Vanesa Torres Navarro, MD; Edgardo Torres, MD; and Dorcas Ruiz, MD, for their work on translating the article. To see the full translated Resident Journal Review article, please go to http://www.aaem.org/international/.

Resident Editor's Letter - continued from page 24

part of your responsibility is to serve as a role model for others. You can always model professionalism and teach by example to those around you.

As one of my mentors says, the ED is the modern home of diagnosis. We see the entire breadth of patient problems across the entire range of acuity. The ED is THE place for medical students to hone their history and physical skills and to learn to develop their differential and plans. It is a challenging, but fulfilling, place for residents to learn how to teach. We should all strive to become better teachers—a skill that will serve our students, our profession and ourselves.

I welcome comments to my articles. Please email: wen.leana@gmail.com.

MEDICAL STUDENT COUNCIL PRESIDENT'S MESSAGE

Feedback as a Means of Improvement

Brett Rosen, AAEM/RSA Medical Student Council President

There isn't a single person reading this article that is "perfect" – sorry! Each one of us likely strives for perfection but fully knows that we cannot be perfect in everything. Our goal then is to always learn something and become better, which bodes the question of how we can continue to become a better person each and every day. The primary way we become better is with feedback, both self-feedback and that given by others. One of the most discussed topics in undergraduate and graduate medical education today is the process of feedback. What is the best way of giving feedback? How often should we give feedback? What about *quality* vs. *quantity* of feedback?

If medical school does one thing aside from providing an education, it is learning the basics about giving and receiving feedback. I will share some of the tips that I have learned. Feedback has been an integral part of my medical education as I went through a pre-clinical problem-based group learning curriculum.

The single biggest factor in both the quality and quantity of feedback you receive, really, is you. If you are open to feedback and try to improve based upon it, you are more likely to be given feedback. If you tend to get defensive about every piece of feedback or are one of those individuals that "has an explanation for everything," you will receive very little feedback, and it will probably be of a lower quality. If you want feedback, you should also actively seek feedback from others. The sky is the limit in terms of who you get it from – attendings, residents, nurses, techs and even fellow students. Almost everyone looks at something different and can provide you with a different perspective.

It is easier to give positive feedback than constructive criticism, and this is why the majority of all feedback is positive. Many people prefer not to give "negative" feedback or constructive criticism because they fear that they will offend someone or that the person will take it personally. Sometimes you need to be proactive to get the constructive feedback. If you are open and genuinely care about what you hear, you will find that it will become more of a normal occurrence to get that kind of feedback.

Why is this important to us in emergency medicine? Every shift will provide you with a different group of people – staff, patients, residents and attendings. This leads to different people that can provide you with feedback after each shift. It is important as a student to learn the art of feedback. The first thing to do is reflect on your performance yourself and try to think what you could change or what you did well. After you do this, try to get a couple of minutes with the resident and attending that you worked with for the shift to ask what you can do better. Get both the good and the bad. Maybe you did an awesome job with your differential but could improve upon your presentation and procedural skills. You will find that if you act upon your feedback, your feedback will improve in both quantity and quality. This translates down the road to better evaluations, better letters, and most importantly, becoming a better person and physician.

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

FAAEM
always means
board certified

SAVE THE DATE

MEDITERRANEAN
EMERGENCY MEDICINE CONGRESS
www.emcongress.org

KOS, Greece

10–14 September **2011**

EuSEM
European Society for Emergency Medicine

FAAEM
always means
board certified

Hellenic Society for Emergency Medicine (HESEM)

Abstract Submission & Registration are open

Oral presentation deadline: 20 May 2011 at 11:59 PM ET

Poster presentations ONLY: 10 June 2011 at 11:59 PM ET