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COMMONSENSE

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COMMONSENSE

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AAEM Mission Statement

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

1. Every individual should have unencumbered access to quality emergency care provided by a specialist in emergency medicine.
2. The practice of emergency medicine is best conducted by a specialist in emergency medicine.
3. A specialist in emergency medicine is a physician who has achieved, through personal dedication and sacrifice, certification by either the American Board of Emergency Medicine (ABEM) or the American Osteopathic Board of Emergency Medicine (AOBEM).
4. The personal and professional welfare of the individual specialist in emergency medicine is a primary concern to the AAEM.
5. The Academy supports fair and equitable practice environments necessary to allow the specialist in emergency medicine to deliver the highest quality of patient care. Such an environment includes provisions for due process and the absence of restrictive covenants.
6. The Academy supports residency programs and graduate medical education, which are essential to the continued enrichment of emergency medicine and to ensure a high 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)
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*Fellows-in-Training Member: $75 (Must be graduates of an ACGME or AOA approved EM Program and be enrolled in a fellowship)
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Affiliate Member: $365 (Non-voting status; must have been, but is no longer ABEM or AOBEM certified in EM)
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*Fellows-in-Training membership includes Young Physicians Section (YPS) membership.

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President's Message

An Encouraging Sign

William T. Durkin, Jr., MD MBA FAAEM

I received communication this week from a group of senior residents who see an opportunity to take a contract currently held by a CMG. They have gone through the initial phase; now they need help/advice as to how to proceed with the bid and subsequent initiation of the contract and are coming to us for that assistance. We are only too happy to help out with this request!

Less than two years ago, we didn't have as much to offer. Though the Academy espoused independent democratic groups, we had little available to members who sought to gain a contract or needed assistance in maintaining one they already had. With the help of many, the Practice Management Committee was established last year. This expert body is now available to assist these young physicians and others like them who may see an opportunity and wish to capitalize upon it. We could also use the expertise of others who have established and run their own groups. I encourage each of you with such experience to become a member of the Practice Management Committee. Here is your chance to give back.

It is encouraging to see that physicians are beginning to come to the Academy for such assistance. Most people I have talked to who have managed large physician groups agree that a local independent group will do a much better job than a CMG, provided it is properly managed. The entrepreneurship of these young physicians is to be commended. May they inspire other members who read this to go out and do the same!

"Board Certified, Residency Trained" = Age Discrimination?

Shortly after becoming AAEM president, I received an email from a respected former colleague. He wanted to let me know that he felt that the above phrase was being used to keep the seasoned physicians from being eligible for certain jobs. I have since heard similar observations from some other physicians in the same cohort. I find this to be very unfortunate.

The practice track closed in 1988. This means that anyone who wanted to grandfather in and be eligible to take the ABEM exams had to have had the equivalent of five years practice experience by the end of 1988. Hard to believe that someone with over twenty-five years of EM experience and recertified twice is considered less of a candidate than someone just coming out of training.

To my knowledge, we are the only specialty that has such ads. All the others ask that candidates be board certified. Since 1988, the only means to become board certified is to have successfully completed an accredited residency program. So any emergency physician who is board certified has over two decades of experience and/or has completed a residency program. It seems that using the phrase "board certified, residency trained" could be taken as showing a preference for candidates in a younger cohort. Excluding those with decades of experience, which allows most of them to be very efficient and provide a different perspective to the practice, is short-changing your group. ■

Contact the President: president@aaem.org

Mentoring

Andy Walker, MD FAAEM
AAEM Board of Directors

As the editor of AAEM's bi-monthly newsletter Common Sense, *Dr. Walker welcomes your comments and suggestions. You can easily reach Dr. Walker by submitting letters to the editor using the online form at www.aaem.org/publications/common-sense.*

AAEM's Young Physicians Section (YPS) runs a mentoring program for its members, and as one of its volunteer mentors, I have found it highly rewarding. If you are looking for a way help the next generation of emergency physicians along, and perhaps help them avoid some of the mistakes you made, I recommend it. In my experience, academic physicians seem to find mentors more easily than emergency physicians in community hospitals, but both academic and nonacademic docs are needed as mentors. You can enroll as a mentor, find a mentor, and learn about the program at the YPS website: http://www.ypsaaem.org.

In the spirit of that program, I offer some nonmedical advice for those emergency physicians who are now in their last year of training or beginning practice. Be aware that this advice is general, and you must use your own judgment to individualize it to your specific circumstances. Furthermore, I could always be wrong. I urge anyone who disagrees with my advice, or wishes to add to it, to let us know in our new "Letters to the Editor" page through the AAEM website: http://www.aaem.org/publications/common-sense/letters-to-the-editor.

- Live beneath your means. It is impossible to save, invest, or pay off debt if you spend all the money you take in. I know you have been practicing delayed gratification for a long time, and I am not saying you shouldn't splurge on something and have some fun. What I am saying is that once you indulge yourself a bit, buckle down and live so that you can save 15-20% of your income – not including whatever an employer may be setting aside in your retirement account. If you are an independent contractor getting no retirement help from an employer, it should be even more – 25-30% (and don't forget that independent contractors have to pay quarterly income taxes). Stay out of debt as much as you can, and pay off debt as quickly as you can. Don't buy a house so expensive that you become a slave to your mortgage, working so many shifts per month that you neglect your family or yourself. While the standard advice is to have at least three months worth of income saved in cash or some other safe and liquid form, I believe emergency physicians should have at least six months of income saved. Outside of academia, our jobs are inherently unstable. A contract can change hands anytime; especially if you have signed a contract with a restrictive covenant in it, you might have to move to find a new job. It is a tremendous comfort to know that you can live easily for six months when you find yourself unemployed – or have to choose between staying where you are and being treated unfairly versus picking up and moving to a better opportunity. Money may not buy happiness, but it does buy freedom – and freedom is pretty damn good. Save your money.
- Rent, don't own. No matter how thoroughly you have evaluated a job, you never really know what it will be like until you have lived in it for a year. What's more, if there is some kind of surprise that forces you to renegotiate with your group, you will be in a much stronger position if your employer knows you are renting and can thus pick up and move more easily than you could if you bought a house and have a mortgage. Renting for a year or so also gives you a chance to get a feel for a new city, its neighborhoods, and the local real estate market. I realize that at this point in economic history, this piece of advice should be taken with a grain of salt. House prices and interest rates are extremely low, and if your job is in a city with many hospitals and ED groups, you could change jobs without having to move. Just be aware of the advantages of starting off in a new city as a renter.
- Insure wisely. If you don't have children or a spouse who can't work and be self-supporting, you don't need life insurance. What you do need is disability insurance. You are far more likely to become disabled than to die prematurely. Make sure your policy is an "own occupation" policy rather than an "any occupation" policy. The former protects you if become unable to practice emergency medicine, the latter only if you can't work at all. If you do need life insurance, get term insurance. It makes little money for the insurance salesman, which is why he will try so hard to sell you a whole life or variable life policy, but don't be talked into mixing insurance and investing.
- Be a faithful and disciplined investor. If you don't make time your friend, it is your enemy. The sooner you start investing, the more time is on your side. In my opinion, almost no one can beat the market consistently over time – Warren Buffet is the exception that proves the rule. About 75% of actively managed mutual funds fail to beat passively managed index funds. You can't predict the market, and you can't control inflation. You can control how much you invest and how much you pay to invest, so keep your fees low – under 1%. Diversify widely. Educate yourself. There are countless good books on personal finance and investing. Read a few. I especially admire John Bogle, the founder of Vanguard.
- Participate in organized medicine. Or, since you are already a member of AAEM, I should say, continue to participate. The biggest enemy physicians have is their own sense of hopelessness, but a difficult fight is not the same thing as an impossible fight. Hopelessness keeps many physicians from joining local and state medical societies, turning their hopelessness into a self-fulfilling prophecy. In my experience, however, medical societies often have great success in lobbying at the state level. Join your state medical society. And remember, although smaller and much less expensive than some organizations for emergency physicians, AAEM wields influence far out of proportion to its size, because we are looked at as the moral compass of our specialty. We can accomplish even more with more members and a bigger budget. Recruit new members! ■

COMMONSENSE NEWS
Submit Your Letter

Contact the Editor online at www.AAEM.org

"Doc Fix" Still Under Consideration

Kathleen Ream, Director of Government Affairs

On July 18, Representative Michael Burgess (R-TX) introduced a bill that would give Congress a quick-and-dirty option for averting a 27% cut in Medicare pay for physicians in January. The *Assuring Medicare Stability and Access for Seniors Act of 2012* — H.R. 6142 — would freeze Medicare rates at their current level through 2013, thus postponing a cut until January 1, 2014.

Of the three bills floated this year to deal with the Medicare reimbursement issue, the legislation from Burgess appears to be the most passable. A more ambitious bipartisan bill introduced in May would scrap the sustainable growth rate (SGR) formula that Medicare uses to set physician pay, phase out fee-for-service reimbursement, and replace it with a system that rewards physicians for high-quality, low-cost care. The high price tag of the bill — *the Medicare Physician Payment Innovation Act of 2012* — makes passage unlikely in an election year.

A bill from Senator Rand Paul (R-KY) also would eliminate the SGR formula and give physicians annual Medicare raises equal to increases in the Consumer Price Index up to 3%. Paul proposes to offset the cost of his bill, which he puts at $440 billion, by repealing Medicaid expansion and premium subsidy payments under the *Patient Protection and Affordable Care Act* (PPACA). This bill also has dim prospects because Democrats who control the Senate have vowed to protect the PPACA.

Representative Burgess is on record stating that his bill would cost roughly $20 billion. It does not offer any "pay for" to make it budget neutral, but Burgess has stated that a deficit-reduction bill passed by the House in May and now awaiting Senate action would free up enough money to fund H.R. 6142.

Burgess introduced his legislation with the goal of passing it before the November general election. Otherwise, the effort to stave off a 27% pay cut could take a back seat to a set of more pressing issues facing Congress at the end of 2012: the expiration of the tax cuts enacted during the George W. Bush administration, $1.2 trillion in automatic spending cuts mandated by last year's debt-ceiling deal, and the need to raise the debt ceiling again.

Discovery May be Stayed while Motion to Dismiss is Pending

On April 9, 2012, in a case claiming that a hospital violated EMTALA, a magistrate judge of the U.S. District Court for the District of Nevada granted the hospital its motion to stay discovery, pending disposition of the hospital's motions to dismiss, if it likely appears that the motion to dismiss will be granted (Money v. Banner Health, D. Nev., No. 3:11cv800, 4/9/12).

The Facts

At approximately 2:30pm on November 4, 2010, Kenneth Money presented at the ED of Banner Hospital in Fallon, Nevada, complaining of chest pain radiating to his jaw. Money initially was assessed by a nurse and subsequently seen and treated by Dr. Donald Gandy. Following a review of Money's medical history and a physical examination, Gandy ordered a series of medications, including Clonidine and morphine.

Afterward, Money also was examined by Dr. Warren P. Thai who diagnosed hypertension, back pain, and morbid obesity.

An EKG was performed, and although the test reading "was essentially normal," Money's condition apparently started declining. Thai and Gandy ordered additional tests, and at 11:45pm they diagnosed Money with acute myocardial infarction. He was treated for a heart attack and for cardiac ischemia, and was transferred to Banner Hospital's intensive care unit. At 12:33am, an unidentified doctor signed a request to air transfer Money to St. Mary's Hospital in Reno; but at 12:39am, he went into cardiac arrest. Despite attempts to revive him, Money was pronounced dead at 1:12am.

Nearly a year later, on November 3, 2011, Mrs. Sherry Money, the Estate of Mr. Money, and Kenny Money filed suit against Banner Hospital and Drs. Thai and Gandy, alleging that the circumstances surrounding Money's death gave rise to a federal cause of action under EMTALA. Plaintiffs claim that the hospital violated both elements of EMTALA: failing to screen Money and failing to stabilize him. In addition, Plaintiffs asserted state law claims (i.e., traditional medical malpractice and wrongful death) against Banner Hospital and Drs. Thai and Gandy.

In January 2012, Banner Hospital and Dr. Thai filed two motions to dismiss, including one motion questioning federal jurisdiction, arguing Plaintiffs' failure to articulate a viable EMTALA claim. Defendants contend that Kenny Money was both screened and stabilized consistent with EMTALA requirements, and that "EMTALA would not give rise to either a screening or stabilization cause of action because Mr. Money was admitted to Banner Hospital. Defendants further argue that Plaintiffs' complaint fails with respect to Plaintiffs' EMTALA claims, because they merely reflect a 'formulaic recitation of the elements of a cause of action.'"

Then "Banner Hospital and Dr. Thai filed a Motion to Stay Discovery pending disposition of Defendants' Motions to Dismiss. Dr. Gandy joined in Banner Hospital's and Dr. Thai's Motion to Stay." At issue is "whether a stay of discovery should or should not be granted ... dependent on whether this court determines it is probable, the underlying Motion to Dismiss will be granted."

The Ruling

The court used a well reasoned two-part test for assessing whether and under what conditions discovery should be stayed. First the court must determine that "an underlying motion to dismiss must be potentially dispositive of the entire case, or at least dispositive on the issue on which discovery stay is sought. Second, the court must determine whether the pending motion can be decided without additional discovery. In applying this two-part test, the court evaluating the motion to stay must take a so-called 'preliminary peek' at the merits of the underlying pending dispositive motion to assess whether a stay of discovery is warranted." If the party moving to stay satisfies both prongs of the test, discovery may be stayed.

Continued on next page

In completing its "preliminary peek" of Defendants' motion to dismiss, the court found deficiencies in Plaintiffs' pleadings. It stated that the "complaint parrots the required elements for an EMTALA cause of action without averring specific facts as to how Defendants, Banner Hospital in particular, either failed to screen the patient or failed to stabilize him before transfer. Plaintiffs' Complaint and Opposition to Defendants' Motions to Dismiss both allege Banner's noncompliance with its own procedures but does not specify what the 'usual procedures' are and how these 'usual procedures' differed with the treatment provided Mr. Money ... [Also] the facts alleged in Plaintiffs' Complaint do not give rise to a viable EMTALA (i.e., failure to screen and/or failure to stabilize) cause of action."

Central to the court's analysis was that the only defendant named with regard to Plaintiffs' EMTALA causes of action was Banner Hospital. The court noted that EMTALA only authorizes suits against hospitals, not physicians. "Thus, if there is no basis under the facts as alleged herein for an EMTALA claim against Banner Hospital, it necessarily follows that there is no federal jurisdiction for this court to hear this lawsuit, and Plaintiffs' state law causes of action would have to be dismissed."

Continuing, the court wrote that what gives "rise to a viable EMTALA claim is a failure to screen the patient, or if screened, that the screening differed markedly from that provided other patients ... Here, based on Plaintiffs' pleadings, the inescapable conclusion is Mr. Money was, in fact, screened consistent with EMTALA requirements ... Faulty, incorrect, or 'cursory' screening does not violate EMTALA."

Moreover, Kenny Money was admitted to the hospital. "The fact that Mr. Money was admitted is critical," the court ruled, "because by statute, Banner Hospital's obligations under EMTALA end when an individual like Mr. Money is screened and thereafter admitted for inpatient care ... [thus preventing] Plaintiffs from relying on EMTALA as a predicate for federal jurisdiction."

Likewise, with the "failure to stabilize" argument, the court concluded that the complaint did not state a claim on which relief could be granted, because under EMTALA a hospital's duty to "stabilize" a patient only arises in connection with the transfer of that patient to a different hospital. The court held that similar to the "failure to screen" claims, "Plaintiffs' 'failure to stabilize' claim also fails herein because a hospital's liability under EMTALA terminates when a patient is admitted for inpatient care ... Once again, it appears that Plaintiffs have pled themselves out of court by proffering evidence that demonstrates that Banner Hospital fulfilled its EMTALA obligations."

Plaintiffs also asserted that Kenny Money's admission was a "sham." To the contrary, the court found that "an impartial reading of the Complaint infers that Defendants repeatedly attempted to treat and stabilize Mr. Money before he died. These facts undermine Plaintiffs' ... argument that Banner Hospital had no intention of treating Mr. Money."

Convinced that Plaintiffs' EMTALA claims would fail, the court reasoned that it "will not have jurisdiction over the claims Plaintiffs assert against Banner Hospital and therefore, the court must refrain from proceeding with Plaintiffs' state law claims against Drs. Thai and Gandy." Furthermore, the court ruled that staying discovery was proper because the court can decide the underlying motion to dismiss without further discovery. "Anticipating that Defendants' motions to dismiss will eventually be granted, the court concludes that discovery should be stayed herein pending final resolution of the motions to dismiss ... [and] THEREFORE ORDERED that Defendants' Motion to Stay Discovery pending disposition of Defendants' motions to dismiss is GRANTED."

Final Resolution: EMTALA Action Failed

The magistrate judge was right on the money: His evaluation that the underlying pending motion to dismiss the Money case would be granted, was so decided by the district court on July 13, 2012, (Money v. Banner Health, D. Nev., No. 3:11-cv-00800-LRH-WGC, 7/13/12).

The United States District Court for the District of Nevada reviewed the documents and pleadings and found that Plaintiffs' "allegations fail to establish that Money was screened in an inappropriate manner, or that Banner failed to meet EMTALA's stabilization requirements. It is undisputed that Money was ultimately admitted into Banner and treated at the hospital thereby cutting off Banner's liability under EMTALA." The court also determined that since Money was "examined and treated throughout his time at Banner, eventually leading to Banner's decision to transfer Money to another hospital," Plaintiffs' complaint fails "to allege that Banner only admitted Money to avoid liability under EMTALA." Because EMTALA does not require a correct diagnosis, the court stated that "it is irrelevant that Banner may have misdiagnosed Money's condition." The court therefore granted Banner's motion to dismiss Plaintiffs' EMTALA claim.

Finally, the court declined to exercise supplemental jurisdiction over Plaintiffs' related state law claims for medical negligence/malpractice. The federal district court concluded that having dismissed Plaintiffs' sole federal claim, it also "shall dismiss Plaintiffs' related state law claims without prejudice."

To examine the court's April 9, 2012, opinion go to http://docs.justia.com/cases/federal/district courts/nevada/nvdce/3:2011cv00800/84260/23/0.pdf?1334150416.

For the July 13, 2012, opinion, go to http://docs.justia.com/cases/federal/district-courts/nevada/nvdce/3:2011cv00800/84260/25/.

Request from Clinic to Transfer Patient Does Not Trigger Hospital's EMTALA Duty

On May 9, 2012, the U.S. District Court for the District of Kansas dismissed a claim asserting that a hospital violated EMTALA by refusing a clinic's request to transfer a patient to its ED when the patient requires specialized treatment for an emergency (Penn v. Salina Regional Health Center, D. Kan., No. 6:11 cv 1243, 5/9/12).

The Facts

The COMCARE operated clinic is co-owned by Ottawa County Health Center, a critical access hospital, and the local Health Planning Commission in Minneapolis, Kansas. The physicians at COMCARE are employed by COMCARE, and many of them also have employment agreements with Ottawa County Health Center to provide emergency services at the hospital. Experiencing "pressure and aching in her

Continued on next page

upper chest which radiated into her neck, as well as constant pain in both arms and her jaw" Theresa A. Penn, age 45, presented to the COMCARE clinic in the afternoon on January 14, 2011.

Dr. Kelly Yoxall, Penn's primary care physician, examined Penn, concluding that Penn's symptoms "were consistent with acute coronary syndrome and acute myocardial infarction and that Penn was in a life threatening emergency." Because Salina Regional Health Center was the closest hospital with an ED and specialized facilities, Yoxall called SRHC requesting permission to transfer. Stating that there were no available beds in the intensive care unit, Dr. Curtis D. Kauer, the SRHC on-call cardiologist, refused the transfer request.

Yoxall then contacted a Wichita hospital, 85 miles further away from the clinic than SRHC, whose cardiologist agreed to accept Penn. En route by ambulance to Wichita, Penn "coded" during the trip. Even though emergency surgery was performed at the Wichita hospital, Penn died shortly after midnight on January 15, 2011.

Michael E. Penn, as Special Administrator of the Estate of Theresa Penn, filed a lawsuit against the hospital and the on-call cardiologist alleging that the refusal to accept the transfer of Penn was a violation of EMTALA. SRHC responded with a motion to dismiss, arguing that Plaintiff's complaint alone is legally insufficient to state a claim for which relief may be granted.

The Ruling

The Court first noted that under EMTALA, for hospitals with an ED, "if any individual ... comes to the emergency department and a request is made on the individual's behalf for examination or treatment for a medical condition, the hospital must provide for an appropriate medical screening examination within the capability of the hospital's emergency department." The Court then iterated the definition of "comes to" with respect to an individual who is not a patient but who has "requested an examination or treatment for a medical condition, or has such a request made on his or her behalf," and who has presented either:

- At a hospital's dedicated emergency department;
- On hospital property; or
- Is in a ground or air ambulance owned and operated by the hospital for purposes of examination and treatment for a medical condition at a hospital's dedicated emergency department, even if the ambulance is not on hospital grounds.

Plaintiff contended that the "come to" requirement was met when Penn was in Yoxall's office when the physician called and spoke with the SRHC on-call cardiologist. The District Court rejected Plaintiff's argument holding that Penn had not "come to" the hospital ED within the EMTALA definition because Penn "had neither presented on Salina Regional's campus nor been in an ambulance owned by Salina Regional."

Plaintiff then made an alternative EMTALA "reverse dumping" claim. "Reverse dumping" occurs when a hospital ED refuses to accept an appropriate transfer from another hospital of a patient requiring its specialized capabilities. SRHC argued "that for a hospital to be liable under EMTALA based on 'reverse dumping,' the request for transfer must come from a hospital, not a clinic or a physician."

The Court agreed with Defendant stating that it was "apparent that 'reverse dumping' requires two hospitals: a 'transferring hospital' and a specialized transferee hospital." Satisfied that Plaintiff could not establish a plausible EMTALA case, the Court dismissed Penn's EMTALA claim and granted Salina Regional's motion to dismiss.

The full text of the court's opinion is at https://ecf.ksd.uscourts.gov/cgibin/show_public_doc?2011cv124337.

Claim Dismissed that Hospital Violated EMTALA when In-Patient Discharged

On May 15, 2012, the U.S. District Court for the Eastern District of Missouri dismissed a plaintiff's claim that a hospital violated EMTALA when it discharged a patient, already admitted to the hospital with a mental illness, prior to stabilizing his emergency medical condition (James v. Jefferson Regional Medical Center, E.D. Mo., No. 4:12-cv-267, 5/15/12).

The Facts

On the evening of January 12, 2010, Earl D. James, Jr. presented to the Jefferson Regional Medical Center (JRMC) ED. James complained of suicidal and homicidal thoughts. At the ED, Dr. Petty Petralia diagnosed James's condition as "Altered Mental other (suicidal ideation, major depression schizoaffective disorder)." In her notes, Petralia also indicated that James is "well known to this facility. He was evaluated by the intake coordinator for the mental health division. He will be admitted for further treatment under Dr. Ardekani."

James then was admitted to JRMC's psychiatric unit where he was examined by Ardekani, who noted that James "is a 32 year-old black, unemployed male who was admitted through the intake." Ardekani's evaluation included James's prior psychiatric history and the proposed plan of treatment that "[u]pon admission, we will detox him. We will start him on medication, and will be looking into a group home or a new placement for the patient. He said he can't sleep so will increase trazdone [sic] from 100 to 300 mg at night."

Early the next day, James was discharged and taken to a shelter because James fought with another patient shortly after Ardekani's examination. James alleged that "he was dropped off in a psychotic state," and that prior to discharge he was "not provided medication or afforded any 'stabilizing treatment.'" He also contended that he remained in a psychotic state for the next ten days. On January 23, 2010, while on the streets of St. Louis, James was assaulted.

Asserting that it was "reasonably foreseeable" that JRMC's "failure to stabilize him would cause him harm," James filed a petition for damages. He claimed that the hospital violated EMTALA for "failure to stabilize before discharge and for failure to provide appropriate transfer." JRMC responded by filing a motion to dismiss plaintiff's petition for "failure to state a claim upon which relief may be granted."

The Ruling

Defendant asserted that it was not liable under EMTALA because James was admitted. JRMC argued that the Centers for Medicare and Medicaid Services "has clarified that a hospital's obligation under

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EMTALA ends either when the individual is stabilized or when that hospital, in good faith, admits an individual with an EMC [emergency medical condition] as an inpatient in order to provide stabilizing treatment. That is, ... EMTALA does not apply to any inpatient, even one who was admitted through the dedicated emergency department and for whom the hospital had initially incurred an EMTALA obligation to stabilize an EMC, and who remained unstabilized after admission as an inpatient."

In response, James contended that Defendant could not satisfy its EMTALA obligations merely by admitting him. To back his claim, James relied on the U.S. Court of Appeals for the Sixth Circuit's decision of Moses v. Providence Hospital and Medical Center Inc. Moses involved claims brought by the estate of a woman who was murdered by her spouse after he was discharged from a hospital and following a psychotic episode. Among its rulings, the Sixth Circuit in Moses overruled a CMS interpretation of EMTALA, instead finding that admission to the hospital does not end the EMTALA requirements to stabilize and treat a patient (Moses v. Providence Hospital and Medical Centers Inc., 6th Cir., No. 07-2111, 4/6/09). [The Moses case was first reported in the article "Estate of Murdered Woman Allowed to Pursue EMTALA Claims," in the July/August 2009 issue of *Common Sense*, available at http://www.aaem.org/UserFiles/file/commonsense0709.pdf.]

Rejecting the analysis in Moses, the U.S. District Court in the Eastern District of Missouri held that a hospital meets its obligations under EMTALA once it admits a patient. The Court wrote that "EMTALA was enacted to prevent 'a distinct and rather narrow problem' of patient 'dumping,' or the practice of refusing to admit or summarily transferring a patient based on a perceived inability to pay for hospital services." The Court further explained that while the law "focuses on uniform treatment of patients presented in hospital emergency departments ... a]fter a patient has been admitted in good faith as an inpatient, professional (i.e., doctor-patient) and fiduciary (i.e., hospital-patient) duties attach to the situation ... State law is perfectly adept at delineating and enforcing these duties; the EMTALA is neither necessary nor intended to enforce them."

"Having determined that an EMTALA violation cannot lie if Plaintiff was admitted," the Court concluded that "Plaintiff's EMTALA claims fail because he clearly was admitted to the hospital." The Court dismissed all of Plaintiff's EMTALA claims, but the state malpractice claims remained for remand to the county circuit court.

The full decision is at http://docs.justia.com/cases/federal/district-courts/missouri/moedce/4:2012cv00267/118631/13/0.pdf?ts=1337165592. ■

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

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 8-22-12.

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

From Care to Compensation — Part 1 - Care to Claim

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.*

Payment for patient care services is a bit of a "black box" for most emergency physicians who have not carefully tracked how their patient encounters turn into income. The Practice Management Committee offers this series as a brief look inside the box.

In this first article, we will cover the process from point of care to the filing of a claim or patient bill. Next, we will discuss how the claim filing moves through to payment.

The effectiveness of billing, coding, and collection is affected by many factors beyond the scope of this article. Here, we will focus on the movement of your encounter information through the billing process or how your chart turns into a bill and then into payment.

How documents or electronic data travel and how they are handled by the billing entity will vary somewhat, depending on whether the practice does independent billing, is in a direct compensation relationship with the hospital, or works in a faculty practice plan or larger medical group. However, three essential components will drive the process regardless of the entity doing the billing: a complete medical record, a registration document, and an ED log or other independent source to control for lost charts.

When you see a patient, some of what happens during the encounter is documented in the hospital's medical record system by way of an EMR, transcription, or paper record. The purpose of the medical record is not just to bill, but to facilitate continuity of care beyond the ED. Never forget this. The record must first facilitate good patient care. A good medical record also prevents some lawsuits and makes those that are filed more easily defended. Unfortunately, much ED record keeping these days, especially by EMRs and templates, makes good patient care incidental to other interests.

When you defend against audits of your billing, and payer audits are inevitable these days, the payer will not be swayed by your exhaustive description of multiple irrelevant exam findings or templated ROS statements that make every patient look the same. You will be better served by how thoroughly your record describes what was done and why. So "think in ink" – use your charting system in the way that best captures your thought process and decisions.

The patient encounter generates at least a triage record, nursing notes, a physician chart, and a billing registration. Most EDs also use log systems for tracking patients, an independent source to control for missing charts. On average, 3-8% of ED encounters don't make it into the billing system on the first pass. Without a chart reconciliation process that matches missing records with the ED log and registration information, you will lose revenue. Treat every chart like an undeposited live check; don't leave it unaccounted for in the billing process.

The triage record and nursing notes are very helpful ancillary documents that tell a more complete story of the patient encounter, but must never be relied upon to tell the most important parts – what was wrong, what was done, and why. Billing for the physician's professional fee must be done solely from the physician's record. However, competent billers can use nursing notes in ways that will affect payment in certain circumstances, so it is useful to make these part of the billing packet.

Once the three basic record components (chart, registration, ED log) are created, they must be transferred into the billing process – electronically, if there is an interface between the billing entity and the hospital, or on paper. We call these combined records "billing packets."

These packets are then indexed, matched, and reconciled by the billing entity to assure that they include all that is needed for accurate coding and billing. Patients who left before treatment, those seen by a private physician, duplicate charts, and hospital no-bills (VIPs, employee health, or other special arrangements) are checked off from the log and missing charts are put on a "shortage list" to be tracked down and brought back into the process. Hint: if your group is never advised about missing charts by the billing entity, it is likely that this process doesn't exist or is broken and needs to be fixed. Billing packets are probably being lost.

Common reasons for missing charts: 1) No physician record at all. For example, the chart is "locked" by the EMR and awaiting someone's final action before it can be pushed to billing, the transcription never made it back into the medical record, the ED record was never uploaded to the hospital-wide EMR, etc. 2) Incomplete physician records, such as a missing physical exam, a missing addendum after labs came back, etc. 3) Electronic conflicts in the transfer process – lost files are very common when sending chart packets out of the hospital and not uncommon even when billing is done internally.

Next, the registration information must be analyzed to determine who is responsible for the bill and insurance must be verified to determine coverage. Insurance information is checked against databases, and bill streaming is set up so that claims go to the proper party in the proper order.

Continued on next page

In ED billing, the patient with insurance should be billed for the copay or deductible amounts, but should not be considered the first source of payment for the total bill. Claims should go first to the insurer, and billing must be sequenced accurately. Payments from patients who are billed for what the insurer should have paid are normally lower than those obtained by pursuing the insurer for its contractual obligations.

The chart must be coded to capture all service fees before a bill to the patient or insurer can be generated. The 1997 HIPAA laws mandate that all payers use the American Medical Association's Current Procedural Terminology (CPT) system to determine compensable services. Payers may choose not to pay for certain CPT services, but this is still the universal standard for reporting services rendered.

Fees are established, and RVUs (Relative Value Units) are assigned for each of the more than 400 common CPT codes used by emergency physicians. These codes are reported on the HCFA 1500 paper claim form or the 5010 electronic transaction, the universal standards mandated by HIPAA. In most locations, 75-85% of all ED claims can now be filed electronically. CPT codes are used by payers to determine the amounts they are willing to pay for each service.

Diagnosis codes (ICD-9 CM) must also be reported on the claim to identify the reasons for treatment – another HIPAA mandate. Payers audit claims for mismatches between diagnosis codes and services and reduce payment if the diagnosis does not support the reported service.

For example, if a scalp laceration was repaired on a patient who had a syncopal episode, the claim would contain a diagnosis of syncope (ICD-9 780.2) as the reason for the visit level (commonly CPT 99284 or 99285), and a diagnosis of open wound of the scalp (ICD-9 873.0) would be reported as the reason for the laceration repair code (14 different scalp repair CPT codes exist – depending on length, depth, and complexity).

If the claim contained only the syncope diagnosis code or matched that ICD-9 code to the wound repair, the payer might respond that syncope alone was not proof that a scalp wound occurred and deny payment for the laceration repair. Much of the down-coding, denial, and delay in claim payment is a result of bad behavior by payers who make up clinically unsupportable diagnosis screening rules, but sometimes the problem is just poor coding.

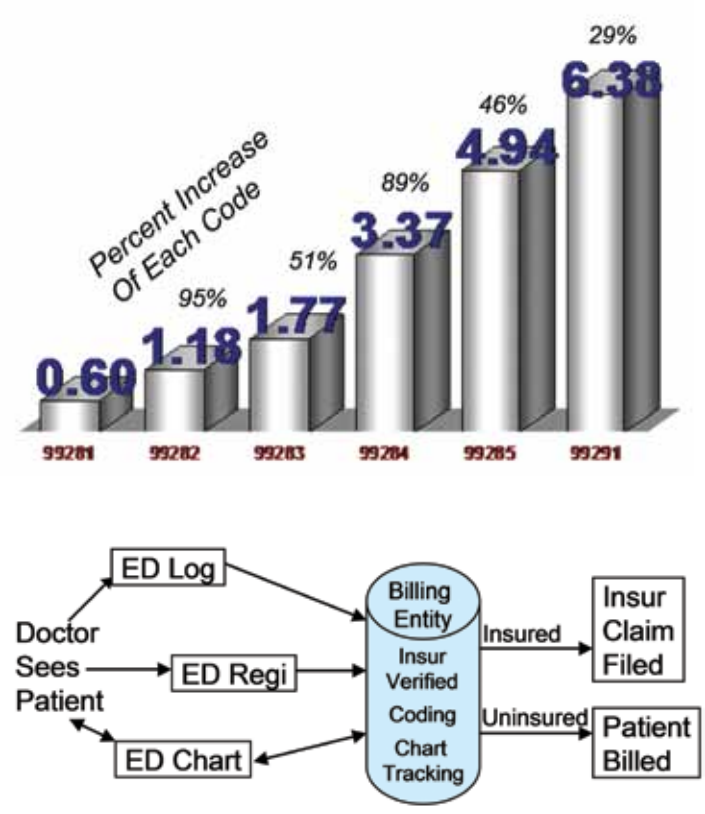
Coding is the process of understanding the words of the physician and classifying the history, exam, and medical decision-making to support the level of care billed – along with any procedures performed – and assigning diagnosis codes that clearly indicate the reasons treatment was provided at the reported level. Every ED visit is given a visit level (99281-99285), critical care (99291), or observation care (99218-99236) code. About 10-15% of ED patients also receive procedural services like wound care, ortho management, sedation, debridement, foreign body removal, etc. Many emergency physicians also bill for EKG, X-ray, and ultrasound interpretations. Billing for interpretive services is sometimes politically charged, since it can conflict with the billing of other specialists.

Like each visit level, each procedural service has clinical content associated with it that the coder must be able to locate in the chart to support the claim for that procedure. Coders must understand what constitutes sufficient proof of the performance of a particular service and how that service is distinguished from others performed in the encounter. Payers might also have to be educated about the clinical content in the chart, as they often misunderstand (or deliberately ignore) the reasons emergency physicians do what they do.

Each CPT code has a fee assigned to it and RVUs associated with it that are established by Medicare and revised and published annually. Practices that reward productivity often pay based on the production of RVUs. Improving your RVU production is often a function of documenting more clearly so that the coder can understand your evaluation, management, decision-making, and thought process and assign the correct codes.

In our next article, we will address the back end of the billing process, where the claim is handled by the payer, the patient gets a bill, payments are received – and down-codes, denials, and delays are managed to assure fair compensation for the physician. ■

2012 Medicare RVUs by Level of Service



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The Calculus of Patient Satisfaction

Tom Scaletta, MD FAAEM

How do calculus and patient satisfaction possibly go together? Allow me to explain. Before entering medical school, I earned an undergraduate degree in mathematics and subsequently worked as a database programmer for an actuarial firm. My favorite college math professor and early mentor knew that college was primarily a bridge for me into medicine. Yet, he often remarked that the skills I was learning in advanced calculus would never be wasted. Amazingly, he was right. After completing an emergency medicine residency, I became keenly interested in administration and currently oversee a 90,000 visit ED in the Chicago area. I now find synergy between mathematical theory and maintaining a top-tier ED that is consistently at or above the 95th percentile in patient satisfaction. In a surreal way I sometimes feel like I am channeling the wisdom he shared with me decades ago to drive process improvements in safety, cost, and satisfaction. Go figure!

Calculus, the mathematics of measuring change, operates under a recurring theme that big things are derived from little things. Achieving excellence in patient satisfaction can be approached like a calculus problem. The complex task of maximizing the patient experience in a high-volume ED requires dividing this goal into many discrete, manageable actions that can have a positive effect on patient satisfaction. Optimization of each component requires interval performance measurement and fine-tuning. Upon reassembly of all the pieces, the solution is demonstrated.

Consider the equation, $B(a,b) = \int h(x)dx$, which represents the formula for the area beneath a certain curve [Figure A]. This curve could correspond to the rise and fall of patient satisfaction related to a particular aspect of service delivery over a period of time. The X axis represents the passage of time where (a) is now and (b) is the future after a discrete process change. The Y axis represents performance.

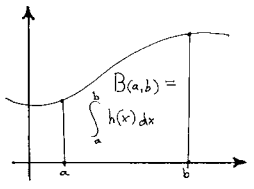

Figure A

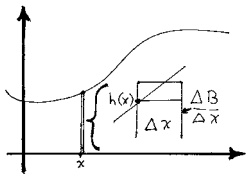

Figure B

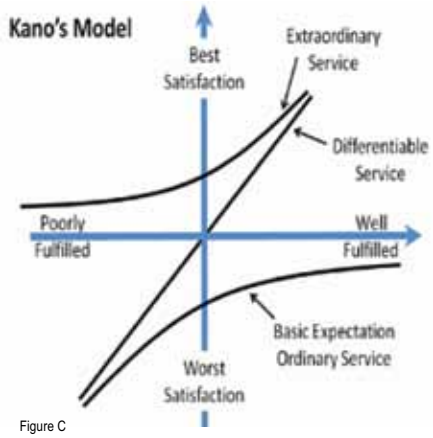

Figure C

The *Infinite Sum Theorem* defines h(x) for any infinitesimally small time interval. These thin slices, denoted as ΔB, equate to h(x) Δx where Δx is the area under the curve, and are much easier to calculate [Figure B]. Subsequently, all these time intervals, when added together, will estimate the area under the curve for a certain time period (like a-b). So solving the complex problem of measuring the area under a changing curve simply requires us to sum up the areas of many thin rectangles.

That's enough calculus for now. It's time to segue to more practical applications.

Before we can dig into patient satisfaction, we must define it. Satisfaction is a layperson's interpretation of the quality of health care delivery. In other words, it is based on perception of actuality, not necessarily actuality. Since each patient is unique, perceptions vary widely. What is important to one may be meaningless to another. To add further complexity, we know a continuum exists among practitioners as to what constitutes the highest quality care.

Performance differentiators are categorized with the mnemonic, QUEST – quality, utilization, efficiency, satisfaction, and teamwork. These categories are tightly interrelated. Cost is split into resource waste (utilization) and time waste (efficiency). In the case below, every aspect of performance was great except for satisfaction. Emergency caregivers need to constantly correct patient (or family) misperceptions of what quality represents. We often try to fulfill the individual's perspective of great service whenever *feasible*. *Feasible* implies there is no sacrifice in a more meaningful aspect of performance. For instance, curtailing test ordering is great unless it jeopardizes patient safety. *Feasible* also implies cost targets are met and any other limitations can be tolerated.

Case Example

A woman limps into the ED with ankle pain and isolated tenderness over her anterior talofibular ligament. The doctor, who is simultaneously managing several sick patients, smiles and says, "You don't need an X-ray. I'll get you out of here in minute." The nurse then applies a stirrup splint, explains the discharge instructions, and directs her to the exit. The patient thinks, "I just forked over $200 (insurance copayment) yet they are brushing me off without an X-ray." The next day, the patient is emailed a self-survey request to assess her experience. She categorizes the doctor as "very poor" prompting the medical director to ask the emergency physician "What happened?" Reflecting back, the doctor defensively says, "We got her in and out faster and better than any ED around. No criteria were met for imaging. Plus, she never told me or the nurse about any unmet expectations. And if I ordered a film, she would have lingered at least an hour since a real trauma was arriving by ambulance." Sound familiar?

The complaint in the case example may have been prevented had the emergency physician or primary nurse asked if the patient had any questions or concerns about the care being rendered before discharge. Eliciting patient concerns would have likely shed light on the expectation of an X-ray and, perhaps, a discussion of the Ottawa Ankle Rules.

There are so many things that can become a satisfaction issue that perfection is improbable. It is certainly plausible that any of the following

Continued on next page

complaints might be shared on the follow-up phone call:

- "My boyfriend was not allowed in the exam room."
- "They wouldn't let me use my cell phone."
- "I waited forever to see a doctor."
- "The doctor was sloppy; he was unshaven, and his shirt wasn't tucked in."
- "I saw blood stains on the drapes from another case."
- "I asked several times for a drink of water."
- "The orthopedic office doesn't take my insurance."

At Edward Hospital in Naperville, IL, a 75% rate of being awarded the top service score (on a 5-point scale) correlates with the 95th percentile in satisfaction relative to other high-volume, community EDs. Stated differently, despite care being judged as deficient a quarter of the time, an ED can be ranked in the top 5% nationally. (Note that the relationship between top score and satisfaction percentile is sigmoidal and bears an uncanny resemblance to pO2:SpO2 pairings on the normal oxy-hemoglobin dissociation curve.)

Imperfection in patient satisfaction is expected and, in fact, often appropriate. An example is when a non-urgent patient feels "rushed" because an emergent patient requires far more attention from the team. By nature, EDs are "satisfaction-challenged" due to the unpredictable nature of arrival volume/acuity as well as the angst and aggravation that patients experience when faced with an emergency medical condition. This is sometimes unfairly transferred to the ED staff. While some degree of satisfaction failure is not a barrier to being a top performer, when staffing thins and there is only enough time for essential care, satisfaction failure becomes excessive. The difference between a good and a great ED regarding satisfaction reflects persistent efforts to keep the proverbial margin as narrow as possible.

Unlike many other areas of medicine, every ED has a unique struggle. Patients must succumb to the will of providers that they have just met. Emergency physicians that connect effortlessly and garner confidence within minutes are much more likely to watch the next few hours of testing and treatment go by smoothly.

Marginal Opportunities

QUEST improvements represent many marginal opportunities that add up to produce great satisfaction scores. This echoes the calculus axiom, that complexity is an amalgam of simplicity. The marginal change in *perceived* quality for a specific action is symbolized by ΔQp and is equal to Δ(Qd-Qe), the margin between *delivered* and *expected* quality. When Qd > Qe then ΔQp is positive because the service delivery has exceeded expectations, which is always the goal.

The value of a new service is represented by ΔQp/cost. The return on any investment is directly related to the marginal improvement in any aspect of QUEST and inversely related to cost. Cost is any outlay required to initiate and carry out the new service such as time, money, risk, and even angst. Consider that patients are more apt to pay double when quality is triple in their estimation. As ED copayment requirements rise, it is important to add more value to every visit in order to maintain a solid client base and improve reputation. Accountable Care Organizations will market their "fee-for-value" in negotiating contracts with payers as capitation reemerges.

Ordinary and Extraordinary Service

The quality expert, Noriaki Kano, taught the service trichotomy of ordinary, extraordinary, and differentiable [Figure C]. Ordinary service concerns a basic expectation whereby satisfaction remains neutral when fulfilled and extremely negative when not fulfilled. Conversely, extraordinary service represents added value that is entirely unexpected and highly appreciated by the recipient. Extraordinary service is positive when fulfilled and neutral when not (since unanticipated). For instance, next-day patient follow-up after an ED visit (as illustrated in the case example) is an extraordinary service that vastly improves the patient experience and can be accomplished at a relatively low cost. The last form, differentiable service, is a blend between ordinary and extraordinary and linearly relates to performance. For instance, door-to-doctor time can either be a negative experience when excessive, neutral when average, and positive when brief.

Consider that each dimension of service generates a positive, negative, or neutral contribution to overall satisfaction. Further, certain service factors have more impact with some patient types than others. Layering the multiple factors creates an aggregate satisfaction score. As we consider the myriad permutations, including specific doctor-nurse combinations, the equation becomes multi-dimensional, extremely complex, and encompasses the branch of calculus called vector analysis.

Measurement

Measuring satisfaction is measuring perception. With large sample sizes and standardized quantification, we transition away from subjectivity and toward statistical significance regarding how a particular population views the service delivery of an individual provider. Statistically speaking, there is literally *power* in numbers. If you send out paper surveys to 10% of patients and 10% of these are returned, then only 1% are measured. This degree of statistical power may offer a crude idea of how the ED compares to a peer on a quarterly basis. It definitely cannot tell how well an individual provider does from quarter to quarter, and it would be patently unfair to incorporate such arbitrary data into a bonus formula or disciplinary action.

Edward Hospital has performed next day callbacks for seven years. In fact, my original ED callback database was praised by the Robert Wood Johnson Foundation as a best practice. (http://rwjf.org/qualityequality/product.jsp?id=29982). Currently, patients not reached by telephone are sent an automated email or text message link to a brief self-survey about their well-being and satisfaction. Because we sample half our patients, we can tell with certainty if a particular provider is an outlier compared to peers on a monthly basis. We also find that when staff knows patients are contacted the next day, they become more motivated and achieve higher levels of performance. All comments, positive and negative, are fed back to the staff each month and become a rich resource for introspection.

In any improvement exercise, measurement is the key. Specifically, it is essential to carefully study the problem, identify appropriate metrics, establish baseline measurements, make a logical change, repeat the measurements to quantify the benefit, and be cognizant of any unplanned, negative effect.

Continued on next page

Client Relationship Management (CRM)

CRM is the science of encouraging positive relationships, dealing with negative experiences, and defusing angry clients. It is wonderful when extraordinary service is delivered, and expectations are exceeded. Highly-pleased patients may become *evangelists* and expound the virtues of your service line. Certainly, this elevates the reputation of the hospital. Contrast that with dissatisfied patients, or *avengers*, whose basic expectations went unmet. They are often so upset they readily share vivid recollections of their visit (that become more egregious with each retelling) with whoever will listen. In fact, for every negative story teller, ten positive ones are needed to counteract the impact. CRM experts generally agree that it is exponentially more important to expend resources on efforts that prevent dissatisfaction.

Before you can handle an angry client you must first identify one, which does not sound hard to do. Interestingly, and counter to what many physicians believe, angry patients do not always verbalize their discontent. They may fear receiving worse care by complaining or may be uncomfortable confronting any healing arts professional. Thus, it is crucial to appreciate dissatisfaction through indirect cues, like body language. When suspicious, point out that the patient or family member seems to be unhappy about something. Offer to understand more and help with any problems.

Inability or unwillingness to confront an angry patient right away risks that the issue will fester into a much bigger mess. In the ankle sprain case above, the follow-up call and subsequent CRM actions averted a formal letter to the CEO and refusal to pay the balance owed. Sometimes a patient jumps to the false conclusion that some sort of discrimination played a role and notifies a regulatory agency. The longer it takes to reconcile the issue, especially after an influential third party becomes involved, the more defensive the treating physician or department head often becomes. That is not a good place to be.

Though it will interfere with your schedule, it is easier to immediately engage an angry patient rather than put it off. While conflict is uncomfortable, chances are good that when a situation is well-handled there will be no aftermath. In fact, sometimes the patient does an about-face because immediate concern is shown.

An important technique to master is the ability to correct faulty judgment while allowing someone who is irate to maintain self-esteem. An effective strategy is to listen intently, express genuine thankfulness for sharing the concern, paraphrase the person's opinion (no matter how implausible) to show you understand, and then calmly present the facts in a respectful and empathetic manner. Role play and coaching are effective techniques to help hone this skill. Apologize profusely whenever the ED experience falls short for whatever reason. When anger stems from a lack of understanding of customary processes, and yet a reasonable explanation is not accepted, then squeeze out some modicum of empathy by feeling sorry for the individual who struggles so much with logic — without verbalizing that notion, of course!

Service Recovery

Service recovery begins with asking, "What can I do to make this right?" Often the patient just wants the department leaders to be aware so that future cases benefit from some sort of process fix. Depending on the situation, it may make sense to offer a small token, like a meal pass or gift card, to compensate for a relatively minor inconvenience such as a longer than expected wait. Some EDs encourage independent service recovery by empowering charge nurses to distribute such gifts as they choose.

Sometimes a patient will say "I do not expect to be charged for any of this!" because there was a single, non-critical service glitch. When patients have lofty expectations that seem impossible to meet, do not dismiss the demand outright. Instead, offer to funnel the request to a supervisor or an adjudication committee who will get back to them. It is wise to have an organized system to report issues, like an end-of-shift charge nurse summary sent to ED leaders by group email. Decisions to cancel charges or waive an insurance copayment must be vetted in a formal manner so that antitrust laws and payer contracts are not violated. Edward Hospital has a dynamic, interdepartmental Grievance Committee where complaints are heard and addressed and hospital-wide performance opportunities are sought.

Summary

QUEST is a mnemonic that categorizes interrelated performance differentiators – quality, utilization, efficiency, satisfaction, and teamwork. Care must be taken to avoid sacrificing one component (say quality) for another (say efficiency) and to assure cost targets are met. Cost can be in the form of time, money, risk, or angst.

Imperfection in patient satisfaction is expected. This occurs when other patients or other performance factors take priority. Because of the unpredictable nature of ED volume and acuity, we are periodically "satisfaction-challenged."

Our priority is to deliver on all ordinary services, meeting the basic expectations most patients have. Risk of failure with these items must be actively monitored and minimized. Extraordinary service is the result of successful innovations. We should always seek those that meet our cost tolerances. Differentiable service opportunities (like reducing door-to-doctor time and boarder hours) must always be the focus of performance improvement projects.

Patient advocacy does not mean patients are always right. We should correct misperceptions and address angry patients in a professional and practiced manner as soon as possible. Since many do not outwardly express dissatisfaction, look for ominous signs (body language, word choice, etc.) and ask about service concerns. Use service recovery offerings when possible and refer unrealistic requests and unusual situations to the ED directors.

Whenever faced with improving patient satisfaction, approach it like a calculus equation. Know that even the most intimidating problems can have elegant solutions.

I invite you to share ED patient satisfaction ideas and challenges with me at Tom.Scaletta@Smart-ER.net. ■

Tom Scaletta, MD FAAEM
Member, Operations Management Committee

New EM Residency Program at American University of Beirut, Lebanon

Amin Antoine Nabih Kazzi, MD FAAEM

It is with great pleasure that I announce to my AAEM colleagues the establishment of our emergency medicine residency program at the American University of Beirut, and the recent selection of our first class of four interns/residents through our own institutional match (modeled along the NRMP principles).

Our match involved 453 applicants from 30 countries. We matched our four interns out of the top four on our list!

I want to take this opportunity to thank the AAEM International Committee for the great support they have provided to us in Beirut and to introduce our new (and really first) Residency Director, Dr. Gilbert Abou-Dagher; and our new department Chair, Dr. Eveline Hitti. We also have two ABEM-certified, full-time faculty, Dr. Mazen El-Sayed and Dr. Afif Mufarrij, our Directors of Operations and Quality, respectively. Eveline trained at Johns Hopkins, Afif and Gilbert at Henry Ford Hospital, and Mazen at the University of Maryland. I urge you to continue your support and to provide them guidance as needed.

I am becoming more involved in hospital administration, assuming additional responsibilities as the AUB Medical Center Deputy Chief of Staff. I will, of course, remain the full-time old scrub in the ED, working my share of shifts while also addressing national issues of importance to our patients and to the specialty, such as:

1. Establishing an EM specialist professional society.
2. Revising national regulations to secure the proper credentialing of EM specialists and the establishment of a properly accredited specialty certification. (Yes, BCEM is visiting us here too — and with vigor!)
3. Securing proper categorization of EDs, EM services, and hospitals based on their ED, trauma, and critical care capacity.

Dr. Kazzi with some of the nurses, residents, and medical students who worked with him during a recent shift in the ED.

I hope you will continue to support the development of international EM through engaging our programs, faculty, and residents in your committees and activities.

Of course, we are 100% AAEM members. ■

Dr. Kazzi is the Deputy Chief of Staff, AUB Medical Center; Founding Emergency Medicine Residency Program Director and Associate Professor of Emergency Medicine at the American University of Beirut; past president of the American Academy of Emergency Medicine, and immediate past president of the Lebanese Society for Emergency Medicine.

2013 Pediatric Emergency Medicine Subspecialty Certification Examination

The American Board of Emergency Medicine (ABEM) and the American Board of Pediatrics (ABP) will administer the certifying examination in pediatric emergency medicine on Tuesday, April 9, 2013.

Physicians who are certified in emergency medicine by ABEM must submit an application to ABEM. Physicians who are certified in general pediatrics by ABP must submit an application to ABP. Physicians who are certified by both boards may apply through either ABEM or ABP. Upon successful completion of the examination, certification is awarded by the board through which the physician applied.

Applicants must complete an Accreditation Council for Graduate Medical Education (ACGME) accredited fellowship program in pediatric emergency medicine to be eligible to take the examination in 2013. The complete eligibility criteria are available from each board office or at www.abem.org and www.abp.org.

Application materials will be available for physicians applying through ABEM starting August 1, 2012. Completed applications must be submitted to ABEM on or before January 10, 2013. ABP diplomates should contact ABP for application information.

AMERICAN BOARD OF EMERGENCY MEDICINE
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American Board of Emergency Medicine Assessment of Practice Performance for Emergency Physicians

John C. Moorhead, M.D.
ABEM President
Professor, Oregon Health & Science University
Department of Emergency Medicine
Portland, Oregon

Editor's Note: This article is submitted at the request of William T. Durkin, Jr., M.D., President, AAEM

Acknowledgement: The author would like to thank Earl J. Reisdorff, M.D., and Ms. Frances Spring for their assistance with the manuscript.

American Board of Emergency Medicine (ABEM) Assessment of Practice Performance (APP) for Emergency Physicians

Assessment of Practice Performance (APP) is a part of the Maintenance of Certification (MOC) program that is required for diplomats of every medical specialty. The ABEM APP program focuses on the ability to translate medical knowledge into clinical action. APP has two elements: patient care practice improvement and communications/professionalism.

Patient Care Practice Improvement

Practice improvement has always been part of Emergency Medicine. Hospital-based, clinically active, emergency physicians are immersed in an environment that tracks adherence to quality measures. Most emergency departments are active in patient care improvement initiatives that are acceptable to ABEM for meeting the APP requirement (Table 1).

Once an APP clinical area is selected, the physician must identify at least ten patients for initial measurement. The cohort can involve fewer patients for higher-acuity, lower-frequency conditions (e.g., sepsis). The activity does not have to be an individual physician effort, but can be a department-wide activity. The data should be compared against regional or national standards. If benchmarking data is unavailable, the first sample measurement could serve as an initial baseline standard. There must then be an "intervention." This could involve a review of the literature, systems or protocol changes in the emergency department, or reviewing performance at department meetings. Ideally, the physician or department alters practice to improve clinical performance. This is followed by re-measuring at least another ten patients.

The aforementioned process is commonplace in emergency departments. Therefore, the only additional activity that is currently required is for the physician to attest to such activity every five years on the ABEM website. The website's attestation pages use simple, drop-down menus that are easy to complete. Physicians do not submit data to ABEM—they simply attest to the activity's completion. ABEM verifies the attestations using an individual that the physician has identified (e.g., a department chair).

The ABEM APP requirement costs nothing to complete; measures can be used by the entire department; and the measure set can be used repeatedly (as long as the same aforementioned process is applied). ABEM hopes to balance ongoing quality improvement with limited additional burden for individual diplomats.

Communication/Professionalism

APP also has a communication/professionalism requirement, which can be accomplished through patient satisfaction surveys. Many hospitals participate in commercial survey instruments (e.g., Press Ganey® or CAHPS/HCAHPS surveys). However, because not all hospitals use a patient experience of care survey, ABEM has developed one. This survey can be downloaded from the ABEM website free of charge. ABEM requires that at least ten patients be surveyed. Individual physician–specific feedback is the most effective form of feedback. However, this can be logistically difficult in the emergency department. Thus, ABEM accepts the use of aggregate data gathered at the department level.

Additional Pathways

There are other channels through which an ABEM diplomate can meet APP patient care practice improvement requirements. These include completion of the ABMS Patient Safety Improvement Program (see the ABEM website). Additionally, ABEM recognizes the successful completion of APP activities from other ABMS specialty boards for dual-certified physicians. Most recently, ABEM has encouraged external organizations to develop APP activities that might be of interest to emergency physicians. Organizations that wish to obtain pre-approval by ABEM can complete the application available on the ABEM website. ABEM encourages diplomates to participate in MOC activities that are most relevant to their clinical practices. ABEM is committed to allowing physicians to identify those areas for APP that are most relevant to their practice.

If you have any questions or suggestions for additional activities, please contact ABEM by email at moc@abem.org, or calling 517.332.4800 ext. 383.

Table 1. Commonly Accepted APP Activities

ABMS Patient Safety Module

Core Measures

- Acute Myocardial Infarction: aspirin on arrival
- Acute Myocardial Infarction: ACE inhibitor or ARB given for LVSD
- Acute Myocardial Infarction: Beta-blocker within 24 hours of arrival
- Acute Myocardial Infarction: Fibrinolytic within 30 minutes of arrival
- Acute Myocardial Infarction: PCI within 90 minutes of arrival
- Pneumonia: Oxygenation assessment
- Pneumonia: Blood cultures for ICU
- Pneumonia: Blood culture before first antibiotic
- Pneumonia: Antibiotic timing (within 4 hours; within 8 hours)

PQRS Measures

- 12-lead electrocardiogram (ECG) performed for non-traumatic chest pain
- 12-lead electrocardiogram (ECG) performed for syncope

Aspirin at arrival for acute myocardial infarction
Acute pulmonary embolus anticoagulation
Community-acquired pneumonia (CAP): vital signs
Community-acquired pneumonia (CAP): assessment of oxygen saturation
Community-acquired pneumonia (CAP): assessment of mental status
Community-acquired pneumonia (CAP): empiric antibiotic
Heart failure: Left ventricular function testing
Pregnancy test female abdominal pain
Rh immunoglobulin for Rh-negative pregnant women at risk of fetal blood exposure
Ultrasound determination of pregnancy location: Pregnant patients with abdominal pain
Stroke and stroke rehabilitation: deep vein thrombosis prophylaxis (DVT) for stroke or intracranial hemorrhage
Prevention of catheter-related bloodstream infections (CRBSI): CVP insertion protocol
Acute otitis externa: Pain assessment
Acute otitis externa: Systemic antimicrobial therapy – avoidance of inappropriate use
Acute otitis externa: Topical therapy

Door to Balloon Time*
Sepsis Pathways and Goal-directed Therapy Protocols*
Stroke Protocol/Pathways Activation*
Asthma Pathways
Febrile Neutropenia Pathways
Throughput Time Measures
Door to Doctor Times
Left without Being Seen
Unscheduled Return Visits
Other: Programs are generally acceptable if they are relevant to the EM Model and follow the four steps of continuous professional development (CPD)

* For important high-acuity, low-volume clinical issues, diplomates may measure fewer than ten of their own patients. ■

John C. Moorhead, M.D., President
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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

October 3-4, 2012

AAEM Pearls of Wisdom Oral Board Review Course
Las Vegas, NV – SOLD OUT
www.aaem.org/education/oral-board-review-course

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 – SOLD OUT
  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

February 9, 2013

PRECONFERENCE COURSES

- Advanced Ultrasound
- Introductory Ultrasound
- Pediatric Emergencies: Children Are Not Little Adults!

February 9-10, 2013

PRECONFERENCE COURSES

- ED Operations Management: Cracking the Code
- Resuscitation for Emergency Physicians

February 10, 2013

PRECONFERENCE COURSES

- Introduction to Wilderness and Operational Medicine
- Pediatric Emergency Department Simulation
- Student Track

The Cosmopolitan of Las Vegas
Las Vegas, NV
http://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 5-7, 2012

- EMCON 2012, 14th Annual Conference of the Society for Emergency Medicine in India
  New Delhi, India
  www.emcon2012delhi.com

November 12-14, 2012

- Topics in Emergency Medicine
  San Francisco, CA
  www.topicsem.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

January 15-17, 2013

- ICEM 2013
  Muscat, Oman

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.

COMMITTEE REPORT: Clinical Practice

In 2008, the Clinical Practice Committee (CPC) was born from the AAEM Practice Guidelines Committee, which had been functioning successfully for several years. At that time, the Practice Guidelines Committee was given a new mission by the AAEM board of directors: to develop brief policy statements on important clinical issues affecting emergency physicians. Since our inception as the CPC, we have written several papers that are available on the AAEM website, http://www.aaem.org/em-resources/clinical-practice-statements.

Our papers are short, not more than two pages each, but the work behind each paper is based on an in-depth review of the published material on the topic. Source material is graded by the authors based on a methodology that has been developed and approved by the CPC.

After reviewing the literature and writing the paper, the authors then submit the work to be peer-reviewed by a group of committee members. Once the paper has been edited following peer-review, it is submitted to AAEM's board of directors for their approval before publication on the AAEM website, in *The Journal of Emergency Medicine (JEM)*, and elsewhere.

Once approved by the AAEM board, the authors decide on one of two routes to publication in *JEM.* The relationship AAEM has with *JEM* permits publication either in the regular journal, after going through an additional but expedited peer review process, or in the pages reserved by AAEM for its use. The route chosen is dependent on the authors, *JEM*'s editor, and the importance of the topic.

Our committee holds quarterly conference calls throughout the year, and in most years, an in-person meeting at the AAEM Scientific Assembly.

Ideas for papers come from the committee or are submitted to us by the AAEM board, based on member requests for help on issues affecting their clinical practice.

We, as a committee, are always excited when new members with a thirst for writing quality papers on issues of importance to the clinical practice of emergency medicine, join us. If anyone has an interest in joining, please contact tderenne@aaem.org, or submit an application to www.aaem.org/about-aaem/leadership/committees. ■

Steven Rosenbaum, MD FAAEM
Chair, Clinical Practice Committee

COMMITTEE REPORT: EMS

In 2006, an article in *Common Sense* reported on a small group of AAEM members who gathered at the 2003 Scientific Assembly in New Orleans and founded our EMS Committee. Among the areas discussed in the article were the 2005 modernization of our inaugural position statement on EMS, my assumption of the chairmanship of the committee, a liaison with the NAEMSP board, using EMS as a non-controversial area of cooperation between EM specialty societies, our input in the development of the National EMS Scope of Practice, and the development of a one-day version of the NAEMSP Medical Director's course as a pre-conference offering at the 2006 Scientific Assembly in San Antonio.

We have achieved some of these goals and made progress on others. We continue our work in the belief that AAEM brings unique value to the world of emergency medicine because of the Academy's unwavering commitment to its ethical values. We believe we have collaborative, but also unique, contributions to make in the pre-hospital phases of the emergency care continuum. This article is an update on our efforts.

Work Products

"Position Statement Against the Recognition of the American Board of Disaster Medicine Under the Auspices of the ABPS"

Soon after our last update, alert members of the committee saw a press release in which the ABPS, the parent "board" that oversees the Board of Certification in Emergency Medicine (BCEM), created a new ad-hoc board holding itself out as the first body certifying specialists in disaster medicine, a specialty not recognized by the ABMS. AAEM sprang into action and not only supported our committee's drafting of an opposing position statement, but also helped us to convince the NAEMSP to take action. Although they did not sign on to our exact statement due to differences in wording and emphasis, they drafted their own which repudiated any pathway to subspecialty recognition other than through the ABMS.

"Position Statement on Working Conditions and Due Process for EMS Physicians"

Initially intended to be a white paper on due process and compensation for EMS medical directors, this project evolved over time. This is an area dear to the Academy, upon which no other group has a position statement. We started with a literature search on the topic, and thanks largely to the efforts of Dr. Walsh, we confirmed that no study of the matter existed — only salary surveys. AAEM members responded to our survey in 2008–2009, confirming that challenges for EMS medical directors were common and included inadequate support, no protection from termination without cause, and variable — sometimes poor — working conditions.

We began our work on this project with the support of NAEMSP, but with their agreement that the initial draft should come from AAEM, and then be presented to NAEMSP for their approval and input. We thank Drs. Cone and Tan for facilitating that cooperation.

In the last year, especially with the release of the AAEM "Position Statement on Indemnification Clauses" and longstanding support for due process, we completed the draft "Position Statement on Working Conditions and Due Process for Physicians Involved in Oversight of EMS Systems." We will present this to the AAEM board of directors in time for their meeting this fall.

Continued on next page

Other Position Statement
We have partnered with pertinent EM physician organizations and other involved parties to create the "Joint Position Statement on Appropriate and Safe Utilization of Helicopter Emergency Medical Services," led by the Air Medical Physicians Association. This exemplifies the value of our perspective in areas where other societies have a lead role. Dr. Madden represented AAEM on the writing group and Drs. Yee, DeMond, and Wayne were important participants in the debate.

Educational Input to the Scientific Assembly
Pre-hospital care is an important topic in the continuing education of emergency physicians. After planning the first pre-conference workshop for the Scientific Assembly in San Antonio, we worked to contribute an EMS curriculum to the Scientific Assembly on an annual basis. From 2007 to 2011 this was known as the "EMS Panel." During this time, we covered multiple cutting-edge topics, including the value of ALS in EMS, EMS roles in STEMI centers and PCI, resuscitation topics, airway devices, EMS in public health, the development of EMS as a subspecialty, and freestanding EDs which accept EMS patients (Alternate Transport Destinations), to name a few. For the 2013 Scientific Assembly in Las Vegas, we are proposing rapid-fire cross-over EM-EMS topics. Committee members Drs. Wayne, DeMond, San Miguel, Palmer, Cone, Yee, Tan, Alson, and Madden have all participated, along with guest lecturers.

Work Groups
We have been invited to contribute a member to the ACEP-led workgroup on DEA enforcement issues and their effect on EMS systems and physicians. Dr. Yee will provide guidance and report the group's progress back to the full committee.

In addition, we have attempted to help AAEM address questions directed to the President about EMS, such as the issue of input in the new CDC "Guidelines for Field Triage of Injured Patients," athletic trainer certification, and helmet removal after sports accidents.

Recruitment
In the past five years, excellent emergency physicians from a variety of backgrounds have joined the committee, including those from prestigious community and academic institutions and locations from all over the world — Lebanon to Argentina. We have also had our first fellow and resident members.

We continue to invite expressions of interest in the committee, accompanied by a CV and cover letter addressed to Tom Derenne at AAEM's headquarters (tderrene@aaem.org), from those who want to join us. In addition to attendings, we welcome any EMS fellow or PGY 2-4 resident, with a minimum two-year commitment.

Finally, in February, I placed my position as chairman up for expressions of interest by any member wishing to take over the job. I am grateful for the support from my fellow committee members and others, who convinced me to continue in this role. Thanks to former AAEM presidents, Drs. Kazzi, Scaletta, Weiss, and Blumstein for their support. I look forward to working with current AAEM president, Dr. Durkin, who represents EMS as one of the diverse voices in emergency medicine, and with the cumulative perspective and values of the great diverse voices within AAEM. ■

Roger M. Stone, MD MS FAAEM
Chair, EMS Committee

COMMITTEE REPORT: International

Our Mission is to develop international EM as a subspecialty of EM, to promote the role of AAEM in international programs, and to increase awareness among other AAEM committees of opportunities to promote their skill sets abroad.

The International Committee has had a very productive several months. During our first quarter meeting, we decided to invite other AAEM committee leaders to become involved in international EM opportunities. We hope to create a symbiotic relationship with other committees so they will have the opportunity to train physicians abroad in their particular skills, while gaining opportunities to travel, collaborate, and learn from their colleagues in other countries.

Likewise, we determined that there is a need at the AAEM Scientific Assembly to expand the International Committee meeting to include an educational session. This session will be an opportunity for members to learn about ongoing projects, grants, and collaborations in international EM.

In addition, we have explored possibilities for increased AAEM involvement with IFEM, AFEM, and other EM societies outside of the United States. We have also created opportunities for AAEM members to be reviewers for *The African Journal of Emergency Medicine*. We have explored methods to increase resident involvement and are discussing this with the leaders of the AAEM Resident and Student Association (AAEM/RSA).

We are happy to announce that the 9th Annual New York Symposium on International Emergency Medicine was held on August 22–23, 2012. We used the symposium as an opportunity to hold an AAEM International Committee meeting. We also had a meeting of the International Emergency Medicine Fellowship Consortium. This group has evolved into a tool to help international EM fellowships around the world collaborate on funding, resources, and projects. The consortium has constructed a website: www.iemfellowships.com. This site serves as a communication tool for fellowships, helping potential resident applicants gain information about a variety of fellowships and is a portal applicants can use to apply for a fellowship. The board of the consortium is made up of leaders from each of the international colleges, associations, and academies in the consortium, and we have ensured that the AAEM International Committee leadership is closely involved.

Going forward, we plan to continue to expand educational opportunities in international emergency medicine and to meet opportunities in venues outside of the United States. In addition, we look forward to collaborating with other committees and national academies and federations. ■

Sassan Naderi, MD FAAEM FACEP
Chair, International Committee

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CHAPTER REPORT: California AAEM

The beginning of a new year ushered in a new CAL/AAEM executive committee and board of directors for 2012–2013. In California, the terms are of one year duration and follow the academic year of July-June. This year we see Trevor J. Mills, MD MPH FAAEM, in his second term as president; Jennifer L. Kanapicki, MD FAAEM, as vice president; Sandra Thomasian, MD, as our new secretary; Shahram Lotfipour, MD MPH FAAEM, as he returns as treasurer; and John Christensen, MD FAAEM, Lisa Mills, MD FAAEM, Joanne Williams, MD FAAEM, and Keith Yablonicky, MD FAAEM, as the board of directors.

Currently, our membership is at an all time high, and we have increased the number of 100% California residency programs to include David Geffen School of Medicine at UCLA, LAC + USC Medical Center, Stanford University Hospital, University of California-San Diego Medical Center, University of California-San Francisco, and University of California-Irvine. It is one of the major goals of our chapter to include all of the EM residencies in California as 100% members. As a reminder, it is FREE for resident members to join, and they receive many of the benefits of full voting members.

The upcoming year promises at least two special local events — Northern California and San Diego Speakers Series. These two events feature selected internationally renowned speakers in an intimate setting. This year, along with an educational component, look for round table discussions regarding local issues affecting the California EM community. We are planning to have a CAL/AAEM reception at the 19th Annual AAEM Scientific Assembly in Las Vegas, February 9–13, 2013, so look for us there as well.

Speaking of community, it is fitting that our state chapter has multiple social media networking opportunities. We recently updated our state chapter website (www.calaaem.org), and have a Facebook page (www.facebook.com/pages/CalAAEM/) and Twitter account (twitter.com/CALAAEM). If you are old school, you can email me directly at calaaempres@aaem.org. This year, look for Google+ and LinkedIn accounts to emerge. Last but certainly not least, CAL/AAEM has an active up-to-the-minute news feed, providing our members with important local and national news: the CAL/AAEM News Service, run by Bryan Sloane, Deputy Editor, and past CAL/AAEM president, Brian Potts, MD MBA FAAEM, Managing Editor. ■

Trevor Mills, MD MPH FAAEM
President, California Chapter

CHAPTER REPORT: Missouri AAEM

The Missouri State Chapter has set up a new dues structure of $100.00 per voting member. We have also decided to invite AAEM members from contiguous states to join the Missouri State Chapter, as outlined in our bylaws. Doug Char, MD FAAEM, has been elected as the newest member of our board of directors. This September, MOAAEM will host a social hour at the regional SAEM meeting in St Louis. Please join us if you attend the meeting! ■

Ross Heller, MD FAAEM
Chair, Missouri Chapter

CHAPTER REPORT: Texas AAEM

Musings from deep in the heart of Texas

Waiting behind the slowest foursome in Texas, I began a conversation with a player in the group behind ours. At some point the topic morphed to occupations, and I asked his. He replied, "I'm retired." How peculiar, I thought. No qualifications, no identity or ego issues. Just "retired."

How many physicians can retire without saying they are a "retired physician" — and a former chair of the old noise department and still working part-time on Mondays? I am not talking about financial retirement. Are we afraid that the moniker "Doc" will set in the west, never to rise again? Perhaps it is the Albert Schweitzer in physicians that drive them to care for so many for so long, but I believe there is often more to it than that.

The golfing retiree was also a successful professional, but comfortable with the fact that his skills — as he entered his seventh decade — did not require the same identification as they did in his fourth decade. He was also no longer hitting from the back tees. Perhaps I am projecting, but there are many physicians who could learn from this. Of course, one should take pride in a career of helping others through the practice of medicine — especially emergency medicine. But at some point, get a life.

For those who are at the other end of the career timeline, I would look forward to a great ride. I was in my mid-teens when Medicare was rolled out. It was very controversial. My father, a physician, noted that those who embraced the changes and worked within them would do well. He was right.

If none of this makes sense, let's talk it over at the Texas chapter meeting in Austin, Thursday, November 1st, 2012. ■

Jon Jaffe, MD FAAEM
President, Texas Chapter

Implications of the ACA Ruling for Young EM Physicians

Michael Tang, MD PhD FAAEM

In the last few months, there has been much speculation on how the June 2012 Supreme Court ruling upholding the Affordable Care Act (ACA) will affect emergency departments across the U.S. The ACA, which is the most significant revision of the U.S. health care system since Medicare and Medicaid were created in 1965, is known more formally as the Patient Protection and Affordable Care Act (PPACA), and less formally as Obamacare.

Consider, for a moment, the details of how this important change in the business of U.S. health care came about. It was after three months of deliberation that a divided Supreme Court voted 5-4, with the dramatically late support of Chief Justice Roberts, in favor of upholding the ACA's individual mandate to purchase health insurance. Individuals may choose to opt-out, but they will be charged a "tax" penalty for doing so. Additionally, the court ruling allows individual states to opt-out of expanded Medicaid coverage.

At the end of July, the Congressional Budget Office (CBO) concluded that the Supreme Court's ruling allowing states to opt-out of Medicaid expansion would result in $84 billion in savings to the Federal Government by 2022. The CBO also predicted that the upholding of the ACA individual mandate would still result in an overall reduction of the number of uninsured individuals in the U.S., compared to the present situation. Perhaps the most positive upshot of the ACA ruling is the opportunity for patients with pre-existing medical conditions to obtain health insurance through expanded Medicaid.

Among physicians there is a widely held expectation that, in view of the already limited number of primary care physicians, emergency departments will see their volumes go up in the future, especially on the non-acute side. At the same time, overall reimbursements to hospitals are expected to decline, which was probably inevitable anyway. What remains to be determined is how much of the shrinking pie of reimbursements will be awarded to emergency departments. This will be determined, in part, by the advocacy efforts of emergency physicians.

Much uncertainty remains. For example, it is unclear how and whether emergency departments will be reimbursed for uninsured patients who opt-out of coverage. Furthermore, young emergency physicians who are looking forward to saving lives will continue to face the challenge of a medical education system that saddles them with crippling debt while they work in a revised health care system.

As a member of YPS I, like many others in the field, am looking forward to a busy and challenging future for emergency physicians. ■

Special thanks to Dr. Robert McNamara and Dr. Larry Weiss for valuable discussions during the preparation of this article.

AAEM/RSA President's Message

The Value of Emergency Medicine — How an Emergency Medicine Resident Needed the ED

Leana S. Wen, MD MSc
AAEM/RSA President

As emergency physicians who are trained in acute resuscitation and thrive in high-stress situations, we tend to roll our eyes at the less acute complaints our patients come in with. "Back pain for three months? Headache for a week? Why are they here now?" I admit that I've grumbled about the so-called "inappropriate use of the ED," especially in the wee hours of the morning.

Something happened a few weeks ago that made me appreciate the importance of the ED. Let me tell you about a 29yoF, previously healthy, 4th year emergency medicine resident, who went to her shift at the Brigham and Women's ED and felt progressively more fatigued over the course of the day. She came home and felt nauseous, but was able to eat the Chinese take-out dinner that her husband brought back. Right after dinner she went to bed but couldn't sleep because she developed a gnawing, diffuse abdominal pain. Then she began throwing up, and kept throwing up — at least ten times in the next hour.

Being a physician, she came up with a differential diagnosis. This was most likely viral gastroenteritis. It was going around; she had recently seen patients who had it. However, she didn't have diarrhea, and other than fatigue, no viral symptoms. It could be bad food, but her husband ate the same thing — and she, being Chinese, was sick of Chinese food always being blamed as the culprit. She had no prior surgeries and doubted an obstruction. She had no headache and doubted an intracranial process. She had no urinary symptoms or flank pain and doubted UTI or kidney stone. Any woman could be pregnant, and though the suddenness of her symptoms made that less likely, an ectopic was theoretically possible.

Not wanting to go to the ED in the middle of the night and burden her already over-worked colleagues, she set about to self-diagnose and self-treat. She sent her husband to the local 24-hour CVS to buy a pregnancy test and to pick up the Zofran ODT that she prescribed herself. The test was negative, and the Zofran made her vomiting stop, but as the morning came her abdominal pain was still there. In fact, it was now localized more to the right lower quadrant and it hurt to walk.

I'm sure you see where this is going. You're probably wondering whether you would have bitten the bullet and gone to the ED at that point to rule out appendicitis. Well, this 29yoF was me, and I really didn't want to check in as a patient or get the radiation from a CT. As it happened, the ED attending that day was an ultrasound specialist and was kind enough to do a bedside ultrasound. My appendix looked fine, and she could see intestinal thickening that was consistent with a diagnosis of enteritis. I got my diagnosis, and over the next few days, I recovered with my appendix intact.

Had someone like me actually checked in as a patient, I could see how there might be grumbling from the providers. "A young woman with viral gastro who's actually getting better — why is she here?" "If she doesn't want a CT, why did she come to the ED?" Or, had I gone to the PCP and gotten referred to rule out appy, "Shouldn't the PCP know better?"

What I learned from this experience is that it's always easy to say in retrospect that the patient didn't have to come to the ED. In the moment, when the patient is scared and in pain, it's not so clear. Even as a senior resident, I couldn't tell if I had something benign that would go away on its own (gastro) or an acute process that required urgent intervention (appy). How can we expect our patients to know whether their chest pain is the same angina as usual or something more worrisome, or how to apply to the Ottawa rules to see if they have a sprained ankle or need an X-ray?

My flirtation with possible appy has certainly made me more sympathetic to our patients who come in with seemingly "non-acute" complaints. It also has me thinking on a larger scale about proposed policies that impose penalties on our patients for using the ED. Don't get me wrong. There is a need for more PCPs, and our patients will benefit from increased access to primary care. However, patients don't

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always know whether they have primary care versus emergency complaints. I turned out to have enteritis, something a PCP can address. But had I been a "normal" patient, I wouldn't have been able to treat my own symptoms and then walk in to get a bedside ultrasound from an attending ultrasonographer — I would have had to check in to the ED. Would it have been fair to penalize me for that ED visit? It's important that our policy makers consider that even well-informed patients with good access to primary care need the ED, and that emergency medicine has inherent value in sorting out all patient presentations.

For our part, we EPs need to stop complaining about our patients. Yes, we would rather be resuscitating the multi-trauma victim or the septic patient, but we also need to maintain and create value in our specialty. We need to keep advocating for issues such as having board certified EPs staffing EDs. We need to remind policy makers that EPs are on the frontline of medical care, and our voices ought to be heard. We need to convince hospital administrators that we are the ones with experience in managing flow and improving quality and safety, and we will bring value to the organizations they lead. We need to keep showing our students and residents that the ED is now the home of diagnosis and embrace our role as teachers and innovators. Emergency medicine is a dynamic and exciting specialty, and I am so excited to be part of it. ■

*I would love to hear your comments on my columns! Please email me, wen.leana@gmail.com and follow me on Twitter, @DrLeanaWen, and my blog, http://whendoctorsdontlisten.blogspot.com. Along with Dr. Kosowsky, Clinical Director of the Brigham & Women's ED, I am publishing a book about patient involvement in health care, "*When Doctors Don't Listen: How to Prevent Misdiagnoses and Unnecessary Tests." *Please visit www.whendoctorsdontlisten.com.*

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Resident Journal Review

Pulmonary Embolism

Authors: Susan Cheng, MD MPH; Jonathan Yeo, MD; Eli Brown, MD; Allison Regan, MD
Edited by: Michael C. Bond, MD FAAEM; Jay Khadpe, MD FAAEM

This Resident Journal Review focuses on pulmonary embolism (PE), a disease that remains a considerable diagnostic challenge for the emergency physician given its high risk for significant morbidity and mortality. Recent years have seen a sizeable increase in utilization of diagnostic testing such as CT scans and D-Dimers, which has prompted concern over cost and the potential side effects for patients. The following review discusses several recent topics in the diagnosis and treatment of PE and venous thromboembolism, including the use of clinical signs in developing pretest probability, accuracy of clinical decision rules, home versus inpatient treatment for deep venous thrombosis, and new oral therapies.

Balwinder Singh, Ajay K Parsaik, Dipti Agarwal, Alok Surana, Soniya Mascarenhas, Subhash Chandra. Diagnostic Accuracy of Pulmonary Embolism Rule-Out Criteria: A Systematic Review and Meta-analysis. *Annals of Emergency Medicine.* 2012 Jun;59(6):517-20.e1-4.

Pulmonary embolism often presents with nonspecific signs and symptoms, making it a difficult diagnosis for EM physicians. For this reason, many physicians consider using clinical decision rules such as the pulmonary embolism rule-out criteria (PERC) score in patients at low risk for PE. The PERC score in particular consists of eight criteria, and if a patient meets all eight criteria, they are considered low risk for PE that any additional testing such as D-Dimer is unnecessary.

In this systematic review and meta-analysis, the authors sought to evaluate the accuracy of utilizing the PERC score to be able to defer use of a D-Dimer in the emergency department (ED). Inclusion criteria were the following: studies that evaluated the diagnostic performance of the PERC score to rule out PE, reported original research, and were performed in the ED. The authors also developed a "checklist" to assess quality of methodology of studies specifically involving clinical decision rules. The checklist included the following statements, for which each study received a yes or no/unclear: (1) patients were selected in an unbiased fashion; (2) the study sample included a wide-spectrum PE pretest probability for which PERC was designed; (3) predictor variables were assessed without knowledge of the outcome; (4) outcomes were assessed without knowledge of the predictor variables; (5) outcomes were accurately defined; (6) loss-to-follow-up rate of less than 10%; and (7) explicit interpretation of the risk score by clinicians in practice without knowledge of the outcome. The primary outcome of interest was the diagnosis of PE or deep venous thrombosis (DVT) or death caused by venous thromboembolism within 90 days of the initial ED visit.

Ultimately, 11 studies including 12 cohorts were selected, totaling 13,885 patients from six countries (United States, United Kingdom, Switzerland, Belgium, France, and New Zealand). Two cohorts were retrospective, while the rest were prospective. Follow-up periods ranged from 14 to 90 days. The pooled sensitivity, specificity, positive likelihood ratio, and negative likelihood ratio were 0.97, 0.23, 1.24, and 0.18, respectively. The overall rate of missed PEs was 0.32%, or 44 of 13,885 cases. A subgroup analysis was performed based on prevalence of PE which divided studies into two groups — one with prevalence less than 10% and the other with prevalence greater than 10%. The pooled specificity was 0.16 in the group with the higher prevalence and 0.24 in the lower prevalence group.

This meta-analysis finds that when the pretest probability is low, PERC is very sensitive in detecting PE, therefore, making D-Dimer or other diagnostic testing unwarranted. However, this study has several limitations. The first, which is mentioned by the authors, is the small number of studies that are available that meet inclusion criteria. The second is the low specificity of the PERC rule, the pooled value of which was only 0.23 in this study. However, one could argue that the PERC rule is meant to be used by physicians to rule out a disease with high morbidity and mortality, while there are other diagnostic tests which can be used to more accurately "rule in" the disease. Screening tests are designed to be highly sensitive, and not necessarily specific, so this specificity of 0.23 for the PERC rule is acceptable.

Venkatesh AK, Kline JA, Courtney DM, Camargo CA, Plewa MC, Nordenholz KE, Moore CL, Richman PB, Smithline HA, Beam DM, Kabrhel C. Evaluation of Pulmonary Embolism in the Emergency Department and Consistency With a National Quality Measure: Quantifying the Opportunity for Improvement. *Archives of Internal Medicine.* 2012 Jul 9;172(13): 1028-32.

In 2011, the National Quality Forum (NQF) performed a retrospective analysis of use of computed tomography of the pulmonary arteries (CTPA) to evaluate for PE in patients with low pretest probability of PE. They concluded that 7-25% of CTPA studies are avoidable. In this study, the authors sought to prospectively evaluate patients for the same purpose of identifying CTPA studies that may have been avoidable.

The study was a multicenter, prospective, observational study of ED patients from 12 U.S. hospitals (10 academic and 2 community hospitals). Inclusion criteria were ED patients with suspected PE for which a diagnostic test was ordered, such as D-Dimer, CTPA, ventilation/perfusion (VQ) scan or pulmonary angiogram. After the tests were ordered, but before the results were available, clinicians then prospectively collected data by interviewing the patient and reviewing the medical record. This data included elements included in the Wells score, the physician's most likely diagnosis, as well as clinical gestalt for pretest probability of PE (classified as low, medium, or high). Patients were excluded who were being evaluated in the ED for DVT but not for PE and those for whom the treating physician had knowledge about a diagnostic imaging study which was positive for PE within the last seven days of the patient presenting to the ED. The primary outcome of interest was "avoidable imaging." This was classified as CTPA or VQ scan in hemodynamically stable patients with low pretest probability (Wells score <2)

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and in whom D-Dimer test was either not performed or had a negative result.

There were a total of 6,089 patients enrolled in this study, 5,940 of which were classified as hemodynamically stable. Using the Wells score, 4,113 patients (69%) were determined to have low pretest probability for PE (<2 points) 1,634 (28%) as having intermediate pretest probability (2-6 points), and 193 (3%) as having high pretest probability (>6 points). D-Dimer tests were performed in 4,263 patients. A total of 3,710 of enrolled patients had diagnostic imaging and were hemodynamically stable. Of these patients, 2,238 (54%) had low pretest probability (Wells score <2 points). For the patients who had imaging, 1,205 (32%) met NQF criteria for "avoidable imaging." Subgroup analyses was performed using modified Wells score with <4 points being classified as unlikely to have PE and <6 points classified as low or intermediate pretest probability for PE. For these subgroup analyses, it was concluded that about one-third of diagnostic imaging may be avoidable. Fifty patients (1.3% of those who underwent imaging) were diagnosed with PE despite having been categorized as having had avoidable imaging, though no D-Dimer was sent in these patients. Furthermore, eight patients (0.2% of those imaged) were diagnosed with PE after a negative D-Dimer and also with imaging that was deemed as potentially avoidable. Interestingly, analysis demonstrated that certain patient characteristics, particularly older age, sickle cell disease, and inactive cancer, were most associated with the performance of avoidable imaging.

These results have important implications for clinical practice given that they suggest that one in three diagnostic imaging studies performed to rule out PE in patients with low pretest probability of disease are potentially avoidable. These findings parallel those of the NQF. As hospitals enrolled in PE research may be more likely to follow clinical guidelines, it may actually underestimate the amount of avoidable imaging when compared to other institutions. However, among a small percentage of the total patients who were imaged, there were several cases of "missed" PEs in the setting of either negative D-Dimers or cases where no D-Dimer was performed. This must be taken into consideration given the high morbidity and mortality associated with PE. However, the clinical significance of these "missed" PEs is not known from this article.

Drescher FS, Chandrika S, Weir I, Weintraub JT, Berman L, Lee R, Van Buskirk PD, Wang Y, Adewunmi A, Fine JM. Effectiveness and Acceptability of a Computerizes Decision Support System Using Modified Wells Criteria for Evaluation of Suspected Pulmonary Embolism. *Ann Emerg Med.* 2011; 57: 613-621.

There is variability and overuse of CTPA to diagnose PE despite the availability of validated decision rules that improve the accuracy rate of CTPA to diagnose and safely rule out PE. The authors embedded an electronic evidence-based computerized decision support system using a modified dichotomized Wells score into the order entry system at an individual institution. A Wells score above 4 was categorized as "PE likely", while 4 or less was categorized as "PE unlikely." In the clinical setting, a prompt for the decision aid automatically appeared on the computer when an emergency physician entered an order for CTPA or D-Dimer testing. The physician was able to opt out or proceed to use the decision aid to generate recommendations to obtain a D-Dimer or proceed directly to CTPA for high-risk scores. The decision to follow the recommendations of the computer decision aid was left to the discretion of the emergency physician.

The study aimed to increase positivity rates of CTPA for PE and evaluate the acceptability of this added computerized decision aid to emergency physicians. The primary outcomes were the positivity rates of CTPA for PE during the pre-introduction and study period. A CTPA was labeled as positive if a defined filling defect was visible and negative if a filling defect was not visible or there was suboptimal visualization of the pulmonary vessels with no additional treatment pursued by the emergency physician. Patients were also followed for six months to evaluate if patients returned for repeat evaluation of PE.

A total of 404 cases were eligible during the intervention period (March through June 2008), but the emergency physician opted out of the decision entirely in 11 cases. Of the remaining 393 cases, 229 or 58% underwent CTPA with or without D-Dimer testing. In the pre-intervention period, 17 of 205 CTPA tests for PE were positive (8.3%; 95% CI 4.9% to 12.9%) compared to 29 out of 229 during the intervention period (12.7%; 95% CI 8.6% to 17.7%). Note that although there was a 4.4% increase in CTPA positivity rates during the intervention period compared to the pre-intervention period, the study may have been underpowered because the 95% confidence intervals overlap.

During the intervention period, the number of positive CTPAs without D-Dimer testing increased from 0 cases to 11 cases (change of 12.7%;

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95% CI 5.8% to 20%). Only eight patients returned to the ED within six months for repeat evaluation for PE. No patients with negative CTPA for PE on initial visit had subsequent PE on return visit.

Acceptance of the computerized decision support system varied amongst the emergency physicians, and only 39% (7 out of 19 physicians) always followed the CTPA recommendations. Reasons for non-adherence to recommendations included too much time spent at the computer away from direct patient care, lack of belief that the decision aid was helpful, and preference for a more intuitive approach to evaluate for PE. In a subset analysis of encounters with emergency physicians that were compliant with the computerized decision support system, 168 CTPA tests were ordered for patients with a high-risk Wells score or positive D-Dimer, and 28 were positive for PE (16.7%, 95% CI 11.4% to 23.2%). This is an increase in the positivity rate of 8.4% compared to the pre-intervention period (95% CI 1.7% to 15.4%). This subset analysis compared to the overall results suggests that poor physician adherence limited the effectiveness of the computerized decision support system.

The study was limited due to lack of acceptance by emergency physicians, and it was underpowered. The comparison group was retrospective, and the study could not control for temporal related factors. The patient population during the pre-intervention period may have had different characteristics than the patient population during the intervention period. In addition, follow-up was conducted via hospital record review at the individual institution and did not use direct patient follow-up which may have revealed additional evaluations for PE at other institutions.

The authors call for more judicious use of CTPA to evaluate PE citing risk of medical radiation, cost of further evaluation of unintended findings on CTPA, increased numbers of false positive CTPA tests, and harm from subsequent anticoagulation. Although there was a small increase in positivity rates of CTPA during the intervention period and the increase was doubled among a subset of compliant emergency physicians, the computerized decision support system was poorly accepted among emergency physicians. There is a need for an effective computerized decision support system for evaluation of PE that considers both patient characteristics and improves the compliance of emergency physicians.

Kline JA, Corredor DM, Hogg MM, Hernandez J, Jones AE. Normalization of Vital Signs Does Not Reduce the Probability of Acute Pulmonary Embolism in Symptomatic Emergency Department Patients. *Academic Emergency Medicine* (2012) 19:11-17.

The objective of this prospective, noninterventional, single-center study was to evaluate if normalization of an initially abnormal vital sign can be used to lower the suspicion for PE. Research associates identified patients by surveying the electronic tracking system for any CTPA ordered from the ED at Carolinas Medical Center in Charlotte, NC. They were then asked to enroll in the study if they had at least one sign or symptoms of PE and at least one risk factor. If enrolled, four sets of vital signs including pulse rate, respiratory rate, shock index, and pulse oximetry were recorded. The protocol did not mandate any change in frequency or method of measuring vital signs; instead they were recorded as part of standard care. Prior to obtaining the CTPA, research coordinators approached the primary clinician in charge of ordering it with the question, "Do you believe the patient has an alternative diagnosis that is more likely than PE?" Their responses were recorded, and follow-up then occurred at 45 and 90 days after enrollment to determine any deaths, any adverse clinical events in general, and any imaging or diagnosis of new PE or DVT.

A total of 192 patients were enrolled between May 31, 2007, and March 3, 2008. Of those, 35 patients (18%) had a CTPA that was positive for acute PE. At the time of enrollment, clinicians estimated an alternative diagnosis was more likely than PE in 109 of 192 patients (57%). All patients had vital signs at triage, and 174 (91%), 135 (70%), and 106 (55%) had subsequent second, third and fourth sets obtained, respectively. The median time intervals for repeated vital sign were 2:20, 4:16, and 5:42. The median time to CTPA completion was 1.3 hours after the second set of vital signs was completed.

The diagnostic accuracy for each vital sign at each time was examined to evaluate if normalization can be used to lower suspicion for PE, and none demonstrated discriminative value across repeated measurements. In fact, the percentage change in vital signs was similar between patients with and without PE. This study, therefore, does not support the use of observing a patient's abnormal vital signs for normalization as rationale for lowering the pretest probability of a patient having a PE. However, one major limitation is that this study only included patients with risk factors for thromboembolism as well as those demonstrating signs and symptoms consistent with a PE, thereby restricting the study population to those with moderate to high pretest probability for PE. This limits the utility of this study, in that the results would be more clinically relevant had patients who were low risk for PE been included.

Othieno R, Abu Affan M, Okpo E. Home versus in-patient treatment for deep vein thrombosis. *Cochrane Database of Systematic Reviews* 2011, Issue 3.

DVT is a common diagnosis that we encounter in the ED. It is known to affect one to two per thousand adults per year. Risk factors for developing a DVT include malignancy, post surgery, trauma, and immobilization. The gold standard for diagnosis includes ascending venography and duplex ultrasound. Patients who are hospitalized are usually treated with unfractionated heparin (UFH) or low molecular weight heparin (LMWH) for about five days and overlapped with oral anticoagulation. Many trials have been conducted regarding UFH versus LMWH with some showing that LMWH was at least as effective as UFH if not more. Therefore, anticoagulation with LMWH has become the treatment modality for patients without renal dysfunction in many clinical practices.

The Cochrane Collaboration sought to address the current data on the home versus in-patient treatment of DVT. Their findings were published in 2007 and republished this past year in 2011. Six randomized control trials incorporating 1,708 patients with DVT who were treated with anticoagulation at home or in the hospital were reviewed. This review found that the risk of recurrent venous thromboembolism (VTE) was less in patients treated at home. They were also less likely to have major

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bleeding and deaths but more likely to have minor bleeding complications when compared to patients treated in the hospital.

The objective of the analysis was to compare the incidence of complication of VTE when treated at home versus in-patient. Secondary objectives included patient satisfaction and cost effectiveness between both groups. Only randomized controlled trials (RCTs) were included in this study. The complications of VTE included were PE, recurrent DVT, venous gangrene, major and minor bleeding, and death. Studies were found by searching in the Cochrane Peripheral Vascular Disease Group trials register and the Cochrane Library. The trials register had been created from regular electronic searches in MEDLINE, EMBASE, and CINAHL.

Three major trials (Koopman 1996,[1] Levine 1996,[2] Chong 2005[3]) and three smaller trials (Boccalon 2000,[4] Daskalopoulos 2005,[5] Ramacciotti 2004[6]) were included in the study comprising of a total of 1,708 patients. Koopman had 400 participants (202 home and 198 hospital). Levine had 500 participants (247 home and 253 hospital). Chong had 298 participants (150 home and 148 hospital). Boccalon and Ramacciotti had 201 participants each (99 home and 102 hospital in Boccalon, 104 home and 97 hospital in Ramacciotti), and Daskalopoulos had 108 participants (55 home and 53 hospital). Of the six trials, only Boccalon used LMWH in both treatment arms. The other studies used LMWH in the home treatment groups and UFH in the hospital treatment groups.

The VTE recurrence rate was 11.3% in the hospital group versus 9.1% in the home group in the Daskalopoulos study. The rate was 9.5% versus 2.7%, respectively in the Chong trial. The other trials also reported similar results with increased rate of VTE recurrence in the hospital treatment groups. The Boccalon trial, which is the only trial that used LMWH for both arms, had a recurrence rate of 2% for the hospital group versus 1% for the home group. The Chong trial was the only trial that showed statistical significance. The pooled results produced a significant difference with a fixed-effect RR of 0.61 (95% confidence interval 0.42 to 0.9). The rate of major bleeding was reported as 7.5% in the hospital treatment group and 3.6% in the home treatment group in the Daskalopoulos study. In the Koopman trial, the rate was 2% versus 0.5%, respectively. The Boccalon trial reported similar rates between both groups. Pooling the results showed no statistical significance with RR 0.67 and 95% CI 0.33 to 1.36. The death rates were also higher in the hospital treatment groups versus the home treatment groups in five out of the six studies with the sixth study not reporting on death (Ramacciotti trial). Individual and pooled results were not statistically significant, with RR 0.72 and 95% CI 0.45 to 1.15. Other outcome measures included patient satisfaction and cost of treatment. Four studies (Koopman, Levine, Boccalon, Daskalopoulos) showed improved cost effectiveness in the home treatment group, mainly due to the high cost of in-patient treatment. In the original Koopman trial, patients were given quality of life questionnaires at the end of the treatment course and at 12 and 24 weeks. In terms of "physical activity" and "social functioning" criteria, quality of life was reported to be higher in the patients receiving treatment at home.

This review has several limitations, one of which is the high rate of exclusion of patients from the studies. For example, the Koopman trial excluded 49% of patients with DVT prior to randomization (16% because they refused consent). The Levine trial excluded 78% of patients (11% had refused consent), and the Chong trial excluded 23% prior to randomization. The Daskalopoulos trial excluded 7.4% of the 108 eligible patients, mostly due to withdrawal of consent or development of heparin-induced thrombocytopenia. The other potential limitation of this review is the high percentage of study participants who were allocated to the home treatment group who ultimately required hospitalization. Only 36% of participants in the Koopman trial were treated entirely at home, while 39% had a short hospital stay and 25% were treated entirely in the hospital. Fifty percent of the participants in the Levine trial were treated entirely at home. Seventy-seven percent of patients in the "home" treatment arm in the Chong trial were admitted to the hospital. The Ramacciotti trial also reported hospitalization for 64% of the home treatment group.

This Cochrane review demonstrates that patients treated at home with LMWH are less likely to have VTE recurrence compared to those treated in the hospital with UFH or LMWH. This finding was statistically significant when data from all of the included studies was pooled. The compilation of the RCTs reviewed here also showed lower mortality, lower rates of major bleeding, and higher minor bleeding rates with patients treated at home; however, this was not statistically significant. Home management was also more cost effective and led to higher quality of life scores reported by patients.

The EINSTEIN-PE Investigators. Oral Rivaroxaban for the Treatment of Symptomatic Pulmonary Embolism. *New England Journal of Medicine*. (April 5, 2012) 366;14.

The traditional treatment for patients with PE has been to bridge with heparin or enoxaparin while waiting for warfarin to become therapeutic. A major limitation to this approach is the need for frequent laboratory monitoring in addition to regular dose adjustments to maintain a therapeutic INR. Rivaroxaban is an oral direct inhibitor of factor Xa that is dosed daily and does not require laboratory monitoring.

The goal of the EINSTEIN-PE study was to compare rivaroxoban to the standard therapy of enoxaparin and warfarin in patients with an acute symptomatic PE with or without DVT. It was a randomized, open-label, event-driven, noninferiority trial that enrolled 4,832 patients at 263 sites in 38 countries between March 2007 and March 2011.

Prior to randomization, the intended treatment was determined by treating physicians for a length of 3, 6, or 12 months. Patients were then randomized to treatment by standard therapy or with rivaroxoban. Those randomized to the standard therapy group were started on enoxaparin at a dose of 1.0mg per kilogram twice daily and either warfarin or acenocoumarol within 48 hours of randomization. Patients received at least five days of enoxaparin, which was discontinued when the INR ranged between 2.0 and 3.0 for two consecutive days. Those randomized to rivaroxaban therapy received 15mg twice daily for three weeks, then 20mg once daily for the remainder of treatment duration.

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Of the 4,832 patients, 2,419 were assigned to receive rivaroxaban and 2,413 standard therapy. The mean treatment study duration was approximately nine months. While undergoing treatment, the primary efficacy outcome (defined as a symptomatic recurrent venous thromboembolism) was found in 50 patients (2.1%) in the rivaroxaban group versus 44 patients (1.8%) in the standard therapy group, yielding a hazard ratio of 1.12 (95% confidence interval 0.75 to 1.68). The principal safety outcome (defined as a clinically relevant bleed) occurred in 10.3% of patients taking rivaroxaban compared to 11.4% of those in the standard therapy group, yielding a hazard ratio of 0.9 (95% confidence interval 0.76 to 1.07). Major bleeding occurred in 1.1% of patients in the rivaroxaban group and in 2.2% of patients in the standard therapy group, with a hazard ratio of 0.49 (95% CI 0.31 to 0.79).

One potential limitation to this study is that, prior to randomization into the rivaroxaban or standard therapy groups, all patients received LMWH for varying amounts of time, though almost all patients received LMWH for less than 48 hours. While the authors argue that the administration of LMWH for such a brief period should not affect results, it is possible that receiving LMWH for up to 48 hours could have some impact. The other, and perhaps more significant, limitation of this study is that it was an open trial, meaning that neither patients nor researchers were blinded as to what treatment was being administered. However, while the criteria for diagnosing recurrence of venous thromboembolism were objective diagnostic findings, the open design may have had more of an impact on secondary outcomes.

In this study comparing rivaroxaban with standard therapy with LMWH or UFH for treatment of PE, the authors found that rivaroxaban was noninferior to standard therapy in preventing recurrence of venous thromboembolism. The study also suggests that rivaroxaban has a similar risk of causing clinically relevant bleeding and may even carry a lower risk of major bleeding when compared to standard therapy. This study has important clinical implications, as rivaroxaban can be administered at a fixed dose and via the oral route. However, though it is a benefit to patients that rivaroxaban does not require drug level monitoring, there should be additional research to investigate methods for reversal of anticoagulation in the event of major bleeding.

Summary:

This Resident Journal Review includes recent studies concerning the diagnosis and treatment of PE, a disease that is commonly encountered by the emergency physician and carries a high risk for morbidity and mortality when it goes unrecognized. The studies, which focused on improving the diagnosis of PE, cited overuse of CTPAs and other diagnostic modalities as impetus to improve decision rules. For example, Venkatesh et al. found that nearly one-third of patients who had a low pre-test probability for PE had diagnostic imaging that was avoidable. The study by Balwinder et al. concluded that, in patients with low pre-test probability of PE, the PERC score should be used and is very sensitive in detecting PE, thereby making any additional diagnostic testing unnecessary. In Drescher et al., computerized decision aides used by emergency physicians increased the positivity rate of CTPAs, although many emergency physicians were not amenable to using the decision aide. The final two articles focused on treatment of venous thromboembolism. The Cochrane review by Othieno et al. found that outpatient treatment of DVT led to reduced recurrence of venous thromboembolism compared to inpatient treatment, as well as reduced cost and increased patient self-reported quality of life. The *NEJM* study comparing oral rivaroxaban to standard therapy for treatment of PE found rivaroxaban to be a viable alternative to standard therapy in terms of similar rate of recurrence and perhaps a decreased risk for adverse effects. These studies all have important implications for clinical practice, in particular for reducing health care spending and increasing efficiency of diagnostic testing. ■

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Medical Student Council President's Message

Spotlight On Leaders in Emergency Medicine: Gus Garmel, MD FAAEM

Interview by Mary Calderone
AAEM/RSA Medical Student Council President

Gus Garmel, MD FAAEM

The "Spotlight On" series re-started by Dr. Leana S. Wen, AAEM/RSA president, will be continued this year by Mary Calderone, AAEM/RSA Medical Student Council President. The "Spotlight On" series highlights interviews with leaders in emergency medicine about their experiences, perspectives, and insights. The sixth installment is a conversation with a leader in EM and AAEM, Dr. Gus Garmel. Dr. Garmel is Co-Program Director of the Stanford/Kaiser EM residency program, Medical Student Clerkship Director (Surg 313D, Stanford University School of Medicine), and senior emergency physician at Kaiser Santa Clara. Dr. Garmel has received numerous teaching awards, including both the Peter Rosen Award from AAEM and the Program Director of the Year Award from AAEM/RSA.

1) Why did you choose emergency medicine?
I chose EM because I enjoyed the clinical challenges that it offered, especially during its formative years as a specialty. I wanted to be in the position to help patients from all walks of life at their time of greatest need, regardless of their reasons for seeking care or their ability to pay. I still consider it an honor to be in this position.

2) Who has been your biggest mentor?
My strongest mentor, without question, was and still is, Glenn Hamilton. I was his chief resident, and still communicate with him to share ideas and discuss professional successes and challenges. This mentor relationship is similar to what I try to offer our alumni, residents, and students. Glenn's educational innovations are unparalleled. Even though I was already a capable and passionate educator, he inspired me to take these skills to the next level.

3) How did you get to your current position?
I moved to California in 1991 after being offered the opportunity to help direct the Stanford/Kaiser EM Residency Program at its inception, a position that ideally matched my passion and skills. The chance to be involved in administrative and educational leadership from the ground floor was incredibly exciting for me as a creative thinker and problem-solver. I was fortunate that the timing was right. I'm sure that my selection had a lot to do with the confidence my mentors had in my abilities. I also think that my passion for education is obvious to those who meet me. This position has afforded me over 21 wonderful years of active involvement in residency training, during which I've witnessed remarkable resident and graduate successes. Several of our graduates are residency directors around the country. Others are talented hospital administrators, researchers, academicians or community physicians. It's rewarding to have had a significant role throughout our program's history, which has given me so much joy.

4) Tell us about your involvement in AAEM.
I first got involved with AAEM around its onset because I supported its values and mission. I've served AAEM as a research forum judge at the Annual Scientific Assembly (SA), initially with Peter Rosen and Bob McNamara, and given lectures at past SAs. I played a role providing AAEM membership for our entire residency program and securing the opportunity for our second-year classes to attend SA. I've also encouraged our residents to become AAEM officers at both state and national levels. I submitted the materials necessary to get an early AAEM Certificate of Workplace Fairness for our ED. I was proud to represent AAEM as the United States Chairperson of the Resident Education Track at MEMC V in Valencia, Spain, and also lectured at the meeting. I continue to support AAEM's contributions to our specialty and what it does for individuals in need of its services. I am proud to be a member of AAEM and respect its strong and important voice.

5) What would you say to trainees and young EPs about why to get involved in AAEM?
Our specialty needs emergency physicians to support it financially and politically with their energy and leadership, so I am a huge advocate of organized EM in general. I am a strong champion of AAEM specifically, because I think it takes the right approach to education and has the right vision about the future of EM, board certification, workplace fairness, and due process. I support AAEM's ideals and principles. I've sat at the table with many of the early founding members, and it has been wonderful to see AAEM evolve and grow.

6) How do you define a "teaching moment," and how do you find time to integrate teaching into busy ED shifts?
In my practice, every moment is a teaching moment. This creates challenges at times, but they are rewarding challenges. By seeing every opportunity as a teachable moment, things can be identified, debated and improved, and people can learn — whether it's a patient, a family member, a resident, a student, or me.

7) What has been the most defining moment in your career thus far?
Every year, graduation day for the Stanford/Kaiser EM senior residents is a defining moment for me because of our commitment to each other over the past three years. Mentoring students, residents, and junior faculty is extremely important to me, and I was fortunate to be honored by EMRA with their mentorship award. The Peter Rosen Award and the Program Director of the Year Award that I received from AAEM and AAEM/RSA, respectively, as our program's Co-Director are humbling distinctions, and I'm incredibly proud of these. As a clinician, every patient encounter is a defining moment for me, which keeps me focused on my responsibilities as an emergency physician.

Continued on next page

8) If you could give one piece of advice to interested applicants in EM, what would it be?

I wrote something a while back titled "The 9 P's That Program Directors Look For," and still believe in them (performance, productivity, professionalism, personality, preparation, persistence, punctuality, passion, and potential). EM residency program directors desire individuals with passion, sensitivity, integrity and potential — potential not only from an intellectual perspective, but also for patient care, academic, research, political, and administrative activities. I consider myself a "resident motivator" because I look for ways to motivate residents (and students) to get the most out of each patient encounter. Applicants should keep their options open about future career possibilities. Even though they might think they know where they're going, this direction may change. It's also important that applicants, residents, and faculty challenge themselves to consistently perform at the highest level, because our patients and our specialty deserve nothing less.

Editor's Note:

When I read this interview, I was struck by the responses to questions 4 & 5. I hope you will go back and read those again. Dr. Garmel uses phrases like "values and mission," "ideals and principles," and "advocate of organized EM." He encourages his residents to seek leadership roles in AAEM and successfully applied for a Certificate of Workplace Fairness for his ED. As he puts it, "I am a strong champion of AAEM specifically, because I think it takes the right approach to education and has the right vision about the future of EM, board certification, workplace fairness, and due process."

If you are reading this, then you too support AAEM's values and mission. For that, I thank you. However, are you doing all you can in your daily professional life to spread those values and further that mission? Are you an active participant in AAEM? Are you trying to recruit new members? Are you encouraging your colleagues to read *Common Sense* and attend Academy meetings like the Scientific Assembly? Emergency physicians have been fighting for the soul of our specialty for years — to make sure it is treated as a legitimate specialty that plays by the same rules as all other specialties, to protect physicians from exploitation and other unfair treatment in the workplace, and to ensure that our rights to due process are honored. Such battles are not won simply because "the good guys always win." The forces arrayed to remove control of the practice of medicine from physicians are greater than ever, and emergency medicine and other hospital-based specialties are the first targets of these forces. As physicians, we have an ethical obligation to make sure we are free to exercise our professional judgment in the best interest of our patients, rather than as coerced by corporations, bureaucrats, administrators, tort lawyers, etc. If we fight this battle as individuals, we will be crushed one at a time. That is why active participation in organized emergency medicine, specifically AAEM, is critical. No other organization completely shares our values or even begins to fight for them the way the Academy does. If you aren't already, get active in AAEM, foster its growth, and become politically aware and active. As Ben Franklin warned the signers of the Declaration of Independence, "We must hang together, or assuredly we shall hang separately." ■

Andy Walker, MD FAAEM
Editor, *Common Sense*

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