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OF THE AMERICAN ACADEMY OF
EMERGENCY MEDICINE

COMMONSENSE

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INSIDE

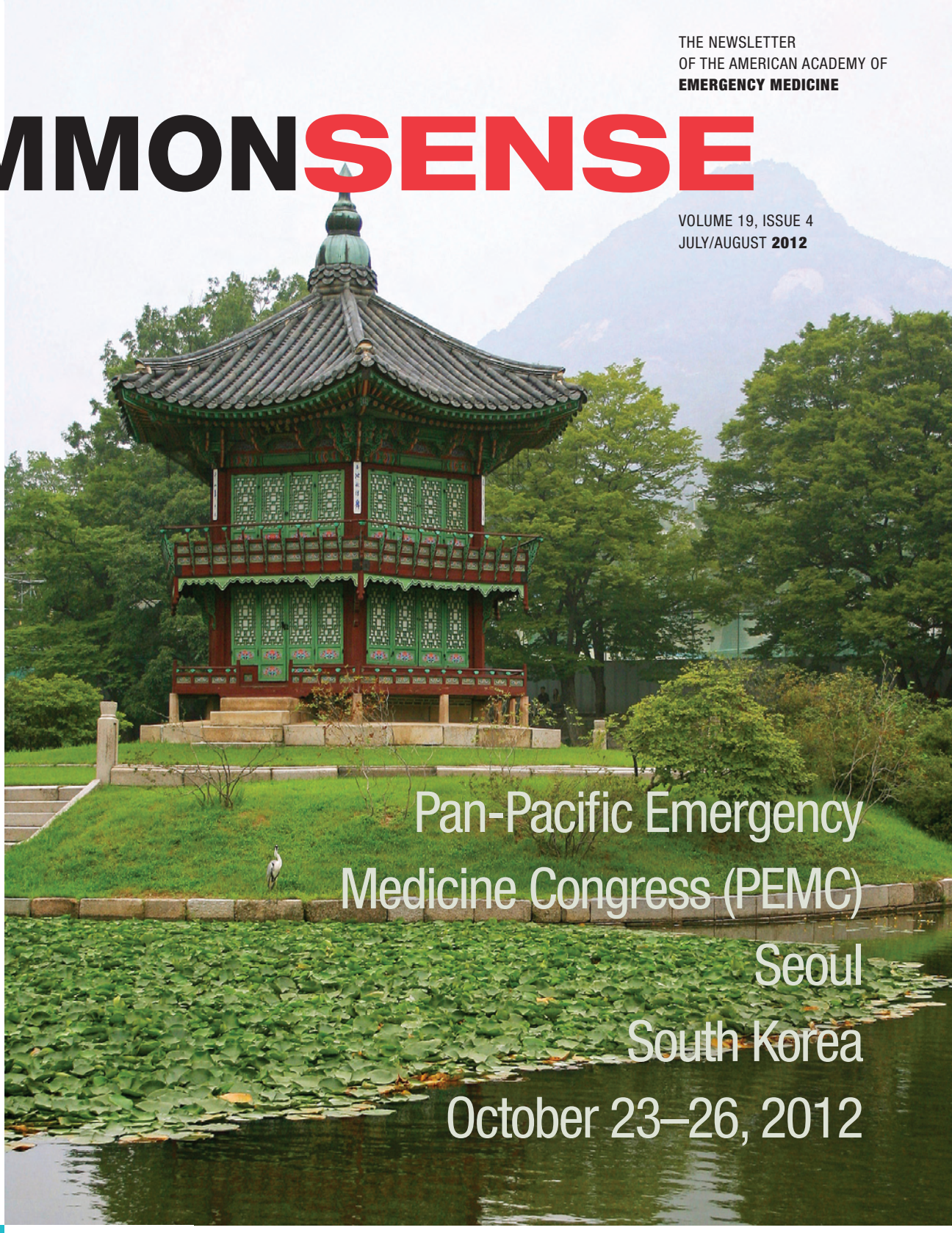

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Table of Contents

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 (Limited to graduates of an ACGME or AOA approved Emergency Medicine Program)
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President's Message

AAEM and International Emergency Medicine

William T. Durkin, Jr., MD MBA FAAEM

Over the past two months I have had the opportunity to represent the Academy at two international conferences: the Inter-American Emergency Medicine Conference held by the Sociedad Argentina de Emergencias (SAE) in Buenos Aires, and the International Conference on Emergency Medicine held by the International Federation for Emergency Medicine (IFEM) in Dublin. Both meetings were very successful, well attended, and provided excellent venues to learn more about the state of EM in various countries throughout the world.

We have been involved with the Argentinean society and its meeting for a number of years now. During this time the specialty has grown in their country, and EM residencies have increased and improved. Our speakers have been very well received and have contributed to the improvement of the specialty within that country. SAE president Dr. Fusco is very proud of his organization and is striving to improve the specialty not only within his own country but also by inviting other South and Central American countries to participate in this conference.

The IFEM had its meeting in Dublin, Ireland this June. The venue was perfect, and they were able to get Michael D. Higgins, the current president of Ireland, to give the keynote address. This shows the importance that this meeting had for Ireland and, indeed, all of the international EM community. Dr. Cameron, past president of IFEM, and his association did a fantastic job in putting together a world-class meeting and outstanding opportunities for networking. I took advantage of all of these networking events to speak to as many people as I could about the state of emergency medicine in their countries and how the Academy might be able to assist them. Many countries are where we were about 35 years ago, in that emergency physicians are internists; critical care specialists, anesthesiologists, and surgeons who—for a variety of reasons—gravitated to the practice of EM. Some view research through the eyes of an internist or surgeon. They have started emergency medicine residency programs but many are in their infancy.

As the American group of emergency specialists, we have much to contribute to and a lot to learn from our international colleagues. We will continue to be very involved. We can provide not only expertise in clinical topics but also in practice development, systems, and processes. By promoting and sponsoring international meetings, we help to improve communications amongst all of the participating countries. We also help to grow and improve the specialty of emergency medicine. Sharing speakers and expertise in developing training programs and partnering with other countries improves our visibility throughout the world community and improves the worldwide practice of emergency medicine. By growing the pie so that medical care improves in all countries, everyone wins. The Academy will continue to be recognized as the leader in international EM.

Lastly, it was a real honor for me to present Dr. Raed Arafat with our International Emergency Medicine Award. Dr. Arafat displayed great courage in standing up to the Romanian president and ultimately making him back down and protecting the nation's EMS system. You have to respect a physician who can stand up to a politician and win! He came to my attention last January, when photos of him in the international press showed him wearing one of our lapel pins. We are definitely a respected organization in the international community! ■

Contact the President: president@aaem.org

Law of the Land

Andy Walker, MD FAAEM
AAEM Board of Directors

The Patient Protection and Affordable Care Act, better known as Obamacare, is the law of the land. Passed by Congress in 2009 and signed into law by President Obama in 2010, it has now withstood judicial review by the Supreme Court almost entirely intact. Contrary to what many commentators predicted, the Court apparently found that invalidating one part of the law did not invalidate it entirely, despite its lack of a severability clause. What does this mean for the United States? For emergency physicians? As Inspector Harry Callahan said in *Magnum Force*, "A man's got to know his limitations." So, the honest answer is that I am not sure.

As an emergency physician, I am hopeful. Not only will ED volume almost certainly go up when more people have insurance, as occurred in Massachusetts after Romneycare became law—more ED patients will be insured. Emergency departments have been America's medical safety net for 25 years, required by law to take care of all comers, regardless of either their ability or willingness to pay for that care—but Congress neglected to include any funding with that mandate. Thus, we have been carrying a huge charity burden ever since EMTALA became law. Obamacare should reduce that burden, shifting some of it from the tiny fraction of Americans who are emergency physicians to taxpayers in general, where it more fairly belongs. And, if having insurance turns out to be the equivalent of being able to get good primary and specialty medical care, many more Americans will be healthier. That would obviously be a great accomplishment.

As a taxpayer, I am nervous. Emergency physicians are in the 20% of Americans who pay roughly 70% of all federal taxes and almost 90% of federal income taxes. In fact, most of us are in the top 5% of taxpayers, those who earn more than about $160,000 per year who pay approximately 60% of federal income taxes—while earning about 35% of the income, by the way. That means we are among the minority of Americans who will be picking up the check. Furthermore, the law includes several tax increases, in addition to the now-famous individual mandate noncompliance penalty. These include an increase in the Medicare tax, which unlike the Social Security tax has no ceiling, and a tax on dividend income. The dividend tax will especially hit those who have fled traditional stocks in search of safer, less volatile investments.

As a citizen, I am frightened. Our country is already hurtling towards financial catastrophe, driven by the entitlement spending that even now consumes almost 60% of the federal budget. When near-future obligations are added to current expenditures, Medicare and Medicaid are the biggest drivers of federal deficit spending—and thus the main economic threat to our nation's future. No mechanism to fully fund Obamacare is included in the bill, and the partial funding that is included assumes cuts in Medicare that Congress has been unwilling to make so far. It will be a surprise if our politicians find the spines they seem to have lost somewhere on the campaign trail, suddenly becoming more courageous and statesmanlike than they have been—so there is no reason to believe those assumed cuts will occur, or that alternatively, the tax base will be broadened to include more Americans. Unless there are additional drastic changes made in Obamacare, Medicare, Medicaid, and the private insurance industry—in our whole health care delivery system— the day of reckoning for the United States will approach even faster.

As someone who believes in the political philosophy of the Founding Fathers, I am disappointed. Patrick Henry said, "The Constitution is not an instrument for the government to restrain the people, it is an instrument for the people to restrain the government—lest it come to dominate our lives and interest." Chief Justice Roberts believes the federal government has powers the framers of the Constitution never dreamed of, based on its authority to tax. It now seems that any of us can be fined for anything, including doing nothing, under the federal government's ability to tax us. I am disappointed with this leap in government power, but not surprised. It will go down in history with other Supreme Court decisions that vastly expanded the power of the federal government: Helvering v. Davis in 1937, which gutted the Ninth and Tenth Amendments and did away with the Enumerated Powers doctrine; Wickard v. Filburn in 1942 and Gonzales v. Raich in 2005, which twisted the Commerce Clause beyond all recognition and made the phrase "interstate commerce" meaningless; and now NFIB v. Sebelius. Even if Obamacare is good public policy, I would feel safer if the Supreme Court had made us amend the Constitution to achieve it.

What do you think of the Supreme Court's decision? Happy, sad, a bit of both, undecided? Do you judge the issue mainly as an emergency physician, a taxpayer, or a citizen? Feel free to celebrate, complain, or argue with other Academy members at the new "Letters to the Editor" feature on the AAEM website. ■

Contact the Editor online at www.AAEM.org

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.

Congress Passes Bill Addressing Drug Shortages

Kathleen Ream, Director of Government Affairs

The Senate passed 92 to 4 the ***Food and Drug Administration Safety Innovation Act*** on June 26, readying the bill for President Obama's signature. The House passed the compromise legislation by voice vote on June 20. The four senators who voted against the compromise were Republicans Rand Paul of Kentucky, Richard M. Burr of North Carolina, and Tom Coburn of Oklahoma, as well as independent Bernard Sanders of Vermont.

The bill includes drug shortage notification language that makes particular reference to drugs used during surgery and emergency care. The Senate amended the drug shortage notification provision in its original bill to require manufacturers of drugs used in the provision of surgery and emergency care to report permanent discontinuances or temporary shortages. The original draft only included "life-supporting" and "life-sustaining" drugs.

Furthermore, the final bill also includes language which expanded one of the required Government Accountability Office studies to evaluate how providers are compensating for a lack of access to preferred drugs in caring for their patients and whether there are impediments to their ability to adjust accordingly that can be ameliorated.

President Obama signed the bill into law on July 9, 2012.

AAEM and AAEM/RSA actively worked on the passage of the bill and its provisions dealing with drug shortages to ensure that the concerns of emergency medicine were taken into consideration.

Screening Claim Cannot Succeed Minus Evidence Hospital Failed to Follow Policies

On March 14, 2012, the U.S. District Court for the District of Colorado granted summary judgment to a hospital after finding that plaintiffs, parents of a girl who died of severe dehydration after being treated for pneumonia in a hospital emergency department, failed to raise a genuine issue of fact that the hospital violated EMTALA (Etter v. Bibby, D. Colo., No. 1:10-cv-557, 3/14/12).

The Facts

On March 22, 2008, Gabrielle Etter, an active thirteen-year-old teenager, was taken by her mother and grandmother to Delta County Memorial Hospital's (DCMH) ED. Etter was evaluated by a triage nurse, who collected information relating to Gabrielle's medical history, current medications she was taking, and her reason for visiting the hospital. During this evaluation, Etter's vital signs were measured, and the patient described her pain level. Based on her initial intake assessment, the nurse classified Etter in triage category NU, non-urgent.

Forty minutes later, ED physician Charles Bibby collected Etter's medical history, performed a physical examination, and ordered a chest X-ray and multiple laboratory studies. "Blood and urine were collected to perform a panel of laboratory studies, but two tests were canceled by an unidentified hospital employee because of an insufficient blood volume in the original sample." Because Gabrielle's chest X-ray indicated pneumonia, the blood tests suggested a bacterial infection, and the urinalysis potentially indicated dehydration, "Bibby determined that additional tests were not medically necessary. Because he did not want to subject Gabrielle to more blood draws, Dr. Bibby approved the previous cancellation of additional tests and diagnosed Gabrielle with influenza and pneumonia … He ordered pain medications and antibiotics to treat Gabrielle's symptoms and illness. These medications were administered in the ED and prescribed to be taken at home following discharge." Before releasing Etter, the nurse collected the patient's discharge vital signs. Etter was discharged on March 22, 2008, and returned home. On March 23, 2008, Gabrielle Etter died.

Plaintiffs Johanna and Arthur Etter brought four claims on behalf of their daughter against Dr. Charles Bibby, Dr. Timothy Meilner, and DCMH. Three claims allege negligence and a breach of duty of care under state malpractice law by all three defendants, and a fourth claim alleges that Defendant DCMH violated EMTALA. Because DCMH has an ED, under EMTALA it has two obligations to patients requesting service: 1) it must conduct an "appropriate medical screening examination" (MSE) to determine the existence of an emergency medical condition (EMC); and 2) if the hospital acquires actual knowledge of an EMC, it must carry out "treatment as may be required to stabilize the medical condition." Plaintiffs alleged that the hospital did not meet either of these obligations in its assessment and treatment of their daughter. DCMH alleged that Plaintiffs failed to show a genuine issue of material fact regarding either Gabrielle's MSE or her EMC diagnosis and stabilization. At issue in this case was Defendant DCMH's Motion for Summary Judgment on both the EMTALA claim and the state malpractice claims.

The Ruling

In making a determination of whether Defendant treated Etter in the same manner as other patients, the court does not assess the adequacy of DCMH's MSE policies. Rather, the federal court must consider only whether the policies were followed. "In support of their MSE claim, Plaintiffs bring three arguments: 1) Defendant DCMH carried out an insufficient panel of metabolic tests; 2) it failed to administer additional tests which ought to have been administered; and 3) it violated its policy when it assigned Gabrielle to an incorrect triage category."

The court determined that as "a threshold matter, the first two arguments fail to claim a violation of hospital policy … Defendant DCMH's MSE policy requires a physician's medical screening to include the collection of a patient history, an appropriate physical examination, and a supportive diagnostic evaluation … Dr. Bibby's actions," wrote the court, "fall well within those dictated by Defendant DCMH's medical screening policy … Every ED has a multitude of medical tests at its availability; whether or not the tests are performed on a given patient is up to the discretion of trained professionals. Unless mandated by hospital policy, I decline to intervene and dictate which tests could or should have been administered. Plaintiffs have not identified a DCMH policy which was violated by the absence of additional medical tests and have failed to identify a genuine issue of material fact with respect to Gabrielle's MSE."

Continued on next page

Likewise, the district court found that the Etters did not provide any admissible evidence in support of their third argument: "Plaintiffs allege that Defendant DCMH violated its policy when it assigned Gabrielle an arguably incorrect triage category … Defendant DCMH's triage policy requires nursing personnel to evaluate the symptoms of each patient arriving in the ED and classify the immediacy of their medical needs into one of four categories. The purpose of this policy is to assure that patients are treated by physicians in a timely fashion … Plaintiffs argue that … based on the severity of her symptoms, Gabrielle should have been classified as having an 'emergent' medical condition. This classification mandates a physician evaluation within five to ten minutes. Gabrielle was seen by Dr. Bibby within forty minutes. Plaintiffs have failed to present evidence that a thirty-minute delay from ten to forty minutes actually impacted Gabrielle's diagnosis or treatment. In the absence of this evidence, these thirty minutes amount to a de minimus variation from Defendant DCMH's policy; this does not amount to a violation of the policy. Plaintiffs have, therefore, failed to identify a genuine issue of material fact about whether Gabrielle was afforded an appropriate MSE; any challenge to the medical diagnosis by Plaintiffs rests in their negligence claims, not EMTALA."

The Etters also contended that the hospital failed to stabilize their daughter. When a hospital knows that a patient has an EMC, it must stabilize the patient before transfer or discharge. When the patient has no diagnosed EMC, the duty to stabilize does not apply. "Under this standard," acknowledged the district court, "Plaintiffs must show that Defendant DCMH had actual knowledge." The court found that "Defendant DCMH has shown that its medical personnel had no actual knowledge of an EMC … In the absence of actual hospital knowledge, there is no EMTALA liability for failure to stabilize."

The federal court continued by explaining that "[a]lthough Plaintiffs argue that EMTALA liability can attach in the absence of actual knowledge, when it should have known that there was an EMC, there is no legal authority supporting this proposition. In fact, every circuit considering the issue has reached the opposite conclusion: actual knowledge of an EMC is a prerequisite to the duty to stabilize … The reason for this conclusion is apparent: if EMTALA dictated a `should have known' standard, it would swallow malpractice and overextend Congress' intended reach."

Defendant DCMH's motion for summary judgment on Plaintiffs' EMTALA claims was granted. And because the jurisdiction over Plaintiffs' malpractice claims was dependent upon the court's jurisdiction over the EMTALA claim, the federal judge declined to "exercise supplemental jurisdiction over what are uniquely state law claims … Accordingly, it is also ordered that Plaintiff's three claims for relief under malpractice are dismissed without prejudice."

The Full text of the court's decision can be accessed at http://law.justia.com/cases/federal/district-courts/colorado/codce/1:2010cv00557/118195/98

EMTALA Amendment for Hospital-Owned Ambulances Applies Retroactively

On November 4, 2011, in reconsidering its earlier decision, the U.S. Court for the Southern District of Indiana granted summary judgment to a hospital, finding that the plaintiffs failed to show they "came to" the hospital's ED as required to maintain a claim under EMTALA. The court determined that, in light of a regulatory amendment clarifying the term "comes to the emergency department" as it relates to hospital-owned ambulances, it had not properly considered the retroactive application of a regulation for purposes of EMTALA (Beller v. Health & Hospital Corp. of Marion County, S.D. Ind., No. 1:03-cv-889, 11/4/11).

The Facts

This court's prior decision refusing to grant Defendant Health and Hospital Corporation of Marion County, Indiana, d/b/a Wishard Memorial Hospital d/b/a Wishard Ambulance Service, was first reported in the Fall 2011 issue of *Common Sense*, "Summary Judgment on Stabilization Claim Denied to Ambulance-Owning Hospital," at www.aaem.org/UserFiles/file/commonsense1111.pdf.

On behalf of her son Joshua Beller, Melissa Welch filed suit alleging that Wishard violated EMTALA by failing to stabilize Beller's emergency medical condition before he and his mother were transferred on June 14, 2001. Wishard filed a motion for summary judgment, which on June 17, 2011, the district court denied. As described in the Fall 2011 *Common Sense* article, at issue was whether a 2003 amendment to 42 C.F.R. § 489.20 applied retroactively to an alleged EMTALA violation that occurred in 2001. The 2001 version of § 489.20 defined "comes to" the ED to mean "that the individual is on the hospital property," which includes hospital-owned ambulances, "even if the ambulance is not on hospital grounds." The 2003 amendment clarified that hospital-owned ambulances are not considered to have "come to" the hospital's ED if they are operating under a community-wide emergency medical service (EMS) protocol and are diverted to the closest appropriate facility. Wishard's hospital-owned ambulance was operating under a community-wide EMS protocol when it transported plaintiffs to another hospital. The court ruled that at the time of the incident the exceptions did not exist, making granting summary judgment inappropriate.

Defendant Wishard responded to the decision by filing a motion for reconsideration. Specifically, Wishard contended that the 2003 amendment, adopted by the U.S. Department of Health and Human Services (DHHS), "clarifying the term 'comes to the emergency department' applies retroactively, and as such, Plaintiffs cannot maintain a claim under the EMTALA." As such, Wishard urged the court to grant summary judgment in its favor, citing "Seventh Circuit case law recognizing that an agency's regulation or rule that clarifies an unsettled or confusing area of law may be applied retroactively."

The Ruling

Where Wishard argued that the 2003 amendment to the EMTALA should be applied retroactively because it was a clarification of the DHHS' 2001 interpretation, Plaintiffs maintained that "the 2003 amendment was not a mere clarification to the DHHS' 2001 regulation, but a substantive change to the regulation that precludes any retroactive effect; therefore, DHHS' 2001 interpretation of the term should apply." Drawing on Seventh Circuit precedent, the court determined that the "2003 Regulation promulgated by the DHHS can be viewed as a clarification amendment because the DHHS intended to alleviate confusion surrounding ambulances operating under EMS protocols. For example, the DHHS stated that its reason

Continued on next page

for adopting the 2003 Regulation was 'to clarify the responsibilities of hospital-owned ambulances so that these ambulances can be more fully integrated with citywide and local community EMS procedures for responding to medical emergencies'."

The court gave "deference to the DHHS' interpretation of the 2003 regulation as a clarifying amendment to 42 C.F.R. §489.24 as it relates to hospital-owned ambulances operating under communitywide EMS protocols. Moreover, the court finds that the 2003 Regulation may be retroactively applied in this case because DHHS' clarification of the EMTALA's reach over hospital-owned ambulances operating under EMS protocols had been a constant source of confusion for hospitals."

Upon reconsideration, the court concluded that it committed an error of law when it previously denied Wishard's summary judgment motion "without regard to the Seventh Circuit's rulings with respect to retroactive application of administrative regulations. In light of the Court's review of the law, the Court finds the 2003 Regulation is controlling and applies retroactively in regards to interpreting the term 'comes to the emergency department' under 42 C.F.R. § 489.24."

The court granted Wishard's motion for reconsideration, entitling defendant to summary judgment as a matter of law. The court also vacated its previous decision.

To review the full text of the district court's opinion, go to http://law.justia.com/cases/federal/district-courts/indiana/insdce/1:2003cv00889/2739/143 ■

EMTALA case synopsis prepared by Terri L. Nally, Principal, KAR Associates, Inc.

Law and Emergency Medicine:

Indemnification Clauses in Emergency Physician Contracts

Larry D. Weiss, MD JD FAAEM

Law and Emergency Medicine *is a new feature that will be appearing regularly in* Common Sense. *Articles will focus on legal, regulatory, and political issues that affect emergency physicians. We need and welcome your feedback, and if you have expertise you would like to share with other members of the Academy, we also welcome article submissions. Please contact the editor at cseditor@aaem.org.*

Most of the abusive, and frankly exploitative, practices in emergency medicine directly emanate from provisions in emergency physician contracts. One of the newer, more ominous, and increasingly common contractual clauses attempts to saddle emergency physicians with uninsurable risks. These clauses have the innocuous title of "hold harmless" or "indemnification" clauses. Often, the language appears deceptively evenhanded, stating that all parties to the contract will hold each other harmless or indemnify each other.

To "indemnify" or to "hold harmless" means to insure another party's risk. The danger lies in the fact that in the ordinary course of clinical activities, these clauses often result in one-way indemnification whereby emergency physicians protect their employers, their contract groups, or their hospitals. Generally, under these agreements, an allegedly negligent party indemnifies other parties at risk due to "vicarious liability." Employers have vicarious liability for acts their employees commit in the ordinary course of employment. This applies to groups or hospitals employing physicians. Likewise, contract holders and hospitals may have vicarious liability for independent contractor physicians if the patient reasonably concluded that the physician acted as an apparent agent of the hospital.

If a patient files a medical malpractice case against you, alleges vicarious liability against your hospital, and you signed a contract agreeing to indemnify the hospital—you will pay for the hospital's attorney fees, court costs, and any jury verdict rendered against the hospital! You may also have to pay for any settlement agreements whereby the hospital makes a payment to the plaintiff. However, virtually no medical malpractice policies provide coverage for indemnification agreements. Thus, the physician will have uninsured risks resulting in personal liability. Not only do these clauses force you to assume uninsurable risk, in reality, the obligations are not mutual. When will a plaintiff allege primary negligence on the part of a hospital and then claim that you have vicarious liability? This never happens, because you will not have responsibility for the acts of a hospital or an employer.

Several years ago when I served as in-house counsel for a large physician-owned emergency medicine group, a hospital administrator insisted that our group sign an indemnification clause as a condition for maintaining the contract to manage the emergency department. We looked all over the United States and Europe and could not find a malpractice policy that covered indemnification. Finally, we told the hospital administrator we would agree to indemnify the hospital if he could find us a policy that covered indemnification. He finally relented when he realized that no such policy existed.

The presence of an indemnification clause in a physician contract should provide notice to the physician that something is wrong with the position being offered. Perhaps an overzealous attorney inserted the clause into the contract. On the other hand, a hospital or group may have inserted the indemnification clause in an effort to take advantage of unwary physicians. AAEM considers this an ominous practice worthy of condemnation. Therefore, at its February 2012 meeting, the AAEM board of directors approved a position statement declaring that emergency physician contracts should not include indemnification clauses. (Position Statement can be read at www.aaem.org/em-resources/position-statements.)

In summary, indemnification clauses create uninsurable risks for physicians. They often represent a deceptive attempt to unfairly shift risk to unwary physicians. Physicians who discover such a clause in their contracts should either look for another job or retain the services of a contract attorney if they otherwise find the offered position desirable. ■

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 who contributed from 1-1-12 to 7-13-12.

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

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The Business of Emergency Medicine

2012 Emergency Medicine CPT Statistics – Medicare

Mr. James R. Blakeman

The Business of Emergency Medicine *is a new feature that will be appearing regularly in* Common Sense. *Articles will focus on the private practice of emergency medicine, sharing knowledge that will help emergency physicians start, maintain, and grow independent practice groups. We need and welcome your feedback, and if you have expertise you would like to share with other Academy members, we welcome article submissions. Please contact the editor at cseditor@aaem.org.*

Each year the Centers for Medicare and Medicaid Services (CMS) publishes Part B Medicare Annual Data (BMAD), reporting the usage of CPT codes and Medicare allowed amounts for the prior year. The annual data include all claims with dates of service in the prior year, processed by Medicare contractors by June 30th of the following year. The agency estimates that this covers 96% of all claims that will be filed for the year of service.

The BMAD data allow for trend reporting and benchmarking analysis. Some interesting trends appear from the data that independent practices might find helpful when reviewing their coding practices. The data also allow for predictions of the net Medicare payment changes that result from annual Medicare policy changes. Similar data are not available from non-Medicare sources, so benchmarking across all payers is still an estimate.

For example, the following tables show the total Relative Value Unit (RVU) changes for each EM service and for the 30 procedure codes most commonly reported to Medicare in the emergency department setting (not including inpatients, outpatient clinic, or other non-ED services). The BMAD data pertain to claims processed before June 30, 2011, for patients seen in 2010.

Table 1:

E/M Codes Billed to Medicare by Spec. 93 Emer Med in 2010

CPT	Description	E/Ms Billed by Specialty 93 in 2010	Billed Per 10K Pts	Percent of E/M Services	2011 RVU	2012 RVU	RVU Increase / Decrease
99281	ED Level 1 E/M	40,415	25	0.3%	0.61	0.60	-1.6%
99282	ED Level 2 E/M	307,247	193	1.9%	1.19	1.18	-0.8%
99283	ED Level 3 E/M	2,509,018	1,579	15.7%	1.80	1.77	-1.7%
99284	ED Level 4 E/M	4,174,281	2,627	26.1%	3.40	3.37	-0.9%
99285	ED Level 5 E/M	7,738,683	4,870	48.5%	4.98	4.94	-0.8%
99291	Critical Care 1st hour	1,120,933	705	7.0%	6.40	6.38	-0.3%
99218	Low Level Obs- Different Day	5,313	3	0.0%	1.90	2.77	45.8%
99219	Mid Level Obs- Different Day	13,341	8	0.1%	3.17	3.81	20.2%
99220	High Level Obs- Different Day	41,466	26	0.3%	4.43	5.23	18.1%
99234	Low Level Obs- Same Day	2,550	2	0.0%	3.88	3.86	-0.5%
99235	Mid Level Obs- Same Day	5,554	3	0.0%	5.07	4.84	-4.5%
99236	High Level Obs- Same Day	11,680	7	0.1%	6.30	6.23	-1.1%
	TOTALS	15,970,481	10,050	100.0%			-0.8%

Table 2:

Procedures Billed to Medicare by Spec. 93 Emer Med in 2010

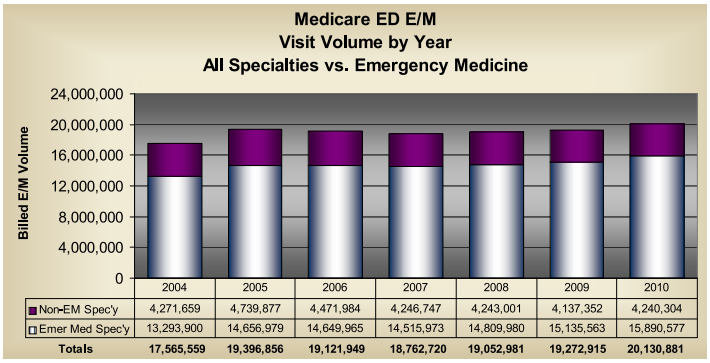
CPT	Description	Procedures Billed by Spec 93 in 2010	Billed Per 10K Pts	Percent of Visits w/ procedure	2011 RVU	2012 RVU	RVU Increase / Decrease
93010	Electrocardiogram report	2,927,675	1842	18.3%	0.26	0.25	-3.8%
93042	Rhythm ECG, report	437,163	275	2.7%	0.22	0.21	-4.5%
71010	Chest x-ray	152,924	96	1.0%	0.26	0.26	0.0%
31500	Insert emergency airway	121,671	77	0.8%	3.24	3.24	0.0%
99292	Critical care, addÆl 30 min	99,323	63	0.6%	3.21	3.20	-0.3%
12001	Repair superficial wound(s)	84,255	53	0.5%	1.62	1.46	-9.9%
12002	Repair superficial wound(s)	73,125	46	0.5%	2.08	1.90	-8.7%
36556	Insert non-tunnel cv cath	66,277	42	0.4%	3.62	3.60	-0.6%
99183	Hyperbaric oxygen therapy	56,502	36	0.4%	3.49	3.51	0.6%
92950	Heart/lung resuscitation cpr	53,901	34	0.3%	5.14	5.39	4.9%
12011	Repair superficial wound(s)	52,976	33	0.3%	1.94	1.79	-7.7%
11042	Debridement subq >20 sq cm	47,763	30	0.3%	1.40	1.75	25.0%
71020	Chest x-ray	47,528	30	0.3%	0.32	0.31	-3.1%
30901	Control of nosebleed	41,560	26	0.3%	1.69	1.68	-0.6%
99217	Observation care discharge	38,398	24	0.2%	2.04	2.06	1.0%
97597	Selective debridement >20 sq/cm	36,680	23	0.2%	0.71	0.70	-1.4%
12013	Repair superficial wound(s)	32,282	20	0.2%	2.19	2.01	-8.2%
29125	Apply forearm splint	25,058	16	0.2%	1.25	1.15	-8.0%
10061	I&D Abscess, complic/multi	24,952	16	0.2%	4.69	5.09	8.5%
10060	I&D Abscess, simple	19,954	13	0.1%	2.71	2.77	2.2%
43760	Change gastrostomy tube	19,930	13	0.1%	1.47	1.45	-1.4%
99144	Mod Sedation, adult, 1st 30 min.	19,771	12	0.1%	0.00	0.00	0.0%
62270	Spinal fluid tap, diagnostic	18,559	12	0.1%	2.32	2.30	-0.9%
21800	Rib fx, closed treatment	18,230	11	0.1%	3.04	3.28	7.9%
G0168	Wound closure, Dermabond	17,659	11	0.1%	0.76	0.78	2.6%
29515	Application lower leg splint	16,063	10	0.1%	1.43	1.45	1.4%
30903	Control nosebleed, complex	15,324	10	0.1%	2.40	2.38	-0.8%
51702	Insert temp bladder cath	14,973	9	0.1%	0.91	0.89	-2.2%
12004	Repair superficial wound(s)	11,776	7	0.1%	2.53	2.34	-7.5%
20610	Drain/inject, joint/bursa	11,590	7	0.1%	1.46	1.46	0.0%
	TOTALS	4,603,842	2,897	28.8%			

Continued on next page

We compared 2010 Medicare utilization data with data from 2008 (Graph 1), to find that ED visits had increased 5.7%, from 19,052,981 to 20,130,881, while allowed amounts for the same EM services (Graph 2) increased from $2,320,375,375 to $2,714,174,631, a 17.0% pay increase.

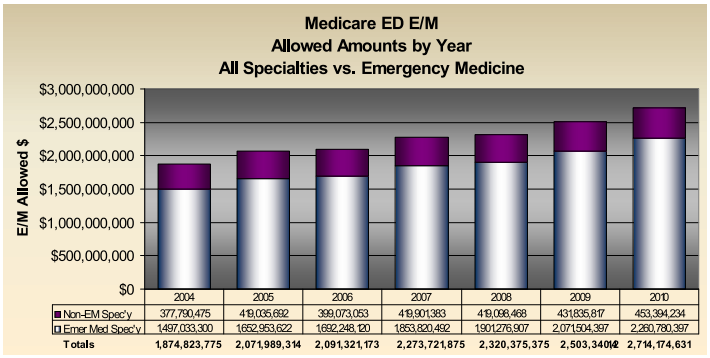
Some of the increase is explained by RVU and conversion factor changes in the 2-year period, which caused payments per RVU for emergency physician services to rise about 6.0%. The rest of the 17.0% pay increase came from increased overall volume and reporting more intensive services, particularly 99285 (ED Level 5 E/M) and critical care codes. Utilization of these two services went up 15.7% in the two year period, and pay allowances increased 22.2%.

Graph 1



	2004	2005	2006	2007	2008	2009	2010
Non-EM Spec'y	4,271,659	4,739,877	4,471,984	4,246,747	4,243,001	4,137,352	4,240,304
Emer Med Spec'y	13,293,900	14,656,979	14,649,965	14,515,973	14,809,980	15,135,563	15,890,577
Totals	**17,565,559**	**19,396,856**	**19,121,949**	**18,762,720**	**19,052,981**	**19,272,915**	**20,130,881**

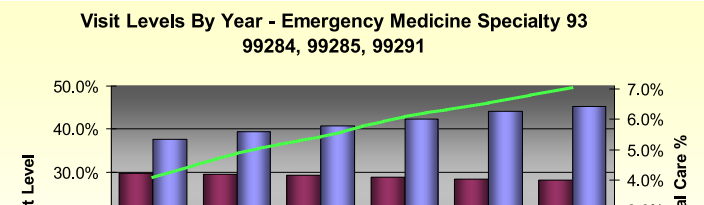
Graph 2



	2004	2005	2006	2007	2008	2009	2010
Non-EM Spec'y	377,790,475	419,035,692	399,073,053	419,901,383	419,098,468	431,835,817	453,394,234
Emer Med Spec'y	1,497,033,300	1,652,953,622	1,692,248,120	1,853,820,492	1,901,276,907	2,071,504,397	2,260,780,397
Totals	**1,874,823,775**	**2,071,989,314**	**2,091,321,173**	**2,273,721,875**	**2,320,375,375**	**2,503,340,214**	**2,714,174,631**

Graph 3 below shows that in 2005, 99285 services were claimed 37.7% of the time by Emergency Medicine Specialty 93 (CPT 99291 Critical Care 1st Hour is included as an ED EM service). By 2010, that rate had climbed to 45.3%, a rise of 20% in use of the high level EM code. Critical care services (CPT 99291) rose from a rate of 4.1% in 2005 to 7.1% in 2010, a rise of 73.0%.

Graph 3



	2005	2006	2007	2008	2009	2010
99284	29.7%	29.5%	29.3%	28.9%	28.3%	28.3%
99285	37.7%	39.3%	40.7%	42.4%	44.2%	45.3%
99291	4.1%	4.9%	5.4%	6.1%	6.5%	7.1%

While emergency physician services receive less than 3.0% of the total Medicare Part B payments each year, the use of 99285 has been among the top 10 most expensive CPT codes reported each of the last five years. In 2010, we were number seven on the list of the most allowed payments for the year. The CPT 99285 generated $1,591,242,089 in allowed amounts in 2010. That is a 21.0% pay increase from this single CPT code in just two years.

This rate of increase in total payments to emergency physicians comes at the price of increased scrutiny, as CMS has noticed that ED physician service payments are among the fastest growing in the house of medicine. Medicare beneficiaries, who are aging and getting sicker each year, would reasonably require more intensive services. However, higher levels of service are not being reported in the office setting at the rate of increase in the emergency setting. Medicare has been encouraging contractors around the country to perform more medical reviews to determine if inappropriate billing is taking place.

In 2011, the Medicare contractor for California began a statewide pre-payment audit project, looking at thousands of ED physician charts for 99285 services. The contractors for Wisconsin, Michigan, Missouri and Kansas have begun doing the same. This is a considerable burden for billers, who must track down claim review notices sent to hospital medical records departments or to physicians' homes. When notices are not received by billers in time to respond within the 30-day response period, Medicare determines that the claim was billed without a medical record existing to support the service. If you receive a notice from your Medicare contractor, forward it immediately to your billing company. Failure to respond to these requests quickly can cause a more comprehensive audit that will add to the burden of securing appropriate payment.

Please consider joining the Practice Management Committee to lend your experience in the independent practice of emergency medicine. Contact Committee Chair, Craig Norquist, MD FAAEM, at info@aaem.org if you are interested. ■

James R. Blakeman is the Senior Vice President at Emergency Groups' Office, Arcadia, CA

References:

1. Raw data are taken from BMAD for claims filed by June 30, 2011, for dates of service Jan. 1-Dec. 31, 2010. CMS reports the data by Specialty Designation, HCPCS code, modifier and facility versus non-facility. Physicians who have enrolled with Medicare under the specialty of emergency medicine are identified as Specialty 93. Our analysis eliminated all data reported by Specialty 93 for services rendered in a non-facility (office) setting or in the inpatient setting. About 78% of all 99281-99285 ED visit codes were reported by Specialty 93 in 2010.

View from the Podium

Michael L. Epter, DO FAAEM
Education Chair
AAEM Board of Directors

"Follow effective action with quiet reflection … From the quiet reflection will come even more effective action"—James Levin

As I reflect on the past year in my role as Education Chair for the American Academy of Emergency Medicine, I see that it has been a rewarding one for me on multiple levels. Needless to say, to follow Joe Lex and Kevin Rodgers is humbling. Their leadership of this committee and forward thinking have allowed the Academy to be regarded as a leader in emergency medicine education, both nationally and internationally. These educational offerings have expanded to include Academy-sponsored Written and Oral Board Review Courses, as well as sponsorship of international conferences: MEMC last year in Kos, Greece; the Inter-American Emergency Medicine Conference this year in Buenos Aires, Argentina; and the upcoming Pan-Pacific Emergency Medicine Congress in South Korea (October 23-26th, 2012).

Perhaps our "crown jewel," and the one event that epitomizes the work of an outstanding educational team and provides our members with cutting-edge, up to date, results-oriented, and clinically relevant didactic sessions, is the Annual Scientific Assembly.

This year's Scientific Assembly at the Hotel del Coronado in San Diego was attended by nearly 1,000 registrants! The kick-off for the conference was a memorable plenary session titled "Everyday Leadership: Secrets of Great Minds through the Ages," by Amal Mattu, MD FAAEM. Attendees had the privilege of hearing one of the premier speakers in emergency medicine discuss the qualities of extraordinary leaders—whether aspiring to be a successful emergency physician, spouse, parent, or national leader.

Other plenary sessions featured pre-eminent speakers, including doctors DeBlieux, Talan, Sharieff, Mahadevan, and Shih, as well as a joint session led by the internationally acclaimed hosts of EM:RAP—Mel Herbert, MD FAAEM, and Stuart Swadron, MD FAAEM. Day 2 kicked off with a brand-new session titled "Ask the Experts." This unique, innovative session featured panelists presented with challenging cases in critical care, cardiology, and neurology, and their step-by-step approach to problem solving and clinical management.

The Open Mic session, EM Photo Contest, and RSA-YPS track were also successful conference events.

In addition to their publication in the April issue of *JEM*, the top three abstracts from the AAEM/*JEM* Resident and Student Research Competition were featured in *EP Monthly*. This was the debut of this collaboration, and we look forward to an ongoing relationship to highlight the work of our members. Thanks go out to Mark and Logan Plaster of *EP Monthly*.

On another high note, the Academy has been reaccredited by the ACCME as a provider of continuing medical education until 2016. Achievement of this lengthy accreditation cycle would not have been possible without the countless hours invested by Janet Wilson (Associate Executive Director, AAEM) and Marcia Blackman (Meetings Manager, AAEM), along with the ACCME subcommittee.

If you thought it couldn't get any better than the past year—it can and it will! We are currently in the process of planning for the 19th Annual Scientific Assembly. This premier educational event will take place at the newly opened luxury resort The Cosmopolitan in Las Vegas, February 9-13th, 2013. I have had the opportunity to walk the property, and attendees will be impressed, not only with the conference layout, but with the myriad amenities offered by this unique hotel. The Scientific Assembly subcommittee will soon be completing work on the preliminary program for 2013, and this will be highlighted in the next installment of "View from the Podium."

I look forward to continuing the educational mission of the Academy and to "paying it forward" to the future leaders of the Education Committee and AAEM. My passion to serve the membership continues to grow.

I expect and will accept nothing but the best from myself as Education Chair. Please contact me anytime (mepter@medicine.nevada.edu) with your comments or suggestions about how the committee can offer you all that you need to treat the people that matter most to the Academy—our patients. ■

Sickle Cell Disease EM Guidelines Under Development

Leslie Zun, MD MBA FAAEM
AAEM Board Member

On June 18, 2012, the American Academy of Emergency Medicine was represented at the National Heart, Lung and Blood Institute's National Blood Disorders Program Coordinating Committee. The focus of the meeting was to assist in the dissemination of recommendations from the expert panel report on the management of sickle cell disease. Some of the recommendations apply to emergency medicine.

The specific recommendations for EM include those on the treatment of acute vaso-occlusive disorder, fever, acute chest syndrome, and chronic pain. The details of the guidelines have not yet been released.

It was interesting to note that many other organizations were represented, such as the Society for Academic Emergency Medicine.

I will continue to keep AAEM informed of developments and distribute recommendations when they are released. Please let me know if you have any questions or comments by emailing me at info@aaem.org. ■

AAEM Members Honored by IFEM

The International Federation for Emergency Medicine (IFEM) announces that Terrence Mulligan, DO MPH FACOEP FNVSHA FACEP FAAEM FIFEM HPF, has been elected to the IFEM Board. Dr. Mulligan will serve as the North American Regional Representative.

In addition, the IFEM has awarded fellowships to Cherri D. Hobgood, MD FAAEM, and Girish Bobby Kapur, MD MPH FAAEM, at the International Conference on Emergency Medicine in Dublin, Ireland.

According to the IFEM, the Order of the IFEM (FIFEM) is awarded to a nominee biennially. Fellowship is conferred on those who are a members of an IFEM member organization and who have "demonstrated an extensive and continuous commitment to the specialty of Emergency Medicine in their own country and has made significant contributions to supporting the development/advancement of the International Federation for Emergency Medicine." A compete list of FIFEM honorees can be found at http://ifem.cc/About_IFEM/AwardsFIFEM_Honour_Roll.aspx ■

AAEM Member Appointed to National Council

U.S. Transportation Secretary Ray LaHood recently appointed Carol Cunningham, MD FACEP FAAEM, to serve a two-year term on the National Emergency Medical Services Advisory Council (NEMSAC). NEMSAC consists of 25 leaders in emergency medical services who advise the National Highway Traffic Safety Administration (NHTSA) on all EMS-related matters.

"I am both humbled and honored to have the opportunity to serve our nation and our EMS community in this role," stated Dr. Cunningham, who is the State EMS Medical Director for Ohio and an emergency physician at Akron General Medical Center. She is also an associate professor at the Northeast Ohio Medical University, the Medical Director for several local EMS agencies, and chairs the Medical Directors Council at the National Association of State EMS Officials.

According to a NHTSA news release, the Council functions to advise the safety agency and its federal partners regarding issues such as EMS personnel recruitment and retention, quality assurance, data collection, and EMS Education.

The official NHTSA announcement can be read at http://1.usa.gov/M2b5wC. ■

Upcoming Conferences: AAEM Sponsored and Recommended

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

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

AAEM-Sponsored Conferences

August 21-24, 2012
- The AAEM Emergency Medicine Written Board Review Course
  www.aaem.org/education/written-board-review-course

October 3-4, 2012
- AAEM Pearls of Wisdom Oral Board Review Course
  Las Vegas, NV – SOLD OUT

October 20-21, 2012
- AAEM Pearls of Wisdom Oral Board Review Course
  Sheraton Suites Hotel - Philadelphia, PA
  Embassy Suites Outdoor World - Grapevine, TX – SOLD OUT
  Embassy Suites Hotel - Orlando, FL – SOLD OUT
  Embassy Suites Hotel - Rosemont, IL
  Embassy Suites Hotel - Los Angeles, CA
  www.aaem.org/education/oral-board-review-course

October 23-26, 2012
- Pan-Pacific Emergency Medicine Congress
  Coex Convention and Exhibition Center
  Seoul, South Korea
  www.pemc2012.org/

February 9-13, 2013
- 19th Annual Scientific Assembly
  The Cosmopolitan of Las Vegas
  Las Vegas, NV
  www.aaem.org/education/scientific-assembly

AAEM-Recommended Conferences

September 21-23, 2012
- The Difficult Airway Course-Emergency™
  Seattle, WA
  www.theairwaysite.com

October 3-6, 2012
- 7th European Congress on Emergency Medicine
  Antalya, Turkey
  www.eusem2012.org/en

October 26-28, 2012
- The Difficult Airway Course-Emergency™
  Atlanta, GA
  www.theairwaysite.com

October 29-30, 2012
- The Crashing Patient: Resuscitation & Risk Management Conference
  Baltimore, MD
  www.thecrashingpatient.com

November 16-18, 2012
- The Difficult Airway Course-Emergency™
  Las Vegas, NV
  www.theairwaysite.com

December 6-7, 2012
- 3rd Annual National Update on Behavioral Emergencies
  Las Vegas, NV
  www.behavioralemergencies.com

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

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

COMMITTE REPORT: Social Media

Welcome to the newest committee of the American Academy of Emergency Medicine, the Social Media Committee. This committee was created to accomplish a number of goals to benefit AAEM, as the growth of social media outlets and electronic communication continues to change how we communicate.

You will see that our websites have been redesigned to include mobile access and links to Facebook and Twitter. I encourge you to follow AAEM and AAEM/RSA on Twitter (twitter.com/aaeminfo and twitter.com/aaemrsa) and "Like" us on Facebook. You can also Like YPS and USAAEM on Facebook. Social media are made successful through active, engaged participants. The most important thing we aim to do is communicate, in real time, what the AAEM is doing. There will be changes in our publications, both from AAEM and our AAEM/RSA colleagues, to make them more electronically friendly. We will strive to make the Annual Scientific Assembly more engaging in this regard and encourage increased communication via social media.

As a new committee, the first thing we need is MEMBERS! If you have any interest in helping, no matter how big or small a contribution you may make, I encourage you to apply for the Social Media Committee through the AAEM website. Please do not hesitate to contact me at info@aaem.org if you have any questions or have an interest in joining. I look forward to hearing from you and to your involvement in promoting the wonderful things that AAEM does for emergency medicine. ■

Brett Rosen, MD
Chair, Social Media Committee

COMMITTE REPORT: Membership

The Membership Committee is proud to announce the appointment of Andy Mayer, MD FAAEM, as committee co-chair. Dr. Mayer has been a longtime leader in AAEM, and his skills and leadership will help the committee grow and meet the needs of AAEM.

Membership has grown steadily this year, especially among our Full Voting, Associate, young physicians, and resident members.

A new membership category was developed this year: Fellows-in-Training (FiT). This category allows a member from any previous membership category who enters into a fellowship program to pay a reduced rate.

The committee would like to thank the staff at AAEM for all their hard work on this, especially Ginger Czajkowski. ■

Respectfully submitted,

Mark Foppe, DO FAAEM FACOEP
Co-Chair, Membership Committee

Certificate of Excellence in Emergency Department Workplace Fairness

The American Academy of Emergency Medicine strongly supports fair working practices for emergency physicians. Consequently, it will certify excellence in the ED workplace if ED physician employees are guaranteed the following five workplace conditions: due process, financial transparency, financial equity, political equity, and no post-contractual restrictions.

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Emergency physicians are encouraged to contact AAEM (anonymously if desired) at http://www.aaem.org/forms/certificate-of-fairness-report.php to report a listed group that they believe is not in compliance, along with an explanation. Members interested in receiving the Certificate of Workplace Fairness for their group may apply online at www.aaem.org/benefits/certificate-of-workplace-fairness.

COMMITTE REPORT: Operations Management

As the new chair of AAEM's Operations Management Committee, I want to extend a welcome to members of the committee and to the entire Academy. Following the introductory session at the 2012 Scientific Assembly in San Diego this winter, the committee held a meeting in which we reviewed the work of the committee over the last three years. We developed a meeting structure and rhythm and began the immediate work of setting forth the committee's agenda and goals. Before moving further along, I must first thank Dave Eitel, MD MBA, for all of his work as previous chair of the committee and for his contributions to the field of operations management in emergency medicine over the last several years.

This is not about me, but I think it is important to introduce myself. I am residency trained and board certified in emergency medicine. I have been continuously practicing emergency medicine for 30 years, with the exception of an anesthesiology fellowship. I'm currently Chairman of Emergency Medicine at Ochsner Health System and System Chief of Emergency Services for our seven-hospital system. My background is in engineering, and my love is operations management in emergency medicine. Bill Durkin, MD MBA FAAEM, and current president of AAEM, asked me to get involved, and I accepted because I wanted to have a bigger impact on the practice of emergency medicine and how we deliver care to our patients.

So, what is operations management? I think it's the most exciting area of emergency medicine, if you enjoy management and love word problems. However, operations management should be of interest to any emergency physician who has to work in an environment that is operationally challenged, resource-constrained, and professionally frustrating. It is about creating a high performing ED. So, my definition of operations management in emergency medicine sounds somewhat like a mission statement: *a unique body of knowledge and set of tools to effectively analyze, predict, and manage the resources and dynamic demands of the high-variance, complex environment of an emergency department*.

Health care reform is going to happen regardless of the Supreme Court's decision, which may be old news by the time this edition of *Common Sense* arrives. The health care industry is reforming health care because it has to. Operations management is where a lot of this work will be done, finding a way to deliver emergency care with better quality and improved service at a lower cost. The challenge will be determining the elements that deliver on all three.

So, let's get started. The committee currently consists of 15 to 20 interested individuals. This is about the right size for a working committee. At the margins, physicians will move in and out of the committee as their interests evolve and change. Membership in the committee is always open to anyone interested in operations management, keeping in mind that it will be a working committee with a practical agenda. Along those lines, it was decided that the committee would meet monthly—virtually, of course. The challenge will be engaging extremely productive, hard-working physicians with limited bandwidth on a virtual committee over time and distance.

We already have a listserv for the Operations Management Committee and will look at extending that to AAEM's general membership, so that those individuals who wish to contribute ideas without being on the committee may do so. In addition to communicating through *Common Sense* and links to our committee through AAEM's website, we're also considering other social and professional networking options.

We will not succeed unless we can produce real value for the membership of AAEM.

This is a sketch of what we plan to do for the Academy:

1. **Assemble a resource catalog for operations management best practices**
   There are a lot of individuals doing great work out there, in terms of developing operational best practices through innovative process improvement. The objective is to collect these best practices and make them available as a resource tool for groups interested in these initiatives.
2. **Create a data warehouse for ED metrics and operational benchmarks**
   This information is available commercially, but the goal would be to make this available to AAEM members and may involve soliciting AAEM membership for data to populate the warehouse.
3. **Initiate an educational series in *Common Sense***
   In most issues of *Common Sense* we would like to have one of our committee members, many of whom have deep experience in process improvement and operations management, publish an article of interest to the general membership.
4. **Lectures**
   A lecture series on operations management and process improvement at the next Scientific Assembly is a high-value objective.

Well, that should keep the committee busy! Thank you, and I look forward to our work together. ■

Joe Guarisco, MD FAAEM FACEP
Chair, Operations Management Committee
jguarisco@ochsner.org

COMMITTE REPORT: State Chapter

Since my installation as the State Chapter Committee chairman at the Scientific Assembly in San Diego, the committee has gotten off to a good start. My main charge is to increase communication with and support for current chapters and to assist in the creation of new state chapters.

I've been coordinating with the AAEM staff to review our existing chapters, their membership levels, and chapter leadership. I've communicated with individuals seeking to start chapters in Illinois, Mississippi, and Colorado. We are also working to re-establish and reinvigorate the Wisconsin state chapter. We are reviewing the state chapter start-up toolkit and will revise it as needed. We are lucky to have received input on this from our two newest state chapters, Virginia and Missouri.

One of our strategies is communicating with past and present AAEM, YPS, and AAEM/RSA leaders to get them involved in their state chapters. We would also like to work with academic programs to find AAEM supporters among faculty who could serve as leaders for, or liaisons with, their state chapters.

If you are an AAEM member and interested in working with us to establish a new state chapter, or want to become involved in your existing state chapter, please contact me. We need you! ■

Brian Potts, MD MBA FAAEM
Chair, State Chapter Committee
brianpottsmd@gmail.com

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CHAPTER REPORT: Delaware Valley AAEM

The Delaware Valley Residents' Day and Annual Meeting was held in Philadelphia in November. This has been an annual event for many years, last year drawing over 100 attendees (attendings and residents) from all three states. As usual, there were superb lectures and the famous LLSA review given by Mike Silverman, MD FAAEM, and Richard Shih, MD FAAEM.

One of our chapter members, the famous Bob McNamara, MD FAAEM, was appointed to the AAEM board of directors by the AAEM Past Presidents' Council as the Past Presidents' Council Representative. Congratulations are also due to member Zack Repanshek, MD, Chief Resident at Temple, who received the AAEM Resident of the Year Award at the Annual Scientific Assembly in San Diego. ■

Brian Levine, MD FAAEM
President, Delaware Valley Chapter

CHAPTER REPORT: Tennessee AAEM

The big news for the Tennessee Chapter of the American Academy of Emergency Medicine this year is that our chapter president, David W. Lawhorn, MD FAAEM, was elected to AAEM's board of directors at the Scientific Assembly in San Diego. Dr. Lawhorn is responsible for founding TNAAEM, in addition to being its current president. His predecessor as TNAAEM president, Kevin Beier, MD FAAEM, also served on the Academy's board of directors. Dr. Lawhorn shares another thing in common with Dr. Beier: Both are winners of the James Keaney Award, one of the highest honors AAEM can bestow on a member. Has any other state chapter achieved this distinction?

Another TNAAEM member, Andy Walker, MD FAAEM, is completing his final term on the Academy's board of directors and recently took over as editor of *Common Sense*. He also serves on the editorial board of *Tennessee Medicine*—the journal of the Tennessee Medical Association.

The Tennessee legislature just ended its two-year session without passing the tort reform bill that TNAAEM has been pushing, which would redefine malpractice in emergency care as gross rather than simple negligence. TNAAEM believes that any reform short of this would fail to change the toxic environment in which emergency physicians and on-call specialists in the state practice, with the perverse incentives for defensive medicine that such an environment fosters. Rest assured that TNAAEM will continue to work with the Tennessee Medical Association and the state chapter of American College of Emergency Physicians to achieve meaningful tort reform. Our fight goes on! ■

Andy Walker, MD FAAEM
Vice President, Tennessee Chapter

CHAPTER REPORT: Virginia AAEM

Although founded just last year, the Virginia Chapter is already up to 142 members! Special thanks to two groups of emergency physicians that signed up en masse: Chesapeake Emergency Physicians and Fredericksburg Emergency Medical Alliance. Our member benefits to date have included a joint social event with the Uniformed Services Chapter at the 2012 Scientific Assembly in San Diego as well as print and online access to the *Western Journal of Emergency Medicine*.

We recently completed a survey to assess the needs of our members. It is clear that our members have two primary interests: continuing medical education and political advocacy. To respond to our members' needs, we have formed task forces to develop CME and political activities. In addition, it is clear that our members value the support we provide to residents and medical students by allowing them to join for free, so we plan to continue these free memberships.

If anyone has any questions, comments, or suggestions, please contact me. ■

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President, Virginia Chapter
jschofer@gmail.com

AAEM 100% ED Groups

AAEM 100% ED Group Membership

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

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

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

For a complete listing of 2012 100% ED Group members, go to www.aaem.org/membership/aaem-ed-group-membership

How to Deal with Difficult Consultants

Jonathan S. Jones, MD FAAEM
YPS Member

"Are you an idiot?"
"I didn't know you completed a fellowship in jerkiness."

These are two questions we've all felt like asking some of our *favorite* consultants, and I'm sure a few of us *have* uttered statements similar to these. Difficult consultants are quite possibly the worst part of being an emergency physician, and while there will always be difficult people in this world, we needn't let them ruin our day (or night).

There are ways we can *win* our battles with these people. Several tactics can help us when dealing with difficult people (and I'd be happy to write about them if this column is useful), but unless we know *what* we want from our consultant and *why* we want it, no tactic will help us. If we don't know this prior to calling the consultant, then we've already lost our main advantage—we know more about the patient then the consultant does.

What do we want from our consultants? To unconditionally agree with us, to realize that we are smarter than they are, or to admit that they are idiots? That may feel like a victory, but it is not. We need to shift the focus from ourselves to the patient. What we seek is an admission, an expedited consult, or a guaranteed clinic appointment in the morning. We also need to determine, prior to speaking with the consultant, if there is an acceptable alternative. I may want to admit my high-risk chest pain patient with normal cardiac markers to the cardiologist, but is it also acceptable to admit him to an ED chest pain unit if the cardiologist promises to check on the patient in the morning and help determine appropriate risk stratification? Maybe it is, maybe it isn't, but this is something I need to consider prior to calling the cardiologist.

So often I hear my residents asking a consultant to "come evaluate the patient." Is this what we really want? We've already evaluated the patient and determined an appropriate course of action; we don't need someone else to evaluate the patient. We want a recommendation from the consultant, not an evaluation. Many times, we don't really want a recommendation either; we want the consultant to execute our recommendation. It sounds simple, but knowing what you want is the first step in getting what you want.

The second step is to know why you want it. I'm not talking about basic medical knowledge (it's a little harder to fix that), but about the real reasons we want the consultant to act. We've all had that elderly patient with slightly elevated BUN/creatinine that we would like to admit for "dehydration and renal insufficiency," but is the real problem that his only caregiver is his equally frail and elderly wife who has dementia? Don't hide this from the consultant; tell him what you honestly want and why you feel it's necessary. It's easy for a consultant to argue that mild dehydration isn't the same as acute renal failure and that it can easily be treated with simple oral hydration as an outpatient. It's harder to argue that a patient with early pre-renal failure is going to improve by going back to the same situation that started the condition.

All too often we try to hide the real reason for the consult. We know what our consultants dislike, but by failing to be open with our consultants or trying to skirt the issue, we hurt our credibility and earn the distrust of our colleagues.

A common reason I hear for wanting an admission is, "I don't feel comfortable sending this patient home." Again, we are selling ourselves short by not using all our advantages (information) to get the consultant to do what we want. There are innumerable responses that the difficult or rude consultant can make to the above statement, and some may not even be inappropriate, given the uselessness of the statement. What we should do instead is tell the consultant why we don't feel comfortable sending the patient home.

Some difficult consultants are difficult because we don't help them be cooperative. What we end up doing is asking a consultant to reach the same logical conclusion we reached, but we hold back some of the (often vital) information that we used in reaching that conclusion. Decide what you want, why you want it, and then share this with your consultant. This information will improve your future interactions with that "favorite" consultant. ■

Attention YPS and Graduating Resident Members

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AAEM/RSA President's Message

A Senior Resident's Perspective on International Emergency Medicine

Leana S. Wen, MD MSc
AAEM/RSA President

International emergency medicine (IEM) is one of the most popular subspecialties in our field. As a senior resident, I have seen many a trainee light up when I discuss IEM. But even though IEM is a great buzzword, it can mean different things to different people. Does it refer to a clinical rotation to see how EM is practiced in other parts of the world? How about developing emergency systems or providing humanitarian relief? Where does research or teaching fit in? In my first president's column, I want to share my passion for IEM with you by providing some guidance and advice that I wish I had received when I was first drawn into IEM.

Unlike some of my IEM colleagues who were born to do international work, I had my heart set on a career in domestic health policy. It wasn't until medical school that I was exposed to international health. A fellowship at the World Health Organization made it clear that the issues I was working on in the United States were magnified many times over in other countries. Geneva was an eye-opener, but I felt a need to work "on the ground," so I went to Rwanda to do fieldwork on gender-based violence and subsequently to the Democratic Republic of the Congo and Burundi as a journalist reporting on war and health.[1] Through this exposure I saw the urgent need for research to understand systems and evaluate interventions, and I decided to go to the U.K. for two years to study economics and policy. I came into residency with more tools and a stronger passion for IEM research. Now, entering my fourth year, I have conducted systems design and evaluations in several countries,[2,3,4] a health care workforce evaluation in South Africa,[5,6,7] and a global health professional study.[8]

Everyone's path in IEM is different, and I share my background with you so that you can see my circuitous path in this journey. Students and residents often ask about getting involved with IEM and what things they should consider in building an IEM career. Here are some thoughts:

1) The only way to know whether or not you will like something is to try it. If you are new to international work, find an opportunity, and jump on it. Don't be picky about location or type of experience. Many schools and residencies will have an international rotation. Most likely it is a one-month clinical experience, but occasionally it is a research project (e.g., studying malnutrition) or an educational opportunity (e.g., teaching point-of-care ultrasound). There may be a relief mission that needs your help. Some of my residency classmates went to assist with the disasters in Haiti and Japan. These were not things that they planned, but they jumped on opportunities that came up. Explore multiple options. Your own program is the most natural place to start, but also look elsewhere in your university. The American Medical Student Association (www.amsa.org) has medical student elective listings. AAEM/RSA is also establishing an international rotation database (www.aaemrsa.org). Keep your eyes and ears open, and ask other residents and attending physicians to be on the lookout for you.

2) There has been a lot written in recent years about "medical tourism."[9,10] While this phrase conjures up unpleasant connotations, and sustainability in international programs is very important to think about, don't discount experiences because of your own (unnecessary) guilt. International rotations are important for your exposure, and whether you end up doing international work or not in your career, your experience will be instructive for you and good for your future patients. Find your own way to meaningfully learn and contribute.

3) Once you've had experience with IEM, decide whether it is something that you feel passion for versus something that you would like to do only occasionally. There is no right or wrong answer—don't feel guilty if your experience showed you that you don't want to live in war-torn countries forever. Be honest about what you like doing and how you think international work will fit into your career. What attracts you most about the work? Does clinical work excite you while research bores you? Are you happiest doing impact evaluations from the comfort of your own home? Would you want to do these things occasionally, or do you love them so much that you need to build it into your career?

Continued on next page

4) Consider the other interests that you have to balance. International fieldwork is hard to find time for in residency, but it might be even more challenging with a young family. Know how your significant other feels about your work. This is a continuing conversation for my husband and me, a South African native whom I met in the United Kingdom. Initially, we thought that we would spend two months of every year abroad, but this is difficult to manage in both of our careers right now. It took me a while to realize that not everything I want has to be done at this very moment. Perhaps this is the time to focus on your family and your clinical work. IEM opportunities will be there when your life settles down. Perhaps later on, you and your family might consider a year or two abroad, or you may be able to take a job with greater travel flexibility. Think about how you want to balance your IEM interest at this point in time, and be flexible to change.

5) Don't discount related work in the U.S. I have come full circle in this regard by starting in domestic health policy, falling in love with IEM, then coming back to U.S. policy. There are huge problems with access to care and health inequities in the U.S., and what you learn through your international experiences will inform your work here—whether it's in policy, advocacy, community activism, or your clinical work. Many international interests can be built into your domestic work and vice versa. If you have an interest in EMS, you can develop your expertise in the U.S. first and then do projects abroad. If you have experience with teaching mid-level providers internationally, you can design similar programs in the U.S. The options are limitless!

6) Build and nourish your network. Identify mentors as early as possible. Seek out those you admire and follow their career paths. Read their work. Ask for advice from those who have IEM careers and those who don't—their perspectives will be just as important for you. Women, it may help to identify female mentors because women face a unique set of challenges. The Academy of Women in Academic Emergency Medicine is a great resource, and this year it is offering free membership to residents.[11] Along the same lines, build your peer group. IEM is a small world, and your peers will encourage and inspire you throughout your professional lifetime.[8,12]

As my mentors have taught me, a successful IEM career necessitates thinking outside the box—and keeping an open mind and open eyes and ears. Speaking of being open, now is the perfect time to get involved! I am very excited to announce that for the first time, AAEM/RSA has an International Committee. It is already becoming the most popular committee for our members, with a record number of applications in our recent call for committees. I am very much looking forward to working with the new committee chair, Dr. Mark Pittman, to lead AAEM/RSA into a new era of IEM involvement. Join us in our mission to advocate for our specialty and our patients and to advance EM worldwide.

As always, I welcome your feedback to my articles and about AAEM/RSA. I can be reached at wen.leana@gmail.com. ■

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RSA Resident Editor's Letter

The Advancing Role of Technology in Emergency Medicine Education and Training: Interview with Scott Weingart, MD

Ali Farzad, MD
AAEM/RSA Publications Committee Chair
Linda J. Kesselring, MS ELS, Copyeditor

Scott Weingart, MD

This article marks the third in a series that highlights the use of technology in emergency medicine (EM) education and the resources that will make your learning more efficient and effective. In previous interviews with other leaders in EM education—Dr. Mel Herbert and Dr. Amal Mattu—we learned how to incorporate the use of websites, podcasts, and EKG videos to stay current with medical information and save more lives. Continuing that theme, I had the pleasure of interviewing Dr. Scott Weingart, an ED intensivist and host of one of the hottest EM blogs and podcasts, EMCrit (www.emcrit.org).

Dr. Weingart is an emergency physician with fellowship training in surgical and trauma critical care. His career goal and the purpose of his blog and podcast are "to bring upstairs care downstairs," that is, to bring ICU-level care to the ED so that patients receive optimum treatment the moment they roll through the door. He is a rising star among EM educators, and his effective teaching methods in addition to his focus on important critical care topics have made him very popular on the national lecture circuit. He uses technology to provide a forum in which cutting-edge EM education is disseminated for free to an audience of thousands of international followers. In this interview, he drops several pearls of wisdom that are as useful to medical students interested in EM as to seasoned attending physicians looking to keep up with new literature and best practices.

AF: *Please start by telling us about yourself and how you became an ED intensivist.*

Dr. Weingart: When I was in med school, I was deciding between anesthesia and emergency medicine because I knew I wanted to do critical care. The question really was whether I should follow a dedicated pathway. Anesthesiologists can become intensivists, or you can go into critical care after internal medicine, surgical, or emergency medicine training. Ultimately, I thought emergency medicine would give me a more broad-based exposure to everything. That's the route I went, and I don't regret it. I think that's a great way to go. I went to emergency medicine residency at Mount Sinai in New York, which is a four-year program. Then I did a one-year trauma and critical care fellowship at the Shock Trauma Center in Baltimore.

When I got out—and when we all get out—we ideally want to work in the ED but also be able to use everything we learned during critical care training. I did that by working in both the SICU and ED at Elmhurst Hospital, the trauma center for Queens, New York. After a few years, I realized that having two bosses was really tough and that I really loved ED critical care. I now do almost all of my shifts in the ED Intensive Care Unit we built at Elmhurst, providing critical care in the ED.

AF: *Not every ED has dedicated intensivists staffing the department. How did you manage to meld EM and critical care into what sounds like the perfect job for you?*

Dr. Weingart: A huge shortage of ICU beds makes that very easy. No matter how much hospital administrators want the patients upstairs for the ICU folks to start working on them, that can't always happen. Then the politics around, "We're just going to do a lot of stuff that you do upstairs downstairs," all disappeared because you can't let the patients languish. You just can't do it.

AF: *Are a lot of other people you work with similarly trained in ED critical care? How does your department work, and how can it be adapted in other departments?*

Dr. Weingart: We call ours a hybrid unit. Today, most big EDs have a resuscitation area that is staffed by an attending physician for at least part of the day. That's what they do for their time in the ED during that shift—they staff all of the resuscitations. If you have that system already in place, and you have all the equipment, and you just stick one ED intensivist in the program, then it becomes very much like having a toxicologist. When you get one tox guy, everyone's tox care improves.

ED folks are perfectly capable of doing critical care in the emergency department. That's what we're trained for; that's what we're built for as a specialty. We've lost our way a little bit, but that's what we are built for. So, if you just get one ED intensivist in there to make protocols, to train nurses, to make everything doable, then all the ED residents and attendings are more than capable of making it happen when you're not there. But, that's what makes this possible—starting with an ED that has a resuscitation area and a dedicated staff.

When I came to Elmhurst, they already had a resuscitation area. They already had nurses and an attending staffing the area. At that point, it was for only 10 hours a day. The hard part is typically convincing the ED that you need a resuscitation area and that it needs to be stocked with equipment similar to that used in critical care units and staffed with skilled nurses. The next step is to convince them that you need an attending there a lot of the time with a dedicated resident. Once you've done those things, if you stick an ED intensivist in the mix, you've got money. That's all you need.

AF: *Sounds ideal for anyone who is interested in practicing critical care in the ED. The opportunities for fellowship training in critical care seem*

Continued on next page

to be increasing for EM-trained physicians. What do you think the role of technology should be in training the next generation of ED critical care specialists? How did you use technology during your training to supplement your own learning, and how are you using technology to help you teach?

Dr. Weingart: In today's world, technology is critical for effective learning. Since I was a med student, I have put all the articles I read on a website just for me. I called it EMBER (Emergency Medicine Based on Evidence and Research). I wasn't disseminating it—it was intended to help me document my learning. The primary reason I did it was because if you don't write down what you read, it rapidly disappears. It was even more necessary for me because I was a challenging resident (i.e. an arrogant bastard). When you tell your attending, "Well, actually no, there's an article that says something a little different from what you're saying," and you can't produce that article within seconds, you sound like an idiot. When you say, "I think I read somewhere—maybe it was *New England Journal* or *JAMA*? I think it was three months ago," the attending is thinking, "This guy's just making crap up. Why is he even talking about this stuff?" On the other hand, if you say, "Well, here's the reference. I'm not going to say that we have to go this way, but if you're interested, this is what it said." They might still think you're an arrogant bastard, but at least they don't write you off as being dumb.

I needed the ability to generate references instantly. The website was there and I was just chucking through stuff and adding to it, and it got popular and evolved into what is now www.crashingpatient.com (a free webtext of ED critical care topics). I don't heavily publicize it or anything. It's still mostly just for me, but thousands of people are now looking at it each month. It prepared me to start online publishing and led to the start of my podcast, EMCrit.

AF: *Tell us more about EMCrit. How did you decide to start it?*

Dr. Weingart: About two years ago, I realized that all the lectures I was presenting to residents were going nowhere after I used them. You teach and then you don't use the material again for another three or four years. I would use it for grand rounds occasionally, and okay, I'm hitting a few people there, but I wasn't doing as many grand rounds before EMCrit, because no one knows your name until you're on the circuit. I realized that I was listening to a lot of non-medical podcasts, and I've always liked them, and I have a big mouth, so I thought I could do this. So I tried a few. It took a little time to get listeners, but thanks to my friends at the Life in the Fast Lane blog (www.lifeinthefastlane.com) and to the other folks in the community of emergency medicine blogging and podcasting, more and more people got word. Now, it's pretty huge and that actually cycled back to the traditional way of medical teaching. I've taught at ACEP for the past two years and at several other conferences. That happened because of EMCrit. The podcast opened those doors for me.

AF: *That's fascinating. I believe it's a sign of how rapidly things are changing in academics due to the influence of technology. The advent of blogging and podcasting has made education more accessible and learning much more efficient. Providing open access to great educational material the way EMCrit does allows people to learn at their own pace and stay up to date. What plans do you have for the future of EMCrit?*

Dr. Weingart: The next phase is to make the material more interactive. A residency could commit to listening to one of these podcasts and then have me for a "virtual grand rounds" as an alternative to a live lecture. I love teaching live and in person, but it's just crazy busy and traveling is not easy. It's a big time commitment, it costs a lot of money, it costs the environment, and it has to be arranged almost a year advance. Why not say, "Scott, after we listen to this podcast as a residency, could you spare a half-hour for a video conference call?" This way, in a short half-hour session, we can address all the questions that came up and have a live group discussion as a residency. With that, now you have something, because you combine the advantages of asynchronous learning with the interaction of live group discussion. One of the problems of podcasting compared with traditional lectures is that it is less interactive and therefore more difficult to answer questions, get feedback, and make sure people really understand what you're saying.

The next step will be to build a home studio that will be able to carry out that interaction with good quality. If this tech stuff gets worked out and if we figure out how to do it easily, then there's no reason not to have all the people who are experts in their respective niches using this method to present the best of emergency medicine education. Why not be able to call Rich Levitan and say, "Rich, we had a tough intubation using the Levitan scope. Maybe you could give us some tips about it." I don't mean to underestimate the power of having someone being there in person because there's something about a live presence that you can't convey in this medium, but you can come pretty close. So, breaking down those barriers is the next step.

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AF: *Clearly, you have incorporated technology successfully to supplement your teaching. What advice do you have for new educators who would like to start using technology to improve their teaching and practice?*

Dr. Weingart: For me, it's three tiers. Tier one, which everyone in medicine should be doing at this point, is to take control of your Web identity. You need some sort of Web presence, so that if I search for your name and stick an MD at the end of it, you show up in the way you would like to portray yourself. If you're tech-savvy, that might be a hand-coded profile page like what I have, but you don't need that. It could be anything. It could be your Google profile page, which is absolutely free, easy to set up, and search engine friendly because it's Google. But you have to do something; if you don't, something else will show up when people do that search. If I Google someone's name and get those horrible for-pay doctor evaluation services as the first 20 links and then maybe a yearbook photo from when the person was a senior in high school, then I know that person is not in the game.

If you're smart, you take control of your identity by using multiple social media sites: something on Facebook and something on Twitter. Because then, when someone has a great opportunity for you, they will be able to contact you. If I have to search for more than five minutes for a way to contact someone, I know they have no idea. If you search for me, you'll find 17 means of contact and they all feed into the same Google account. So take control of your Web identity. That should be done today. It takes about 15 minutes to put up a nice picture of yourself and describe your niche. There's no reason and no excuse not to do it.

Tier two is mastering social media use. There's so much good stuff out there that's so ahead of what you can get by reading journal articles or waiting for textbooks to be published. If you're not doing that, you're not cutting edge anymore. And I promise you, if you're an educator, your residents are doing it, which means they're now smarter than you; which means they will see stuff nine months before you do, and you're no longer in the game. If you think it's not going to be obvious to the people you are supposed to be teaching, you're wrong. So, step two, which everyone in emergency medicine should already be doing, is using Twitter and blogs to get the cutting-edge education. Nowadays, you don't need to read a journal much anymore because guys like Ryan Radecki of EM Lit of Note (www.emlitofnote.com) and Rob Orman of ERCast (www.blog.ercast.org) are looking at all the key EM articles and reviewing them. It really just depends if you're a visual or an auditory learner. If you're listening to the podcasts and reading the blogs, honestly, you don't need to lift a journal. You can, but you won't gain that much or lose that much either way. If you just state, "I'm never going to read another journal for the rest of my career, but I'll spend 20 minutes each day checking the newest blogs and I'll listen to a couple of podcasts each week," I think you'll be better educated than by reading that journal.

Tier three is producing, and a lot of people aren't going to go there—it's hard. It's getting easier, but the hard part is not necessarily the technology; that can be a barrier, but that's easily overcome. The barrier is content. Everyone thinks they have something to say and everyone does for about three months, and that's where most of the blogs fade. You start realizing, "Oh, crap, I need to be on some kind of schedule here because people stop reading if it's very intermittent and that means I have to keep producing," and it becomes work. It really becomes a job, and for most people, it isn't worth it. And that's fine.

There's no need for every single person in the universe to create a blog or a podcast. But that doesn't mean you can never publish anything online. If you prepare a grand rounds lecture that's just fantastic, make sure you record it. There are myriad places where it could be posted so that it has longevity and thousands of people can hear it. So, you don't necessarily need your own blog and podcast. For instance, send it to Free Emergency Medicine Talks (www.freeemergencytalks.net) with Joe Lex. Absolutely free: He'll post it, he'll host it, it's there. Now you can link to it for your residents for all time to come, and you don't have to repeat that lecture. You could do something else and know that other people are going to hear it from outside your residency. Or, if you come up with some great idea that you really want to get out there and it's EM critical care related and you record something, I'll put it on my podcast. Or it will go on EM:RAP. As long as it is good content, I am sure there will be a place for it. The point is that you don't need to have your own blog and podcast to occasionally develop a piece of educational material that should be enduring.

AF: *What advice would you give to current residents and students who are looking to make their learning as effective and efficient as possible?*

Dr. Weingart: It's a great question, and I don't necessarily know the answer. I know what has worked for me. I've done a bunch of reading and

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research on learning styles, and I don't know how much of it is true and how much of it is just crap. I learn from books. If I found a resource like www.crashingpatient.com, I would think, "This is wonderful," and I'd start reading it and I love it, but I wouldn't get as much out of it as if I had done the work myself. There's something to processing source information on your own—information that is not broken down for you too much.

Let's take UpToDate (www.uptodate.com) as an example. It is a beautiful resource, but I think our internal medicine friends are getting dumb as a result of UpToDate because it's so good. It's someone really smart taking away all the formative parts that got them there and giving you the information. When people read summaries and use them as guidelines, they risk losing the ability to really learn the information and know how it was intended to be applied. Maybe they'll extract the important things they'll need for a patient, but I guarantee you, if you ask them a week later about the topic, most of what they read is gone because they didn't process it. It's nice to have a resource that lets you look something up in real time—call that "just-in-time learning"—but it's not the same.

If I had my druthers, I'd send medical students to read the old stuff. Read "Cope's Early Diagnosis of the Acute Abdomen," read Osler's stuff, read the old-school docs because of their beauty and wisdom. The third-year students who want to go into emergency medicine should be reading *Annals of EM* every single month and assiduously writing down what they don't understand so that they can talk about it with the residents when they're actually rotating. Because then, instead of the medical students being annoying "hang-arounds", all of a sudden they are asking really good questions and sounding smart. They're going to do better in their rotations, and they'll make the resident realize, "Oh, wow, I didn't know that myself." Then, maybe they'll ask their attending, or maybe they'll look it up. That is far more powerful than going to a pre-digested source. But at some point, you won't have time for that unless you're insane like me. When you no longer have time to be reading the primary literature, EM:RAP (www.emrap.org) is the best emergency medicine continuing education out there. You have to pay for it once you're an attending, but it's free for residents and students with an RSA membership.

I think EM:RAP is a quality product. My conflict of interest is that I'm one of the EM:RAP speakers, so I'm obviously biased. But I think it's an enormously powerful product for the people who are not reading journals anymore, because co-host Mel Herbert is really getting the cutting-edge stuff. Obviously, I think my blog is a good place to go for emergency critical care as well as Cliff Reid's www.resus.me. The Life in the Fast Lane guys link to everything else good in the universe. So, if you are reading Life in the Fast Lane, you will come across everything you might need in all the other blogs. You should read the other blogs, too, because they're amazing. But if you are time-limited, listen to a few podcasts and read Life in the Fast Lane, and you'll be in very good shape.

AF: *You mentioned that you're insane, but really, how do you keep up with this cutting-edge curriculum that you present on EMCrit? How is it that you stay up-to-date, and what is it that makes you successful?*

Dr. Weingart: I don't know if it makes me successful, but I read everything! When I say that, I mean anything tangential to emergency medicine or critical care in journal form. Obviously, I don't read every single article, but I scan the abstracts. If the information is relevant to us, I read it all the way through. If a monograph or a book looks relevant, I'll read that, too. I spend an enormous amount of my free time reading, but that's not healthy.

What we're finding in the social media world is that if you think you can't miss anything, that's a pathway to insanity. Twitter is the perfect example. Twitter was never meant for you to read every Tweet that's posted by the people you follow. You're supposed to follow a bunch of people, look at their posts when you can, and not necessarily worry about what you're missing. Well, I worry about what I'm missing, so I follow only a small number of people and I read every single Tweet they write. That's not healthy; that's not really possible in our generation. Our generation has too much media to consume, and that approach is not sustainable. I'm hanging on by my fingertips trying to make it possible, but it's not. If you want to do this, you basically better give up any other hobby or free time activity aside from work and reading. So, I don't think my path is a smart one or even a possible one.

AF: *On behalf of all the people who follow your work, I thank you for your efforts. Your willingness to use technology to provide open access to cutting-edge emergency medicine topics is commendable and much appreciated. There are great educators who teach and spread their knowledge on an individual or small group basis, and others like you who have created a forum for widespread dissemination of quality education that helps save lives.* ■

RSA Resident Editor's Note: Please send comments and suggestions for future articles about technology and emergency medicine to alifarzadmd@gmail.com.

Medical Student Council President's Message

The Right Resources

Mary Calderone
AAEM/RSA Medical Student Council President

"Medical school is like trying to drink from a fire hose," a third year student told me on my first day as an M1. I laughed nervously, only to discover as I progressed that it was a fitting analogy. Inundated with lectures, new responsibilities, and clinical skills to learn, medical students are constantly challenged to develop professionally and personally. Having access to the right resources will help you combat the feeling of being overwhelmed and meet the rigorous demands of medical training.

For students interested in emergency medicine, AAEM/RSA is here to provide those resources. The 2012-2013 AAEM/RSA Medical Student Council wants to ensure awareness of all that AAEM/RSA has to offer and is excited to continue to expand our services to meet the needs of student members. We encourage you to take advantage of AAEM/RSA's excellent educational resources, advice for pursuing a career in emergency medicine, networking, and leadership opportunities.

Several resources available through AAEM/RSA will effectively supplement your medical education, with an emphasis on what is most relevant to the field of emergency medicine. Our e-newsletter, *Modern Resident*, will provide you with clinical pearls and keep you updated on breakthroughs in EM. In addition to discounts on several textbooks, AAEM/RSA membership also includes access to an outstanding educational podcast, *Emergency Medicine: Reviews and Perspectives* (www.emrap.org). Taking advantage of these resources will ensure that you are well versed in the topics most relevant to the practice of emergency medicine.

AAEM/RSA also offers resources that will advise you on how to match and succeed in the field. *Rules of the Road for Medical Students,* by Dr. A. Antoine Kazzi and Dr. Joel Schofer, is an excellent guide for pursuing a career in emergency medicine. During your residency application process, take advantage of EM Select—a tool developed by medical students for medical students—to help you stay organized and make the process easier to manage. Be on the lookout for more information about our Midwest and Mid-Atlantic Medical Student Symposia in the fall, where you can hear from and network with program directors and leaders in the field. Don't forget to mark your calendar for the Scientific Assembly student track on February 10th, 2013, in Las Vegas!

In addition, one of the most valuable benefits that AAEM/RSA offers its student members is the multitude of leadership opportunities. As a member, you have the opportunity to write for *Modern Resident*, become a Site Coordinator for your medical school, join an RSA Committee, and run for the Medical Student Council.

Your 2012-2013 Medical Student Council is excited to represent AAEM/RSA's student members and carry on the legacy established by our previous Councils. Vice President Rick Herold (University of North Dakota), Western Regional Representative Faith Quenzer (Western University of Health Sciences), Midwest Regional Representative Bill Burns (Loyola University Stritch School of Medicine), Northern Regional Representative Jason Zeller (Drexel University College of Medicine), Southern Regional Representative Ross Everett (Georgia Health Sciences University), International Student Representative Laila Cochon (Universidad Iberoamericana), and I are dedicated to expanding AAEM/RSA services to best meet your needs as a student member. We encourage you to become involved in AAEM/RSA and to contact us at any time with ideas or questions at info@aaemrsa.org. ■

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