VOICE
OF THE AMERICAN ACADEMY OF
**EMERGENCY MEDICINE**

# COMMONSENSE

VOLUME 24, ISSUE 3
MAY/JUNE **2017**

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## INSIDE





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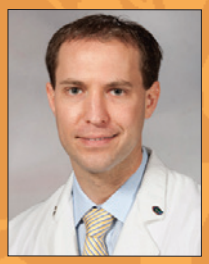

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COMMONSENSE

# Table of Contents



## AAEM Mission Statement

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

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

## Membership Information

Fellow and Full Voting Member: $425 (Must be ABEM or AOBEM certified, or have recertified for 25 years or more in EM or Pediatric EM)
Affiliate Member: $365 (Non-voting status; must have been, but is no longer ABEM or AOBEM certified in EM)
Associate Member: $250 (Limited to graduates of an ACGME or AOA approved Emergency Medicine Program)
*Fellows-in-Training Member: $75 (Must be graduates of an ACGME or AOA approved EM Program and be enrolled in a fellowship)
Emeritus Member: $250 (Please visit www.aaem.org for special eligibility criteria)
International Member: $150 (Non-voting status)
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AAEM-0417-563

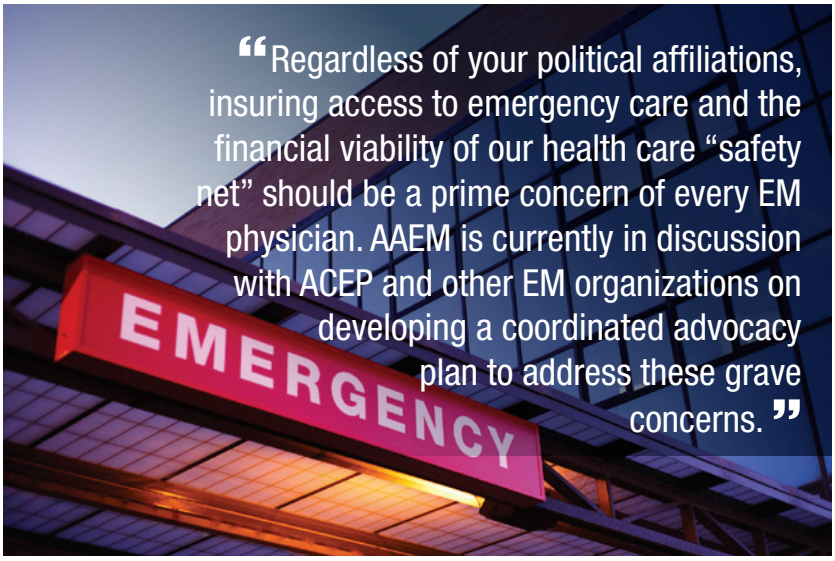
President's Message

# It's Time to Advocate

Kevin Rodgers, MD FAAEM
AAEM President

***Advocacy:*** *(noun)* ad·vo·ca·cy \ˈad-və-kə-sē\: the act or process of supporting a cause or proposal. Popularity: Top 20% of words.

Approximately 136 million U.S. patients (one out of every three Americans) seek emergency care annually. Only 30% of these visits are covered by private insurance, with approximately 35% being covered by Medicaid or CHIP and 18% by Medicare. The Affordable Care Act (ACA) became law nearly seven years ago. Today the number of Americans lacking health insurance that covers emergency care stands at an historic low, and the ACA is credited with reducing the number of uninsured by about 20 million.




"Regardless of your political affiliations, insuring access to emergency care and the financial viability of our health care "safety net" should be a prime concern of every EM physician. AAEM is currently in discussion with ACEP and other EM organizations on developing a coordinated advocacy plan to address these grave concerns."

Is there any doubt that our EDs serve as America's health care safety net? Apparently Congress doesn't get it, at least not those in the House of Representatives who recently passed the American Health Care Act (AHCA), which does not guarantee insurance coverage for emergency medical care. Access and coverage for emergency care is a critical component of the U.S. health care system. Regardless of your overall feeling about the ACA, at least it provides coverage for emergency care.

It is time to advocate, not only for our patients, but also for the EM system that provides them care. Interestingly, in 1986 Congress felt mandatory access to emergency care was important enough to enact EMTALA, but unfortunately it did not consider the financial burden that mandate placed on the U.S. health care system, specifically our EDs. The House version of the AHCA does little to improve the health of Americans. By allowing states to request waivers to exclude certain benefits, including coverage for emergency care, the AHCA could potentially increase the financial burden on emergency departments, forcing them to provide even more unfunded care — possibly even to the point of destroying the safety net.

At the same time, another kind of attack on EM reimbursement is occurring in several states, including Texas, Missouri, Ohio, and Indiana. The prudent layperson rule, also known as the Cardin Bill, is an amendment to the Medicare Act that directs CMS to provide Medicare coverage based on the prudent layperson definition of an emergency.

The prudent layperson rule was subsequently codified as the national standard for EM reimbursement in the Affordable Care Act. However, private insurers are bound by the prudent layperson standard based only on state laws. One of the nations' largest insurers, Anthem BC/BS, has developed a list of about 2000 "non-urgent" conditions it will no longer cover as emergency care. Many potential emergency conditions previously covered under the prudent layperson standard, which is based on presenting symptoms such as pleuritic chest pain rather than final diagnosis, will now be denied. This approach to reimbursement directly negates the prudent layperson rule and the concept that patients cannot be expected to self-diagnose, and ignores the risk that delays in care because patients fear unreimbursed ED bills will lead to more morbidity and mortality.

Regardless of your political opinions, insuring access to emergency care and the financial viability of our health care safety net should be a prime concern of every emergency physician. AAEM is currently in discussions with ACEP and other EM organizations on developing a coordinated advocacy plan to address these grave concerns. The Academy will host its inaugural Health Policy Symposium on June 5, followed by Advocacy Day on Capitol Hill on June 6. Guaranteed due process that cannot be waived in employment contracts, funded and protected access to emergency care, and protection of the prudent layperson standard will be our focus in discussions with Congressional leaders. Please consider joining us in D.C., and at the very least be sure to speak with your Representative and Senators about these issues.

As I close out the first year of my presidential term I would like to recognize a cadre of individuals whose tireless efforts support AAEM's mission

Continued on next page

**AAEM Antitrust Compliance Plan:**

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

and service to the membership. First, tremendous thanks to the board of directors, who have been instrumental in the Academy's recent successes. Although we must unfortunately say farewell to departing board members Joel Schofer, Robert Stuntz, Bob Suter, Les Zun, and Larry Weiss (Past President's Council Representative), I hope these incredibly productive individuals will continue to provide leadership through other Academy venues. I would also like to welcome new members of the board: Jennifer Kanapicki Comer (YPS), Robert Frolichstein, Bobby Kapur, Evie Marcolini, and Howie Blumstein (Past President's Council Representative). Each of these individuals has been a tireless advocate for the Academy and will make AAEM stronger.

I would also like to recognize and thank Chris Doty and Evie Marcolini (co-chairs) and the 16 members of the Scientific Assembly Planning Sub-Committee, for once again developing and implementing the best EM educational meeting in the world. Unfortunately Chris Doty is stepping down as co-chair, but happily is the new President-Elect of CORD. The Academy cannot thank him enough for his tremendous contributions to our organization! As always, the Orlando meeting provided a diverse lineup of cutting edge, focused presentations that will change our practice and positively impact our patients — **and it's still free!** New this year were our small group instructional sessions, which were totally sold out and received rave reviews! Of course Scientific Assembly would not be a success without the incredible support of AAEM staff members Kathy Uy, Emily Marx, Laura Burns, Madeleine Hanan, Tom Derenne, Ginger Czajkowski, Darcy Welsh, Cassidy Davis, and Alissa Fiorentino, under the leadership of Janet Wilson and Kay Whalen. Hats off to everyone who contributed to this incredible, innovative meeting.

Keeping our members informed will continue to be one of my top priorities. We have begun the next website redesign, so if you have any suggestions please let us know. With social media as a priority, the board voted to fund another staff FTE devoted to implementation of a more robust social media presence. We now have thousands of members communicating with AAEM via social media. Please join in! Led by RSA's efforts, the podcast program has been very successful and now boasts over 25 podcasts on clinical, advocacy, and resident-specific topics. Andy Walker has done an exceptional job of developing *Common Sense* into a top-notch platform for the Academy. As Andy steps down as Editor to become Chair of the Government and National Affairs Committee, we cannot thank him enough for his tireless efforts to keep our membership well informed. AAEM welcomes former board member Andy Mayer as the new Editor of *Common Sense*!

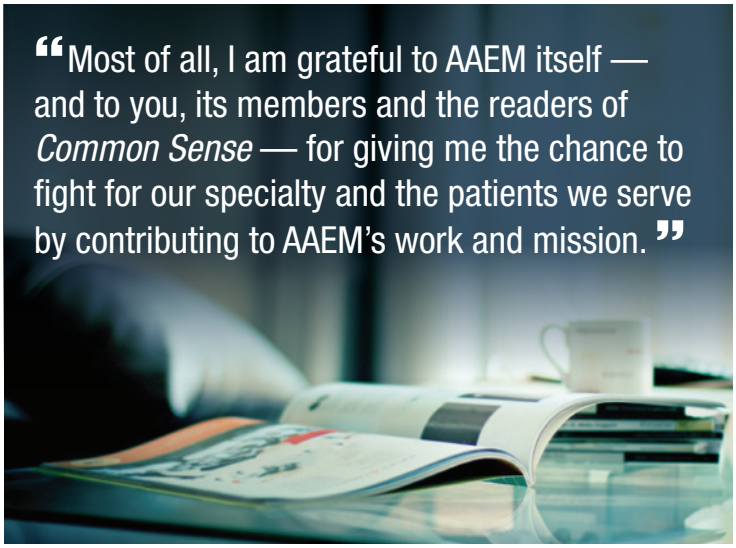
If you are not already a member of an AAEM committee, please consider joining one of our 16 committees. This is a great way to support AAEM, get involved, learn something, meet new colleagues, and help increase the productivity and impact of the Academy. Finally, consider recruiting a colleague to join AAEM. Our ability to accomplish AAEM's mission is directly related to our membership. As they say, there is strength in numbers!

I love to hear feedback from our members — feel free to email me at kgrodger@iu.edu. ■

# Many Thanks

Andy Walker, MD FAAEM
Editor, *Common Sense*

When I became Editor of *Common Sense* over five years ago, it was a newsletter printed in two colors on uncoated paper that averaged less than 30 pages in length. *Common Sense* is now a multicolored magazine printed on high-gloss paper that averages about 50 pages per edition. My biggest problem five years ago was recruiting authors and finding articles that would interest Academy members and be worth reading. Now a core group of authors regularly submit material that I think is worth your time and attention, and I have the luxury of rejecting submissions for reasons of space, quality, or subject matter. In short, editing *Common Sense* was a job I wrestled with at the start that has now become routine, as though the magazine were on autopilot. That means it's time to let someone else take over as Editor. I think all of us do a better job when the task at hand makes us a bit nervous. A little anxiety makes us focus and keeps us energetic. The American Academy of Emergency Medicine is the single most important professional society in our specialty, and its voice — *Common Sense* — deserves no less. So, after a transition period to help him settle into the job, Andy Mayer will be taking over as Editor.




Dr. Mayer is well qualified and we are lucky to have him. He was chief resident at the LSU/Charity Emergency Medicine Residency in New Orleans; has held every position available in AAEM's Louisiana Chapter Division, including president; has served three terms on AAEM's board of directors; has chaired the Academy's Chapter Division Committee and is the outgoing chair of its Membership Committee. A native of New Orleans, after graduating from residency in 1990 Dr. Mayer joined a one-hospital democratic group, West Jefferson Emergency Physicians. West Jefferson Emergency Physicians is perhaps the oldest EM group in Louisiana and was the first of AAEM's 100% membership groups. Three of its members have been president of the Academy's Louisiana Chapter Division. Dr. Mayer became Medical Director of West Jefferson Emergency Physicians on March 1.

Although my exact departure date is uncertain, I want to leave you with my thanks now. First and foremost I must thank AAEM's former president, Bill Durkin, who practically forced me to take the job. I am not exaggerating. I finally gave in and agreed to become Editor when I feared Bill was going to move from figurative to literal arm-twisting. I am glad he was so insistent. I think being Editor of *Common Sense* was the best possible use of my particular skills and interests in the service of AAEM, and thus in the service of emergency medicine, a unique specialty in American medicine and one I continue to love. Thanks, Bill.

I am also grateful to David Vega, who edited *Common Sense* immediately before I took over. He taught me a lot, accurately warned me that I would spend most of my time looking for material worthy of publication, and made the transition between editors easy. I hope I can do as good a job on the transition for Andy Mayer.

Once I realized what I had gotten into, and being lazier than David Vega or any of the preceding editors, I decided to recruit an Assistant Editor. Jonathan Jones was brave enough to take the job, despite being Emergency Medicine Residency Director at the University of Mississippi Medical Center. He has been of more help than I can say, and I am sure Andy Mayer will find him just as valuable.

Last but not least, Laura Burns. For those of you who don't know, one of the ways AAEM saves money and keeps your dues low is by hiring an outside company, EDI, to provide management and administrative services to the Academy. This is a much more cost-effective approach than having a permanent corps of AAEM employees housed in a dedicated AAEM headquarters building. Laura leads the EDI staff assigned to publishing *Common Sense*. She and her colleagues help me edit; lay out the articles, photos, ads, etc.; administer the classified ads and other advertising; take care of printing and mailing; post the online version of *Common Sense*; see to copyright and reprinting issues; and more. They put *Common Sense* together, get it to you, and keep the enterprise running. Editors like me come and go, but the EDI staff remains. The most important and valuable thing I did when I took over as Editor was to go to Milwaukee, talk to Laura and many others at EDI, and learn from them. You do a magnificent job, folks, and I can't thank you enough. I know you will be just as good to Andy Mayer, who I hope will be forever known at EDI as New Andy.

Continued on next page

Most of all, I am grateful to AAEM itself — and to you, its members and the readers of *Common Sense* — for giving me the chance to fight for our specialty and the patients we serve by contributing to AAEM's work and mission. I won't go into detail again here since I have said this in past columns, but AAEM is critical to the health of our specialty and the welfare of board-certified emergency physicians, and thus to the patients we serve. Without the Academy, legitimate board certification in EM wouldn't be the foundation of our specialty and EM might not have achieved the status and esteem it now has. Without the Academy, the private practice of EM by democratic, physician-owned groups might already have disappeared, buried under an avalanche of corporatism. Certainly, many democratic EM groups that are still here would have been wiped out years ago. Without the Academy, good emergency physicians who were fired without peer review or due process because they were trying to do the right thing for patients — including many ACEP members who turned to the College first before coming to the Academy — would have nowhere to go for help. At a time when the medical profession in general, and EM in particular, seems to be in decline because of eroding professional autonomy and a sense that our ancient code of ethics is moot, AAEM is a consistent and reliable beacon of hope. The Academy gives us a way to fight back against the corporations, administrators, bureaucrats, lawyers and others who want to interfere with our professional judgment and insert themselves into the doctor-patient relationship — sometimes robbing us while they do it. The American Academy of Emergency Medicine is an antidote to the cynicism of our age, and a balm for burnout, and I am grateful to have had the opportunity to contribute to it. I urge all of you to look for ways to promote the Academy and its mission, and to do all you can to recruit new members — and write Andy Mayer lots of letters to the editor! ■

# 2017 ABEM 30-Year Certification List

The American Academy of Emergency Medicine is proud to recognize these members of the Academy who recently received a special certificate from the American Board of Emergency Medicine, recognizing that they have been board certified by ABEM for 30 years. Well done!

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# Letters to the Editor

**Letter in response to the March/April 2017 *From the Editor's Desk* column "The Academy and the College"**

Thanks for your strong yet fair response. I have been an AAEM member since residency and an ACEP member as well. I have served in various roles with both. I did not know about the Florida issue or the support of BCEM by ACEP, however. I am going through some personal issues with my academic employer that is looking like it will result in a career reset so the maltreatment of EPs is palpable for me on a global and personal level. In fact, in confidence, it is ironic that my possibly final act was to re-write the credentialing requirements for my subspecialty. Anyway, I wanted you to know that I completely agree with your comments and believe it was fair and balanced. I am sickened by what I have witnessed over the last few years. The issues are not only with the contract management groups but also with large academic hospital groups as well. In these groups one also sees lack of due process, restrictive covenants, lack of transparency, and all the same issues raised for years with the CMGs. Employed physician groups of large hospitals and hospital systems are the new CMGs. I am not sure what I will do about my ACEP membership next year, but I know I will still be working with my AAEM colleagues without a doubt.

— Name withheld by request

Thank you for both your kind words of support for me, and more importantly, for your support of AAEM and its principles. I believe your story is important and our specialty would benefit from its telling. I think you should seriously consider writing your story anonymously for publication in *Common Sense*. I thought academic jobs usually provided for some kind of peer review and due process and were free of restrictive covenants. I was surprised to read,

"I am sickened by what I have witnessed over the last few years. The issues are not only with the contract management groups but also with large academic hospital groups as well. In these groups one also sees lack of due process, restrictive covenants, lack of transparency, and all the same issues raised for years with the CMGs. Employed physician groups of large hospitals and hospital systems are the new CMGs."

I knew of the lack of transparency in academia — and of the dean's tax taken at multiple levels — but not of the other issues. If I am ignorant of these problems in academic emergency medicine, I guarantee you that most AAEM members are too. We will remain ignorant until someone with direct experience explains the situation. Please think hard about being that person.

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

## Response to an Article? Write to Us!

We encourage all readers of *Common Sense* to respond to articles you find interesting, entertaining, educational, or provocative. Help us stimulate a conversation among AAEM members.

**www.aaem.org/publications/common-sense**

# ACA Repeal Efforts Continue Despite Numerous Setbacks

Williams & Jensen, PLLC

President Trump and Congressional Republicans completed the first step of the process to "repeal and replace" the Affordable Care Act (ACA). Trump had aimed to finish health care during his first 100 days in office, but disagreements between Members of his own party has stalled the progress of the legislation for several months. Ultimately, the White House working with House Republican Leadership were able to make changes to the bill to win sufficient votes from two groups on opposite ends of the Republican ideological spectrum — the hard-line "House Freedom Caucus" and the moderate "Tuesday Group." The bill narrowly passed the House by a vote of 217 to 213, with 20 Republicans voting against the legislation.

The latest replacement proposal has led to a debate around coverage of individuals with pre-existing conditions, an element of the ACA that was once considered untouchable. Instead, the latest draft requires coverage of pre-existing conditions, but allows states to apply to waive the requirement. The Department of Health and Human Services (HHS) can grant this waiver under several circumstances, including if the applicant can demonstrate that such a change will lower premiums for individuals in that state. A group of moderate Republicans stands in opposition to this change, arguing that many states will opt to waive this requirement. President Trump and many other Republicans have maintained for the last several years that they would retain several of the most popular elements of the law, including coverage of individuals with pre-existing conditions and allowing children to stay on their parents' coverage until age 26.

A further concern of some moderate Republicans is that the latest proposal also allows states to waive the requirement that insurance plans must cover certain essential health benefits (EHBs). EHBs included in the ACA ranged from pregnancy and maternity care to mental health services and prescription drug coverage. Notably, emergency care was also included on the list of the ten EHBs. Supporters of the ACA argue that this list of EHBs has had a greater effect than just impacting plans that are eligible to be offered on the exchanges. They contend that it has also positively influenced plan offerings off the exchanges.

House Republicans that support the legislation cede that some of these changes may be unpopular, but that is it worth the tradeoff to finally achieve the repeal of ACA along with the individual and employer mandate to purchase health insurance. They also note the aggressive Medicaid reforms included in the legislation, such as the per capita formula that provides enhanced flexibility for states, are important changes that conservatives have sought for decades.

Meanwhile, the Senate remains a steep uphill climb for proponents of ACA repeal. That is because moderate Republicans hold more sway given the slim 52 Republican majority in the chamber. Because the legislation is unlikely to have any support from Democrats, Republicans can only afford two defections, which would allow Vice President Pence to cast the deciding vote. A number of Republican Senators have already come forward to indicate that the bill cannot pass the Senate in its current form. Senate Majority Leader Mitch McConnell (R-KY) has established a task force of 13 Republican Senators that have been asked to come up with modified legislation that can earn the support of the Senate. Further, the procedure that Congressional leaders have used to be able to pass the bill with 51 rather than 60 votes in the Senate, will necessitate the removal of several elements of the House bill.

The stakes remain high for health care reform, as it remains a politically charged issue for both Republicans and Democrats. Both sides hope to use this effort to motivate their base, which makes it even more important that Republicans find success in at least rolling back some major elements of the ACA. Other health care priorities for the new Administration must still be addressed, but are being held back until there is some legislative resolution on the ACA repeal and replace effort. Additional priorities on the agenda include further modification to the physician payment system created by MACRA, the reauthorization of drug user fees that help fund the U.S. Food and Drug Administration, and the reauthorization of the Children's Health Insurance Program (CHIP), which expires September 30.

### Government Funding Deal Secured; Includes Overall Increase in Health Spending

Congress reached an agreement to fund the government through September 30, which marks the end of Fiscal Year 2017. The bill provides $1.163 trillion in total discretionary funding, and includes a modest funding increase for HHS. Total funding for the agency is set at $73.5 billion, which is a nearly $3 billion increase from 2016.

The NIH is a big winner, which is no surprise given strong Congressional support for medical research. NIH will receive a total of $34 billion in funding for Fiscal Year 2017, which represents a $2 billion increase from last year's total. Several Obama-era NIH initiatives including former Vice President Biden's "Cancer Moonshot," the Precision Medicine Initiative, and the BRAIN Initiative, receive increased funding as part of this agreement.

The deal also increases funding for substance abuse prevention and treatment in order to combat the nation's opioid epidemic. The Centers for Medicare and Medicaid Services (CMS) did not fare as well, receiving a cut of around 20 percent.

The agreement stands in contrast to the Administration's proposed budget for Fiscal Year 2018, which would cut the HHS budget by nearly 20 percent and slash NIH funding by billions. ■

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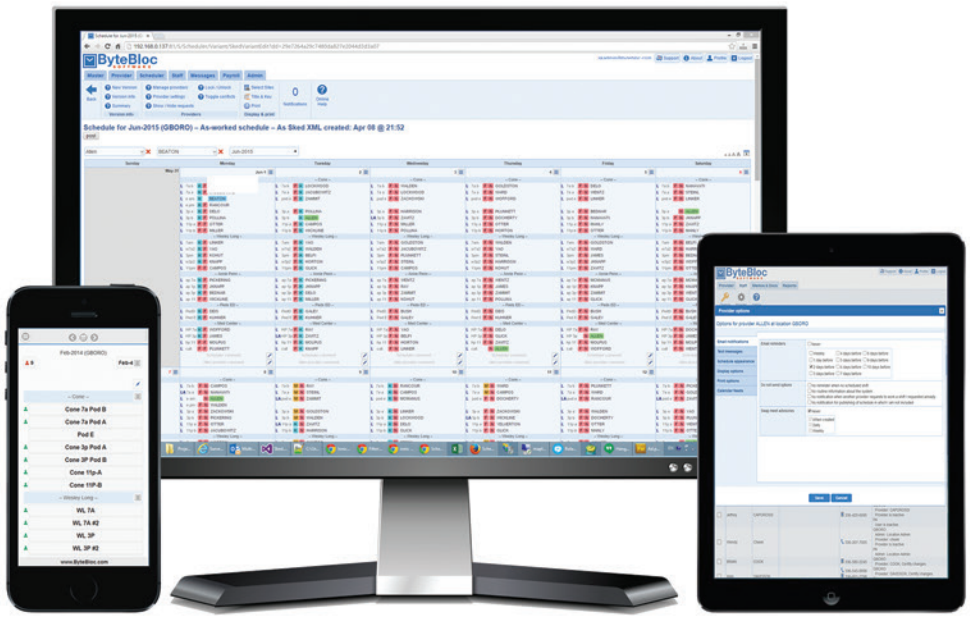

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Levels of recognition to those who donate to the AAEM Foundation have been established. The information below includes a list of the different levels of contributions. The Foundation would like to thank the individuals below who contributed from 11-29-2016 to 4-11-2017.

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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AAEM is featuring the following upcoming conferences and activities for your consideration. For a complete listing of upcoming conferences and other meetings, please visit: www.aaem.org/education/aaem-recommended-conferences-and-activities.

## AAEM CONFERENCES

**August 15-18, 2017**
- Written Board Review Course
  Orlando, FL
  www.aaem.org/written-board-review

**September 16-17, 2017**
- Fall Pearls of Wisdom Oral Board Review Course
  Philadelphia
  www.aaem.org/oral-board-review

**September 23-24, 2017**
- Fall Pearls of Wisdom Oral Board Review Course
  Chicago, Dallas, Orlando
  www.aaem.org/oral-board-review

**September 27-28, 2017**
- Fall Pearls of Wisdom Oral Board Review Course
  Las Vegas
  www.aaem.org/oral-board-review

**April 7-15, 2018**
- 24th Annual AAEM Scientific Assembly – AAEM18
  San Diego Marriott Marquis & Marina
  www.aaem.org/AAEM18

## AAEM JOINTLY PROVIDED CONFERENCES

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

## AAEM RECOMMENDED CONFERENCES

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

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

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

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

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

## Make a Difference with AAEM's Educational Programs

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

Subcommittee activities include reviewing applications, faculty disclosures, presentations, and content for all the direct and jointly provided activities to ensure all guidelines are met that are set by the ACCME (Accreditation Council for Continuing Medical Education).

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

Dollars & Sense

# I Paid Off My Mortgage — Should You?

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

I cut a check and paid off my mortgage in February, making me debt-free. It cut my living expenses by about a third and ensured that in four years, at the age of 45, I'll be financially independent and eligible for military retirement. What a glorious feeling! Should you pay off your mortgage as soon as you can?

## Benefits of Paying Off Your Mortgage

You have one less thing to worry about! You've got food. You've got water. Now you've locked in your shelter and may be debt-free on top of that. You can move from "safety" to "love and belonging" on Maslow's hierarchy of needs.


It reduces your fixed monthly expenses, which goes a long way toward setting you up for retirement, fewer shifts, or even an alternative career path. Housing is usually a large percentage of your monthly expenses, and everyone who decides to purchase their primary domicile should make being mortgage-free a primary goal by the time of retirement.

It saves you money, since you'll likely save tens of thousands of dollars in interest you otherwise would have paid. In addition, if you no longer have a mortgage you should be able to reduce the amount of life and disability insurance you are paying for each month.

Without a mortgage, you can save and invest more money every month. Before I paid off my mortgage, I saved 30% of my gross income. I'm not sure how much I'll save now, but it'll be more than 30%.

When you pay off your mortgage, you are getting a guaranteed rate of return on the investment. In my case, the rate on my mortgage was 3%. I'm usually in the 33% tax bracket, which means that every dollar I put toward paying off my mortgage earned me a guaranteed return of 2%. This is a remarkably similar return when compared to most low-risk bond yields in recent years. In fact, this is exactly why I paid off my mortgage. I wanted to have a small portion of my retirement savings in bonds, but it made no sense to own bonds that would pay me 3-4% while paying 3% on my mortgage. Paying down your mortgage is a reasonable substitute for buying bonds.

There can be asset protection benefits to paying off your home loan. Some states provide unlimited asset protection for home equity, which makes it nearly impossible to lose your home if a lawsuit doesn't go your way. Other states, however, protect very little of your home equity. If you want to see what your state protects, go to this link and look for each state's "homestead exemption": www.assetprotectionbook.com/forum/viewtopic.php?f=142&t=1566.

If you are paying a financial advisor who charges you a fee based on a percentage of your assets under management, by taking some of those assets and using them to pay off your house, you reduce your investment expenses.

## Benefits to Keeping Your Mortgage

When you make your mortgage payment, some of it goes toward principle and increases the equity in your home. For me this was about $2,000/month of forced savings. If you are not financially disciplined, making a mortgage payment will ensure that every month you are squirreling away at least a little bit of money.

Mortgage rates are still near their all-time lows. If you can borrow money at 3-4% and invest it in something that will give you a higher net return, it makes sense to invest the money instead of paying off the mortgage. That said, you have to make sure that you actually invest the money. In addition, there are very few investments that guarantee a return greater than your mortgage. Actually, there probably aren't any, because of the word "guarantee." Yes — stocks, high-yield or corporate bonds, real estate, etc., will probably make more than 3-4%, and you can protect yourself by diversifying — but that is certainly not guaranteed.

The after-tax mortgage rate you are paying may be below inflation. For example, my after-tax mortgage rate was 2%. If inflation had been above 2%, I would have been getting paid (in real terms) to borrow money! The value of real estate tends to rise with inflation but your mortgage payment is fixed, so when inflation increases the value of your house but your mortgage payment remains the same, you are paying the loan back with dollars that are worth less and less as time goes on. When your mortgage is paid off, you give up this benefit.

Continued on next page

### What Should You Do?

Like most financial decisions, situations vary and this decision can be complicated. The best online article I could find that goes through all the complexities of the issue, which my brief article does not, can be found here: https://financialmentor.com/financial-advice/pay-off-mortgage-early-or-invest/7478.

You should always maximize contributions to your retirement accounts, pay off all non-mortgage debt that has a higher interest rate, and save for your children's education before you consider paying your mortgage off early. But if you find yourself having taken care of all of this, and weighing investing in bonds versus paying off your mortgage, you can't beat the peace of mind that comes with being mortgage-free!

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

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

# ABEM Board of Directors Elects Two New Members

At its 2017 winter meeting, the Board of Directors of the American Board of Emergency Medicine (ABEM) elected two new directors: Leon L. Haley, Jr., MD MHSA, and James D. Thomas, MD. Dr. Haley was nominated by the Society for Academic Emergency Medicine (SAEM), and Dr. Thomas was nominated by the emergency medicine community-at-large. SAEM is an ABEM sponsor organization.

Leon L. Haley, Jr., MD MHSA

Dr. Haley is Vice President for Health Affairs, and Dean and Professor of Emergency Medicine at the University of Florida College of Medicine-Jacksonville. He has served as an ABEM Oral Examiner since 2004, and was recently appointed as a Senior Examiner. Dr. Haley completed his residency in emergency medicine at Henry Ford Health System in Detroit, Michigan, and earned a Master in Health Sciences Administration from the University of Michigan in Ann Arbor, Michigan.

James D. Thomas, MD

Dr. Thomas practices emergency medicine at Good Samaritan Medical Center in Brockton, Massachusetts, St. Anne's Hospital in Fall River, Massachusetts, and is on the medical staffs of several other community hospitals in the southeastern Massachusetts. He has served as an ABEM Oral Examiner since 2002, and Senior Oral Examiner since 2014. He also has been an item writer for the ConCert™ Examination since 2012. Dr. Thomas completed his residency training in emergency medicine at St. Vincent Medical Center/The Toledo Hospital in Toledo, Ohio.

Dr. Haley and Dr. Thomas will begin their terms as ABEM directors at the close of the summer Board meeting.

The ABEM Board of Directors is comprised solely of volunteer, board-certified, clinically active emergency physicians who are actively participating in ABEM Maintenance of Certification, a program of continuous learning and periodic assessment.

### About ABEM

*Founded in 1976, the American Board of Emergency Medicine (ABEM) develops and administers the Emergency Medicine certification examination for physicians who have met the ABEM eligibility criteria. Its mission is to ensure the highest standards in the specialty of Emergency Medicine. ABEM has over 33,000 emergency physicians currently certified. ABEM is not a membership organization, but a non-profit, independent, physician assessment and standard-setting organization. ABEM is one of 24 Member Boards of the American Board of Medical Specialties.* ■

# Balance Billing, Florida's HB 221, and What They Mean for You

Chuck Duva, MD CMM

According to a 2011 analysis by Health Services Research, almost ten percent of privately insured individuals have used out-of-network providers and 40 percent of those individuals received "surprise medical bills," a term applied to balance billing by some in the health care industry.[1]

Another report by Consumer Union shows that nearly two-thirds of privately insured Americans will fight these surprise bills, increasing the collection burden on physicians.[2]

In Florida, the House Insurance & Banking Subcommittee has approved HB 221, the balance billing proposal aimed at protecting patients from surprise charges when they receive emergency health care.[3]

As you are likely aware, there is great strife between providers and payers over reimbursements, and patients are stuck in the middle. What does this mean for your collections, and thus for you and those who depend on your income?

"Because many hospitals use contract-based or outsourced emergency physicians, who are not employees of the hospital, patients may find themselves getting bills from out-of-network physicians who cared for them at in-network hospitals. When these physicians are unable to resolve their billing problems with insurers, the bills may be passed on to unsuspecting patients."


### What is balance billing in emergency medicine?

This often occurs when a patient visits an in-network hospital's emergency department but is treated by a physician who is part of an out-of-network emergency medicine group. The same thing can happen with out-of-network anesthesia, radiology, pathology, and hospitalist groups, as well as out-of-network consultants who see the patient.

Balance billing occurs when a provider bills the patient for charges not covered by the patient's insurer. In these cases the insurance company pays less than 100% of the billed charges, and the patient is responsible for the remainder.

Patients sometimes deliberately choose to visit out-of-network providers, but most of the time this is unintentional. Out-of-network services are often provided by emergency physicians in situations where patients have no time to consider insurance matters. Because many hospitals use contract-based or outsourced emergency physicians, who are not employees of the hospital, patients may find themselves getting bills from out-of-network physicians who cared for them at in-network hospitals. When these physicians are unable to resolve their billing problems with insurers, the bills may be passed on to unsuspecting patients.

The nation's largest insurer, UnitedHealthcare, announced that it won't pay the bills of out-of-network emergency physicians, even at in-network hospitals.[4] It is passing the buck to patients.

### Why do physicians stay out-of-network?

Insurers and emergency physicians are often unable to agree on what constitutes fair and reasonable compensation for professional services, especially in light of the huge charity burden inflicted on our nation's emergency departments by EMTALA (the Emergency Medical Treatment and Labor Act), which requires EDs and emergency physicians to care for all patients — regardless of the patient's ability or willingness to pay for that care. This drives huge numbers of uninsured patients to EDs, where providers treat them without compensation. EMTALA does not impact any other specialty or service the way it does emergency medicine and EDs, and it forces emergency physicians to optimize collections from commercial insurers and shift some of the cost of uncompensated care onto insured patients. Payers don't appreciate that rationale during contract negotiations, but it is the reality behind why the low rates frequently offered by payers are not only unacceptable but completely unrealistic, and would lead to the unraveling of our medical safety net.

### Going after collections from insurance companies may result in warfare.

As health insurance provider Aetna has shown, lawsuits aimed at physicians are not out of the question.[5] Aetna sued six out-of-network physicians in New Jersey for allegedly over-charging for their professional services, and is lobbying to stop what it calls "price-gouging."

### Expect consumer understanding to remain low.

Increasing amounts out-of-network care will likely continue to be a trend for emergency providers, even with the risk of insurance lawsuits and patient uproar. Patients often don't have the opportunity to select an

Continued on next page

emergency department when they have an acute need, and even if they are taken to an in-network hospital the ED may be staffed by out-of-network physicians.

The Affordable Care Act (ACA) sought to shed light on out-of-network costs to those registered, but the information that might help these patients has never been published.[6] What's more, skyrocketing premiums are pushing more and more people into high-deductible policies, increasing their out-of-pocket costs while reducing the cost to insurers. Patients are therefore going to be more and more likely to try and negotiate with emergency physicians after the fact, or even refuse to pay anything, and to call their state legislators and complain about their "surprise" medical bills.

### Balance billing could be prohibited and out-of-network fees capped.

States are trying to fill the gaps between insurance companies and providers, so fewer patients are left with surprise bills. Florida is one of many states proposing independent dispute resolution, although there is concern from physician and hospital groups over language that insurers are liable only for "reasonable reimbursement."[7] "Reasonable" should be clearly defined before this moves forward.

Rep. Carlos Trujillo, R-Miami, wants to put an end to balance billing with HB 221. Trujillo says that PPO (preferred provider organization) members are usually the victims of balance billing, and can be driven into bankruptcy.

### What is HB 221?

Among other things, Trujillo's HB 221 would:

1. Require hospitals to post information on their websites on the insurance plans they participate in.
2. Provide clear information for insured patients on the implications of selecting an out-of-network provider.

The proposal has not been without conflict. Physicians, hospitals, and other parties related to emergency care feel it adds to their costs. They also believe more blame should be placed on insurance companies, which don't properly compensate physicians and force them to pass bills on to patients.

### Simplifying collections with an emergency billing company.

Whether part of an independent group or a hospital employee, it's important that your billing partner understands the complex and delicate nature of emergency medicine billing, and provides guidance on the implications of staying out-of-network and balance billing — and counsels you on the implications for your livelihood.

*Dr. Chuck Duva is the President and CEO of DuvaSawko. He is an experienced emergency physician-executive with special talent in managing and regenerating medical practices. Before co-founding DuvaSawko, Dr. Duva practiced emergency medicine for 20 years.*

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# NEW: Join the Emergency Ultrasound Section (EUS-AAEM)

This section is founded to foster the professional development of its members and to educate them regarding point of care ultrasound.

### Objectives

- Disseminate information about ultrasound among EM practitioners regardless of practice setting and experience
- Deliver ongoing educational opportunities for emergency medicine specialists
- Provide resources for the advancement of point of care ultrasound
- Forum for collaboration to encourage ultrasound research and exchange of ideas
- Create regional, national, and international opportunities for providers to convene
- Support fellowship training and research
- Promote resident and medical student education
- Foster program development
- Endorse policy and guideline development
- Collaborate with other specialties utilizing ultrasound

### Want to get involved?

Join today by visiting www.aaem.org/membership/emergency-ultrasound-section. This section is open to all AAEM and AAEM/RSA members. ■

# THANK YOU FOR ATTENDING AAEM17!

## AAEM17 BY THE NUMBERS:

**25** Student ambassadors volunteered at the meeting New Record!

**99** People played Catch the Code and completed a total of 564 challenges

**864** Unique users of the mobile app with 72,184 total page views

**2,000** Pairs of AAEM sunglasses distributed

**5,857** Tweets on the #AAEM17 hashtag with 1,254 participants averaging 60 tweets per hour

**12** Morbidity and Mortality Case Presentations submitted

**55** AAEM/*JEM* Resident and Student Research Competition abstracts submitted

**8** AAEM/RSA & *WestJEM* Population Health Research Competition Submissions

**75** People participated in the 5K Fun Run/Walk

**212** Photo competition submissions accepted - New Record!

**16** People joined in Early Risers Yoga

**1,039** Attendees registered

## 2017 COMPETITION WINNERS

**Photo Competition**
Chelsea Dymond, University of Queensland
Facial Pain and Congestion: Not Just Sinusitis

**Open Mic Competition**
*Winners*
Molly Estes, MD
Massive Transfusion Going Wrong

Maite Huis in 't Veld, MD
So Wrong It's Right: ARVC The Silent Killer

**AAEM/*Journal of Emergency Medicine* Resident and Student Research Competition**
*First Place*
Kimon L.H. Ioannides, MD
The Impact of an ESI II Direct Bedding Initiative

*Second Place*
Sean Stuart, DO
Application of the iTClamp™ in Conjunction with Hemostatic Agents for Control of Lethal Hemorrhage

*Third Place*
Nicholas G. Von Schrott
Nitroglycerin Associated Hypotension In Inferior ST Segment Elevation Myocardial Infarction

**AAEM/RSA & *Western Journal of Emergency Medicine: Integrating Emergency Care with Population Health* Research Competition**
*Winner*
Daniel Gingold, MD MPH, University of Maryland Medical Center
The Impact of Maryland's Medicaid Expansion on Emergency Department High Utilizers

*Runners Up*
Nhan Do, MD, Kern Medical
Combating the Methamphetamine Epidemic: Education is Insufficient

Zachary Olson, MD, The University of Tennessee Health Science Center
Patient Satisfaction Scores Following Food Snack Intervention

# THANK YOU FOR ATTENDING AAEM17!

## 2017 COMPETITION WINNERS – continued

**First Annual Wilderness Medicine Interest Group Photo Competition Winner**

"I took this photo while working as a locum tenens in New Zealand. New Zealand is such an incredibly beautiful country that it is hard to not capture beautiful photos. We were walking along the beach of cathedral cove and found ourselves in a sea cave with a naturally vaulted ceiling overlooking the islands on the bay. I snapped this picture just as another hiker serendipitously wandered into the scene giving perspective to this beautiful scene."

— Robert Lam, MD FAAEM

## 2017 AAEM AWARD WINNERS

**MAAEM Designation**
David W. Lawhorn, MD MAAEM FAAEM

**Young Educator Award**
Semhar Z. Tewelde, MD FAAEM

**David K. Wagner Award**
William T. Durkin, Jr., MD MBA CPE FAAEM

**Resident of the Year Award**
Mary Calderone Haas, MD

**Robert McNamara Award**
Shahram Lotfipour, MD MPH FAAEM FACEP

**Amin Kazzi International Emergency Medicine Leadership Award**
Edgardo Jorge Menendez, MD FIFEM

**James Keaney Leadership Award**
Robert A. Frolichstein, MD FAAEM

**Joe Lex Educator of the Year Award**
Kevin C. Reed, MD FAAEM

**AAEM/RSA Program Director of the Year Award**
Jonathan S. Jones, MD FAAEM

**AAEM/RSA Program Coordinator of the Year Award**
Krista Fukumoto

**2016 Open Mic Winners**
Matthew C. DeLaney, MD FAAEM
Ryan Riberia, MD MPH

**2016 Written Board Course Top Speaker**
Michael E. Winters, MD FAAEM

**Teaching 50 Oral Board Review Courses**
William G. Gossman, MD FAAEM

**Teaching 35 Oral Board Review Courses**
Mitchell J. Goldman, DO FAAEM FAAP

**Teaching 30 Oral Board Review Courses**
Alexandre F. Migala, DO FAAEM

**Teaching 20 Oral Board Review Courses**
Frank L. Christopher, MD FAAEM
Michael H. LeWitt, MD MPH

**Teaching 15 Oral Board Review Courses**
Sudhir Baliga, MD FAAEM
Thomas N. Bottoni, MD FAAEM

**Teaching 10 Oral Board Review Courses**
Rika O'Malley, MD
Timothy J. Rupp, MD MBA FAAEM
Marilyn R. Geninatti, MD FACC FAAEM CWS
Ralf Joffe, DO FAAEM
Edmundo Mandac, MD FAAEM

**Teaching 5 Oral Board Review Courses**
Dennis M. Allin, MD FAAEM
Henry A. Curtis, MD FACEP FAAEM
Lynn Ji, MD MS FACEP
Kristen J. Kent, MD FAAEM
Amanda Christine Rodski, MD MBA FAAEM
Loice A. Swisher, MD FAAEM
Veronica L. Greer, MD FAAEM
Daniel J. Hornyak, MD FAAEM
Robert P. Lam, MD FAAEM
Brady McIntosh, MD FAAEM
Aaron M. Orqvist, MD FAAEM
Reis B. Ritz, MD FAAEM

# THANK YOU TO OUR EXHIBITORS!



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# THANK YOU FOR ATTENDING AAEM17!

## AAEM MEMBER ASSISTS ATTENDEE FROM THE ACADEMY OF OSSEOINTEGRATION MEETING IN ORLANDO

Hello Ms. Whalen,

I'm reaching out to tell you a story and to thank you indirectly for the assistance one of your members provided me during a recent trip to Orlando.

The organization I'm employed with, the Academy of Osseointegration, was having our annual conference in Orlando the same week as your organization's meeting in Orlando. On Friday, 3/17, I was walking back to my hotel after having dinner with a colleague.

Upon stepping off a curb along International Drive, I rolled my ankle and went down into the street, resulting in what was later diagnosed as a broken ankle. One of your attendees, and I assume a member of AAEM, Dr. Mike Rock was walking directly behind me and witnessed what had happened. He immediately stopped to assist me and did what he could to assess my injuries onsite and make sure I was taken care of until an ambulance arrived.

It is my understanding that other attendees at your meeting stopped to assist as well. Considering I was far from home and suffering the extreme pain of this injury, having these good Samaritans who were also trained ER physicians by my side that evening was such a comforting, albeit serendipitous, circumstance.

I write this as a veteran employee in the medical association sector and have acquired the highest respect for the member-docs of our associations. But after this first-hand experience, I felt compelled to reach out and praise the knowledge, kindness and commitment from one of your members to care for me until I was released to someone else's care.

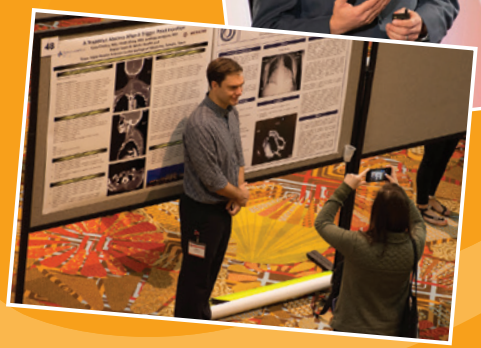
And I wanted his organization to know my gratitude as well. A lucky "break" for me that your meeting was happening in Orlando at the same time as ours!

Very sincerely,

Terri Vargulich
Academy of Osseointegration

# THANK YOU FOR ATTENDING AAEM17!



# AAEM17 WELLNESS WRAP-UP

Amy Faith Ho, MD, AAEM/RSA Wellness Committee Chair
Robert Lam, MD FAAEM, AAEM Wellness Committee Chair

In addition to the usual packed schedule of lectures, small group discussions, posters, research presentations, and social events, the 23rd Annual AAEM Scientific Assembly was also the debut of the Academy's new Wellness Committee. Physician wellness is an increasingly urgent matter in emergency medicine. Suicide amongst emergency physicians is startlingly common, and we as a specialty are finally addressing burnout as a real problem. The Wellness Committee's first Scientific Assembly effort sought to make the conference not only a place for education and networking, but also a mini-retreat from the daily grind that sometimes ails us.

Starting with the yoga event Saturday morning, wellness activities focused on mindfulness and a softer side of medicine. Part meditation and part fitness, the yoga session invited all attendees to an exercise of both mind and body.

Saturday ended with a part open-mic, part stand-up comedy, part story telling event called Airway (airwaystories.com). This was started by two emergency physicians in New York, Mert Erogul and Josh Schiller, and both attended our event. It has become a movement, an outlet for physicians to share stories with a roomful of peers, and provides catharsis, a sense of community, and yes, entertainment. Emceed by the wryly witty and endlessly knowledgeable Billy Mallon, MD FAAEM, Airway featured stories ranging from battles with depression to unfortunate genital encounters to second victim concerns.

Sunday the emphasis shifted more to physical fitness, with a sunrise 5k Fun Run/Walk. Seventy attendees participated, and the top five women and men runners were (in order):

**Women**

1. Andi Wolff – 24:13
2. Amy Ho – 25:04
3. Justine Stremick – 25:07
4. Tegan Luckacs – 25:33
5. Kelly Murphy – 25:33

**Men**

1. Jon Strong – 18:49
2. Robert Westermeyer – 22.59
3. Jonathan Jones – 23:15
4. Alex Flazman – 24:24
5. CJ Winckler – 24:25


A new wellness track of lectures included topics on evidence-based resiliency practices, the effect of exercise on creativity, suicide prevention, and a workshop on mindfulness. Topics related to wellness were also covered in lectures in other tracks, including late career options in EM.

The hidden agenda behind these wellness events is the promotion of five areas of resiliency. Created with inspiration from the Duke Patient Safety Center, these are Self Care, Mindfulness, Purpose, Relationships, and Self Awareness. Many do not know that to practice yoga is to practice mindfulness. The Fun Run/Walk is a reminder that we need to practice self-care. Airway is about normalizing difficult parts of our job through relationships and reminding ourselves of the fundamental purpose and meaning of our work. Finally, at the heart of AAEM are the relationships between its members. The Scientific Assembly is a time to renew old relationships and create new ones.

The Wellness Committee's goal for this Scientific Assembly was to remind us that, as emergency physicians tasked with the health and wellness of so many others, we shouldn't forget ourselves. We hope to bring you many more events at future conferences, but also invite you to start your own personal resiliency plan. Regardless of your age or years in practice, emergency medicine is a lifestyle as much as it is a journey, and you are the critical irreplaceable part of it. We hope our wellness efforts gave you ideas to take back home for your own journey to wellness and resiliency. Always remember that to take care of patients, you first have to take care of yourself.

Here are some online resources to taking the first steps to starting your own personal resilience plan:

**Self-Care:**
https://www.cdc.gov/physicalactivity/basics/adults/index.htm

**Purpose:**
https://www.stepsforward.org/modules/improving-physician-resilience

**Mindfulness and Self Awareness:** Search Inside Yourself Leadership Institute
https://www.youtube.com/user/Siyli

# Wellness and Resiliency Summit

Ashely Alker, MD, AAEM/RSA President '17-'18
Robert Lam, MD FAAEM, AAEM Wellness Committee Chair

AAEM representation: (L-R) AAEM Wellness Committee Chair Robert Lam, AAEM/RSA Advocacy Chair '16-'17 Ashely Alker, AAEM President Kevin Rodgers, AAEM/RSA President '16-'17 Mary Haas, and CORD and AAEM Wellness Committee member Lois Swisher.

Emergency medicine has historically had the highest rate of reported burnout among all specialties. In the 2017 Medscape Lifestyle Survey, 59% of emergency physicians self-identified as "burned out."[1] A survey conducted by the University of North Carolina-Chapel Hill showed that approximately 70% of residents met criteria for burnout. In one survey residents were asked about their quality of life, and 15% reported "life is as bad as it could be."

In January, for the first time ever, all national emergency medicine organizations convened in Dallas for an Emergency Medicine Wellness and Resiliency Summit. In a spirit of collaboration, wellness champions and emergency medicine leaders came together to find solutions for the ongoing crisis in physician wellness and resilience. In attendance were representatives from the Council of Emergency Medicine Residency Directors (CORD), American Academy of Emergency Medicine (AAEM), Society for Academic Emergency Medicine (SAEM), Association of Academic Chairs of Emergency Medicine (AACEM), American College of Osteopathic Emergency Physicians (ACOEP), Accreditation Council for Graduate Medical Education (ACGME), AAEM Resident and Student Association (AAEM/RSA), Emergency Medicine Residents' Association (EMRA), American College of Emergency Physicians (ACEP), American Board of Emergency Medicine (ABEM), and the American Hospital Association (AHA).

This broad representation created a unique opportunity to look at the root causes of burnout and support resilience across the entire arc of an emergency physician's career. Of the many drivers of burnout, AAEM highlighted the need for transparency, fairness, and due process in the workplace; the challenges and relevance of maintenance of certification; the unique challenges facing physicians training in emergency medicine; the use of metrics to give mainly negative feedback; and the epidemic of physician suicide.

As burnout is a complex problem with individual, institutional, and systems-based causes, solutions were proposed in the areas of community practice, academic practice, knowledge gaps, and personal well-being. Much attention was paid to looking at the systems-based drivers of burnout, and to engaging in dialogue with stakeholders like the American Hospital Association, Press Ganey, and vendors of electronic medical record systems. Key questions for research were defined, as well as the need for new tools to measure the joy of EM practice. A summary of the group's consensus, ongoing concerns, and proposed solutions will be released in a landmark publication written by representatives of all participating organizations.

In keeping with the spirit of cooperation and collaboration, attendees discussed the creation of an Emergency Medicine Wellness Institute to nurture collaboration, combine resources, further research, and support emergency physicians. Such an Emergency Medicine Wellness Institute would be a joint venture of all EM organizations.

The consensus from the summit was hopeful. Hopeful that together, not only can we tackle this problem in our own specialty, but we can lead the way for the entire house of medicine. How can you help? Here are some simple things you can do to make a difference for yourself, your organization, and our specialty.

- Do an anonymous online self-assessment of burnout, depression, or stress at www.aaem.org/about-aaem/leadership/committees/wellness-committee.
- Create your own resiliency plan that includes scheduled exercise, mindfulness, and renewed relationships.
- Renew your purpose. A nice resource from the AMA can be found here: https://www.stepsforward.org/modules/improving-physician-resilience.
- Consider job-crafting based on your signature strengths and needs. Can you incorporate your strengths into your work every day? Would working a bit less add to your well-being? Would adding outside interests like education or subspecialty practice in emergency medicine give you greater satisfaction?
- Talk to your institutional leadership about the systemic problems that drive burnout in your group.
- Be part of the solution and join the AAEM Wellness Committee.
- Come to the Annual AAEM Scientific Assembly. Our vision is to make the Scientific Assembly a motivational retreat where you renew your passion for our specialty, learn individual resilience practices, and renew relationships with your colleagues.

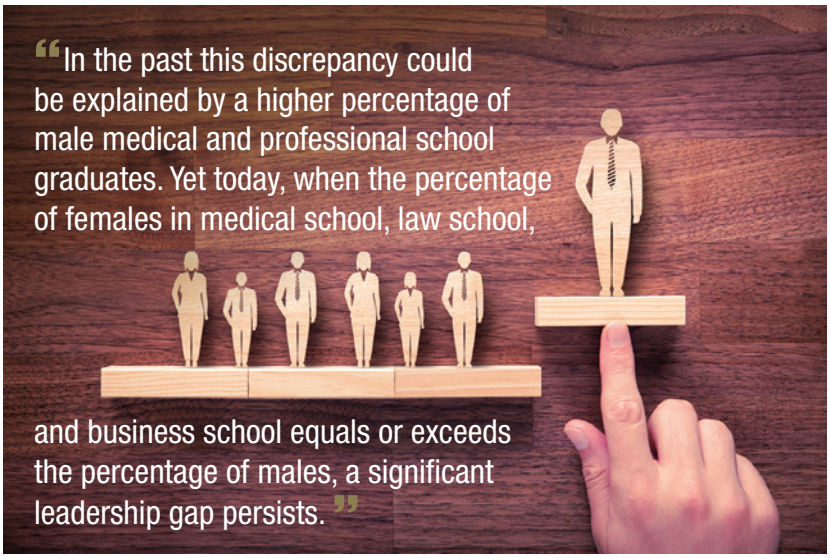
**Reference**

1. Medical Resident Burnout Reaches Epidemic Levels. Medscape.com. http://www.medscape.com/viewarticle/844821. Updated 17 May 2015

# The Gender Gap in Medical Leadership: Glass Ceiling, Domestic Tethers, or Both?

Eveline Hitti, MD MBA FAAEM
Lisa Moreno-Walton, MD MS MSCR FAAEM

The number of women enrolled in medical schools has risen from less than 25% in the 1970s to over 47% today.[1,2] In spite of this, we continue to see striking under-representation of women in leadership positions in academic medicine, professional organizations, and health services in general. Women comprise only 38% of full-time faculty, 21% of full professors, and 30% of new tenures in academic medicine. Only 18% of hospital CEOs are women, and the percentage of female department chairs and deans at U.S. medical schools remains low, at 15% and 16% respectively.[2,3] This leadership gap is not unique to medicine. It mirrors trends in law, where women continue to constitute a disproportionate minority of partners within firms; and business, where women are less likely than men to hold corporate executive positions. In the past this discrepancy could be explained by a higher percentage of male medical and professional school graduates. Yet today, when the percentage of females in medical school, law school, and business school equals or exceeds the percentage of males, a significant leadership gap persists.




Much of the literature on the leadership gap has focused on the seemingly impenetrable "glass ceiling" effect of institutional culture and structure, which prevents women from advancing to senior positions. The glass ceiling is supported by conscious and unconscious gender stereotypes and biases, lack of policies that support work-life balance, lack of mentors or role models for women interested in high-level career advancement, and a paucity of networks that can open doors to women.[3] Sheryl Sandberg's recent book, *Lean In*, focused attention on the individual factors that hinder the advancement of women and has challenged women to overcome their own low expectations and self-defeating behaviors. But are these institutional and individual challenges the main road blocks for women? Are education programs so egalitarian in their policies and cultures that women succeed at the training phase of their careers but fall out in the employment phase, or is there another factor at play?

A closer look at the issue of gender equity at home might begin to explain some of the disparities at work. Women continue to shoulder the lion's share of unpaid domestic work, be it household chores or parenting responsibilities, even in countries where they constitute more than half the workforce. In Australia, women spend twice as much time as men on child-care and unpaid household work.[4] In the U.S., where women constitute 50% of the labor force, they spend an average of 40 hours a week — the equivalent of a second full time job — performing domestic work in the home. Although U.S. fathers have certainly increased their domestic workload over the past 40 years, on a weekly basis it remains half a mother's.[5] Disparities in household responsibilities have historically been explained by economic calculations, but this doesn't necessarily hold in medicine, where the earning potential of both women and men is high. Yet studies on domestic responsibilities have found the same pattern of gender inequity in physician domestic partnerships as in the general population. Shollen et al. report that, despite spending equal hours at work, female academic medical faculty spent substantially more time per week on domestic work than their male colleagues (31 hours vs 19).[6] Jolly et al. found that among high-achieving young physician researchers who were married or partnered, women spent 8.5 hours more per week on domestic activities.[7] Even within specialties notorious for poor work-life balance such as surgery, where average working hours per week are around 60, conflicts between work and personal demands were resolved in favor of the female surgeon's work only 59% of the time, compared to 87.3% of the time for male surgeons.

The implications of such domestic inequities on the career advancement of women are significant. Over two-thirds of high-achieving women decrease their work schedules during their careers, and approximately one third take extended leave from their jobs. In a study of Spanish physicians Ariizabalga found that, after completing their specialty training, women held more than twice the number of part-time medical positions as men. Consequently, while their male colleagues were applying for promotions, female physicians with similar years of professional experience had not yet moved into full-time positions.[8] While approximately half the graduating medical students in the U.S. are women, only 38% of full-time faculty positions are held by women and the departure of women from full-time academia is disproportionately higher than that of men.[2] In the UK's National Health Service, 63% of women work part-time compared to 8% of men.[9] While these flexible tracks may help women remain in the

Continued on next page

workforce during the demanding child-rearing years, getting off track can be detrimental to career advancement and promotion, especially in comparison to men who usually start and remain in full-time service.[3,10]

Women who remain in full-time employment are not immune to the impact of domestic tethers on career advancement. Family responsibilities compete with work responsibilities in the lives of female physicians far more frequently than in the lives of their male colleagues. A large cross-sectional survey of U.S. surgeons found that female surgeons were five times more likely to care for a child home from school than male surgeons. In addition, they more often subjugated their career for their spouse's/partner's when work-life conflicts arose and were more likely to report that their commitment to their children deterred their career advancement. Another study that looked at gender differences in the domestic and parenting work of high-achieving young physician researchers found that women spent more time on household work and less time on research than their male colleagues, suggesting that when home responsibilities compete with research responsibilities, the research productivity of women is more likely to be impacted.[7] The gender disparity in the burden of domestic work inevitably places women at a disadvantage compared to men, who are more at liberty to invest additional time in work and who experience fewer work-life disruptions.

The impact of these disparities stretches beyond productivity and work time. In a qualitative study exploring under-representation of women in leadership positions, one male study participant described his advantage over women: "I could at any time turn up to a meeting on a weeknight. I could be away overnight. I could do what I have to do to be noticed and available."[1] A woman's more restricted ability to attend off-hour meetings and other functions may exclude her from opportunities and from the notice of those who have the power to advance her career. And the restricted mobility of women, who are more likely to be in two-career relationships, can also limit opportunities and advancement options. In a study exploring barriers to leave, female faculty eligible for leave took fewer and shorter sabbaticals.[11] In a survey of health care executives, less than 60% of women reported a willingness to move in pursuit of career advancement compared to more than 75% of men.[3]

Understanding the impact of domestic tethers should not belittle the daunting barrier of the glass ceiling. Even in specialties such as pediatrics and ob-gyn, where women are an overwhelming majority, only 20% and 22% of department chairs are female. This indicates the enduring strength of cultural and structural barriers. At the same time, understanding that equity at work cannot be achieved without equity at home is critical to the advancement of female professionals. Our culture must set an expectation of equitably allocated responsibilities between partners at home, and institutions need to make success possible for both men and women with significant family responsibilities by investing in on-site child care, fitting meetings and development opportunities into regular work hours, and introducing parental leave policies that recognize men as equal partners at home and women as equal partners at work.

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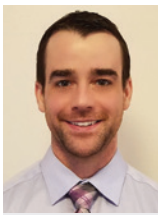
# Vetting FOAM

Jason Hine, MD FAAEM



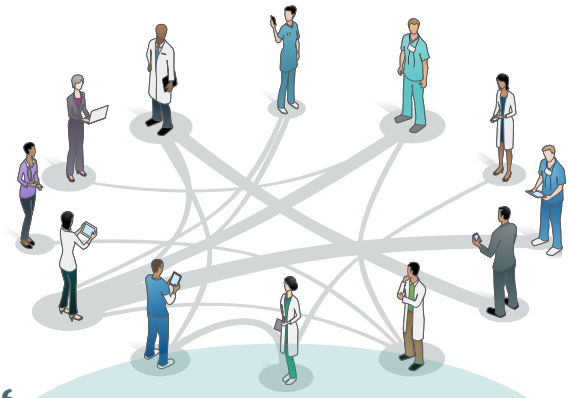
Emergency medicine is a relatively young specialty. Compared to internal medicine and surgery, the two pillars of medicine, it is essentially a toddler. But with this youthfulness comes an advantage. It has allowed us to be on the forefront of medical education's evolution. We have not been bound by traditions or volumes of ancient leather-bound texts handed down through generations. Our forefathers blazed a new trail in medicine and took with them many fresh thinkers and visionaries.

We have some of the most innovative and cutting-edge education of all medical specialties. We have pioneered new ways of teaching, actively seeking out and utilizing technologies as they develop. The most prominent has been FOAM, or free open-access medical education. This once small resource has grown to massive size. With growth, however, come challenges. While the ease of contribution has driven FOAM's success, it has the downside of unregulated and unchecked production.

By its very nature, FOAM gives everyone a voice. This culture of sharing, comparing, and questioning is the machinery through which we are able to propose new ways of thinking, challenge the old, and make progress together. While unimpeded content production has been a part of FOAM since its advent, the explosion of original contributions over the last several years has caused this to be seen as a problem. Back when EM:RAP*, EMCrit, and ERCast were the only big content producers around, it was easier to see you were getting well researched and up to date information from a credible educator. Today's trainee researching a topic on FOAM still has these titans to learn from, but is also presented with hundreds of other podcasts and blogs, all without any external validation.

This needs to change. We need to lay the groundwork for vetting FOAM. Scientific journals have used peer review as one means of quality assurance for decades. While criticism of this system exists, it provides a place to start. In this system, an author produces content and submits it to a journal, which has its own team of peers who review the content for quality and relevance.[1] If the piece gets approval, it is published. There are certainly pros and cons to this formula. Pros include its formulaic nature, the ability to utilize the expertise of relevant authorities in the field and, if functioning in its purest form, the ability to prevent erroneous or irrelevant content from being published. Cons include the biased selection of peers, the journal's association with content which can lead to publication bias, and the huge number of journals which leads to decentralization of information. While this system can serve as a foundation on which to build, it should be stated clearly that FOAM is not scientific research. Its purpose is not the same and therefore it should not undergo the same validation process.

Some have attempted to re-imagine peer review for the FOAM world. Most notably, Academic Life in Emergency Medicine (ALiEM) has created the Approved Instructional Resources (AIR) series, through which their team assesses high-profile FOAM resources. In their system, the board of directors first evaluates blogs and podcasts by a Social Media Index (SMI) score. The SMI gauges the source's amount of exposure in the FOAM community. From there, the content of the resource is assessed and scored in various attributes including accuracy, utility, evidence base, and referencing.[2] Approved resources receive the AIR stamp of approval and are included in ALiEM's Individualized Interactive Instruction (III) initiative.[3]



> "…One can begin to see the system by which FOAM could be globally vetted. Using structures already in place, we have access to a robust and unbiased group of peers... What we currently lack is the organization, collaboration, and unity to do it."

This framework is ALiEM's approach and, like peer review, has its pros and cons. An in-depth look at these would require an entire article. One immediate criticism is in the SMI score. We certainly know that social media popularity does not assure quality. In our current approach to FOAM we rely on the notion that the cream will rise, but one must believe wholly in this idea to adopt the SMI score into the vetting process. Doing so erects a barrier to the talented but as yet undiscovered. On the other hand, in an expanding sea of original productions, it provides some semblance of a selection process.

With this foundation one can begin to see the system by which FOAM could be globally vetted. Using structures already in place, we have access to a robust and unbiased group of peers. In the modern digital era the analysis of a resource can happen asynchronously across states, regions, and the world. What we currently lack is the organization, collaboration, and unity to do it. To be successful, the vetting process will have to be reviewed and accepted by multiple national societies and communities. Open communication and partnership will be vital. If we can do this, our specialty can create a vetting process for FOAM and bring order to this fantastic, powerful resource.

*Have an opinion, commentary, or perspective on the matter? Interested in helping bring this infrastructure to fruition? Please reach out to me via Twitter: @JayHineMD*

** Notably not FOAM.*

**References:**

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3. ALIEM AIR: https://www.aliemu.com/air/.

AAEM/RSA President's Message

# RSA Year in Review

Mary Haas, MD

With the academic year coming to an end, the RSA board took time to reflect on our major accomplishments. The 2016-17 year proved to be a tremendous year of growth for RSA. We began the term with an excellent strategic planning session, where we reviewed the current state of our organization, the direction in which we wanted to go, and how best to move forward. From that came our new logo:

AAEM RSA
Innovate. Educate. Advocate.

We also revised our vision and mission statements to better reflect the current landscape of emergency medicine, and to distinguish our resident- and student-specific initiatives as an organization independent from AAEM, while continuing to honor the core principles of AAEM that we champion for residents and students.

- **Vision:** An accessible, collaborative organization that fosters innovation, education and advocacy for residents and students in emergency medicine.
- **Mission:** We provide resources and opportunities that educate, inspire, and inform emergency medicine trainees. AAEM/RSA also supports and educates residents on the core tenets of AAEM, including the necessity of fair practice environments and the requirement for board certification of all practicing emergency physicians.

In addition, we significantly altered our leadership structure. In the past our various committee chairs also served on the board of directors. This year we expanded the number of leadership positions available to our members by separating committee chair and vice-chair positions from the board of directors. At-large board members will now serve as liaisons to committees. We also combined our Publications and Communications Committees into one Social Media Committee. In the coming year, we will also consolidate our Membership Committee, VP Council, and former student "site coordinators" into an RSA Representatives Council. This will allow us to streamline our recruitment processes and communications with various residency programs and medical schools. We also began using Slack as a means of communication in addition to email, to provide an easier forum for discussion among committees and to keep our discussions organized by topic and project.

Michael Wilk, MD, and Isabel Malone, MD, represented AAEM and AAEM/RSA in Puerto Rico at the ACMT17 joint resident & student toxicology track.

We developed two new awards, including a Program Coordinator Award to be given at the Scientific Assembly, and a Committee Member of the Year Award to honor RSA members who have shown dedication and commitment to RSA's goals and objectives through their committee work.

RSA has also focused on improving collaboration with other EM organizations. For the first time, our board of directors met with the leadership of SAEM, CORD, EMRA, and ABEM at various national conferences. We participated in the EM Wellness Summit hosted by ACEP and CORD, as well as ABEM's EM Consortium on Third Party Standards, and we will serve as sponsors for SAEM's very popular resident dodgeball competition. With EMRA, we co-hosted a social for resident attendees and planned CORD's Resident Track with our EMRA colleagues.

Our Social Media Committee transitioned *Modern Resident*, which was a bi-monthly email newsletter, into the popular peer-reviewed "Modern Resident" blog. Our old "Fact of the Day" has also been turned into a "Tweet of the Day," to increase activity on our Twitter account.

The Education Committee is in the process of developing a podcast curriculum that will help us showcase the wonderful speakers in AAEM, and provide an additional educational resource for our members. We also released our Toxicology App.

We provided nominees to ACGME for a resident representative on the EM RRC, and are proud that one of our nominees was accepted to the position.

Our Advocacy Committee developed brief, high-yield presentations on key advocacy topics and is working on expanding our Advocacy Day in June. We will also provide funded scholarships for our congressional elective.

The International Committee stepped up recruitment, reaching out to residents and students at various international medical schools and residency programs. It also assisted with planning the toxicology track for medical students and residents at ACMT.

Our Membership Committee contacted medical schools and residency programs around the country to recruit additional members. The RSA Diversity & Inclusion subcommittee also worked on vision and mission statements, and continued to work on outreach to underserved medical schools.

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The Medical Student Council planned and executed two successful student symposia: the established and popular Midwest Symposium at Loyola University Chicago's Stritch School of Medicine, and a new event at Mount Sinai Medical School in New York City. We are proud to announce that we had 25 medical student ambassadors at AAEM17 this year.

In response to growing concern about physician wellness and burnout, particularly in emergency medicine, we also established a new Wellness Committee. The committee is gathering survey data from resident and student members that will help guide interventions to promote wellness in emergency medicine trainees.

It has been a privilege and honor to serve as RSA president, and to work with an incredible team of student and resident leaders. I look forward to remaining on the board of directors in the coming academic year, as immediate past-president. I am confident that the incoming president, Ashely Alker, MD, will continue to fuel RSA's incredible momentum in the 2017-18 year, and I will continue to support her in those efforts. ■

AAEM/RSA Editor's Message

# My Letter to Interns

Mike Wilk, MD
Brown EM, PGY1

As I neared the end of an overnight shift early in my intern year, I tried to shake off the fatigue as I prepared for a paracentesis on a patient with hepatic encephalopathy. After finding a large fluid pocket with ultrasound, I stuck the needle into his abdomen. I initially had no return, so I went farther. Again, no return. I eventually handed the syringe to my senior, and watched him press in literally a quarter inch more and get an easy return. "You have got to be kidding me!" I thought to myself. In some ways, this early experience perfectly sums up how internship can feel: I'm starting to get it, but I'm not quite there yet. Intern year remains one of the most challenging but formative years in the emergency physician's career. As I near completion of my intern year, I want to share a few tips and pearls for next year's class.

I won't delve deeply into finances, but I do think it is important to touch on student loans. Whether you choose to ignore them or not, loan payments will come due six months after graduation. For those considering the ten-year Public Loan Forgiveness Program, enroll as soon as possible in one of the income-driven repayment plans such as PAYE or REPAYE. These plans qualify towards the ten years of forgiveness starting in residency, and are very affordable for most residents.

> "You will be pushed to your limit and beyond, but surprisingly may find yourself enjoying your time in the hospital much more than when you were a medical student. Within the first few weeks, your resident-colleagues will feel like family."

Expect to feel overwhelmed and incompetent at times. It is easy to begin wondering if you have what it takes to be a successful resident. You may miss a diagnosis or find yourself unable to complete a procedure on your own. Despite the times I have beaten myself up during these moments, I have tried to keep in mind that I learn more from the times I miss than the times I succeed. When you miss a lumbar puncture or other procedure, ask yourself, "What could I do differently next time to succeed?" You may be wondering if there is anything else you can do to prepare clinically before starting your first month. Regardless of what you do to prepare, the learning curve during your first few months is incredibly steep. Half the battle is simply showing up. I was certainly surprised to find that learning the medicine was not the most difficult part. Instead, it was navigating through our increasingly complex hospital system.

It is no secret that emergency physicians take home the award each year for highest rates of burnout of any specialty. It may be nearly impossible to have work-life balance during residency, but pay attention to wellness. Take advantage of your time off, whether it is spending time with your family or enjoying your favorite hobby.

Learn to say "no." Many of you were highly involved in numerous organizations and projects during medical school. There will again be numerous opportunities to get involved, from teaching medical students to research projects. Remember, it is completely acceptable to say "no." The clinical work hours of residency can be burdensome enough. If you do get involved, try to pick the projects you will truly enjoy or find rewarding.

The ACGME lifted the 16-hour shift limit for this year's incoming class, meaning interns can now be expected to work up to 28 hours in a single shift. This change is unlikely to impact your shifts in the emergency department, but is something to be aware of as you go through your off-service rotations.

You will be pushed to your limit and beyond, but surprisingly may find yourself enjoying your time in the hospital much more than when you were a medical student. Within the first few weeks, your resident-colleagues will feel like family. But most importantly for now, take the precious few weeks of freedom you have left and enjoy life! Intern year will no doubt be one of the most challenging, but at the same time the most exhilarating years of your life. ■

Resident Journal Review

# The Challenge of Identifying a Septic Joint

Authors: Raymond Beyda, MD; Lee Grodin, MD; Jackie Shibata, MD; Ted Segarra MD
Editors: Kelly Maurelus, MD FAAEM and Michael Bond, MD FAAEM

The ED evaluation of patients with acute monoarthritis is often challenging given the broad differential diagnosis and significant morbidity which can result from missed septic arthritis (SA). The following articles aim to simplify the work-up of the undifferentiated hot and swollen joint.

### Couderc M, Pereira B, et al. Predictive Value of the Usual Clinical Signs and Laboratory Tests in the Diagnosis of Septic Arthritis. *CJEM.* 2015. 17(4):403-410.

This study was a prospective observational cohort study of 105 adult patients. Patients with acute monoarthritis were evaluated with white blood count (WBC), erythrocyte sedimentation rate (ESR), C-reactive protein (CRP), uric acid level, joint radiography and some with an ultrasound. Arthrocentesis and analysis of synovial fluid was performed with appearance of the aspirate documented as either clear, turbid, purulent, or hemorrhagic. The history, physical examination, and data obtained from the above studies were synthesized to estimate the probability of SA. Positive cultures from blood or synovial fluid confirmed the diagnosis of SA.

Of 105 patients, 29 (27.6%) had SA and 9 (8.6%) were considered to possibly have SA. The most common diagnosis of remaining 67 patients was crystal-associated arthritis. Multiple rheumatologic joint diseases were also found. Patients with SA were slightly younger (58.6 vs 60.5 years old, p=0.03) and their symptoms lasted longer (2.6 vs 1.8 weeks, p=0.04). Conversely, the non-SA patients presented more acutely, i.e., <24 hours (72.3% vs 46%, p=0.008). Patients with SA reported more chills (39.5% vs 17.9%, p=0.01) and localized erythema (52.6% vs 28.4%, p=0.01) as well as report of potential port of entry through the skin (71.1% vs 46.3%, p=0.01). Finally, a history of crystal-associated arthritis was more common among the non-SA group (28.4% vs 5.3%, p=0.004). ESR and CRP elevations were present more commonly in the SA group (mean ESR 76.1 vs 45.7 [mm], p=0.002 and mean CRP 135 vs 95.1 [mg/L], p=0.015). Suggestive radiographic findings were more frequent in SA patients (29.7% vs 5.1%, p=0.001). Purulent synovial fluid was more common among SA patients (74% vs 26%, p=0.001) and the synovial fluid WBC was higher (54,900 vs 15,000 [cells/microL], p<0.001) in the SA group.

Importantly, no finding was sufficiently sensitive to exclude SA. Positive Gram stain had 100% specificity but only 40% sensitivity. This finding had the highest positive likelihood ratio (LR) approaching infinity, with a disappointing negative LR of only 0.6. Radiographic findings were similarly highly specific (95%) but not sensitive (30%) with a positive LR of 5.8. In this study, radiographic findings suggestive of SA were defined as decreased joint space, demineralization of bone, bony erosions, and joint destruction. Grossly purulent synovial aspirates were somewhat diagnostically useful compared to other collected data with a positive LR of 4.7. Likelihood of SA increased as the synovial fluid WBC count increased with a positive LR of 3.1 for a WBC >50,000 and LR of 3.9 for WBC >100,000 (cells/microL).

One model derived in this study from multivariate analysis used chills (OR=4.7, 95% CI 1.3-17.1), a history of crystal-induced arthritis (OR=0.09, 95% CI 0.01-0.9), purulent synovial fluid (OR=8.4, 95% CI 2.4-28.5), and radiographic findings suggestive of SA (OR=7.1, 95% CI 13-37.9), with a corresponding area under the curve (AUC) of 0.84. A second model used chills, a history of crystal-induced arthritis, synovial WBC greater than 50,000 cells/mm3 (OR=6.8, 95% CI 1.3-36), a port of entry for infection (OR=3, 95% CI 0.9-10.2), and SA risk factors (OR=3.1, 95% CI 0.87-11) including diabetes, cancer, immunosuppression, alcoholism, chronic kidney disease, and chronic steroid therapy, with a corresponding AUC of 0.87.

While no single finding can sufficiently exclude SA, features from the history, physical, radiography, and synovial fluid analysis should all be considered when considering the diagnosis of SA.

### Borzio R, Muchandani N, Pivec, R, et al. Predictors of Septic Arthritis in the Adult Population. *Orthopedics.* 2016. 39(4): 657-663.

This study identified 458 patients with possible SA. Patients with prosthetic or post-operative infections, incomplete clinical or imaging data, atypical pathogens, and femoral osteomyelitis were excluded (n=188). No patients were given antibiotics prior to joint aspiration. Objective laboratory data including ESR, hematocrit, WBC with differentiation, synovial fluid analysis, synovial gram stain and culture was compared.

Using the receiver operating characteristic (ROC) curves, the authors determined the positive and negative likelihood ratios for reported fever, documented fever, weight-bearing status, synovial fluid WBC count, and segmental leukocyte differential. The gold standard for diagnosis of SA was positive synovial fluid culture.

In this study, 22 patients had SA. Of these, 15 (68%) had positive gram stains. Patients with SA were younger than those with other causes. The two groups showed no statistical difference in regards to reported or documented fever, weight-bearing status, ESR, serum WBC count, serum neutrophil percentage, or mean synovial fluid WBC count.

However, the most helpful finding was the mean synovial WBC count. In those with SA, it was 70,581 cells/microL and in those without SA, it was 26,758 cells/microL. The cell count differential of synovial fluid in the two groups had no statistically significant differences (neutrophil, lymphocyte, monocyte, RBC). A synovial WBC count of 64,000 cells/microL was examined using the ROC curve to reveal the AUC. This produced a specificity of 90% and a sensitivity of 40% for SA. The LR for synovial fluid WBC of 40,000 cells/microL was 1.88 (95% CI, 0.90-3.93), for 50,000 cells/microL was 2.02 (95% CI, 0.94-5.11), and for 65,000 cells/microL was 2.8 (95% I 1.2-6.7).

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The authors of this study suggest that a value above this cutoff value [64,000 cells/microL] should be interpreted as true SA and irrigation and debridement should not be delayed for additional studies.

**Margaretten ME, Kohlwes J, Moore D, Bent S. Does This Adult Patient Have Septic Arthritis? *JAMA*. 2007;297(13):1478-88.**

Margaretten, et al., performed a systematic review of studies from 1966-2007 containing original data from patients presenting with acutely swollen or painful joints presenting to a rheumatology clinic, ED, or while hospitalized. Articles were excluded if they did not include a gold standard. The gold standard for diagnosis of SA has traditionally been positive cultures from synovial fluid; however, the authors realized this is a suboptimal gold standard citing that sensitivities of such cultures range from 75-95%. As such, the authors expanded their gold standard to include any of the following: positive Gram stain, positive blood culture, culture-negative aspirate that was described as "macroscopic pus," or response to antibiotics.

Investigators used LRs to distinguish SA from other causes of acutely swollen or painful joints. Only two of the studies reviewed examined risk factors for developing SA. Age older than 80, diabetes mellitus, rheumatoid arthritis, existing prosthesis and skin infection all had positive likelihood ratios (+LR) 2.5-3.5. However recent joint surgery had a +LR of 6.9 and skin infection in combination with joint prosthesis had a +LR of 15. HIV infection was found to have a +LR of 1.7.

Pain in the joint had a sensitivity of 85%, a history of swelling had a sensitivity of 78%, while sweats and rigors were poorly sensitive (27% and 19% respectively). Fever was evaluated in seven studies and had an overall sensitivity of 57%. Interestingly, one study calculated the LR of fever and found a value of 0.67, signifying that SA was less likely when the patient was febrile.

The authors found that elevated serum WBC count (>10,000/microL), ESR (>30mm/h) and CRP (>100 mg/L) all had limited diagnostic power, citing +LRs of less than two for each abnormal value. A synovial fluid

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WBC count less than 25,000/microL had a +LR of 0.32; >25,000/microL had a LR of 2.9; >50,000/microL had a LR of 7.7; lastly a synovial WBC count >100,000/microL had an LR of 28. The authors also included four studies looking at the differential cell count of synovial WBCs and found that differentials which had >90% polymorphonuclear (PMN) cells had a +LR of 3.4. Of note, one study measured synovial lactate dehydrogenase (LDH) and found that while a level >250 U/L was only 50% specific, this cutoff was 100% sensitive for ruling out SA.

There were several limitations to this review. First, only two of the studies included were prospective in design allowing for many biases inherent with retrospective data collection. Secondly, some studies included very few patients. For example, LDH was found to be 100% sensitive, but only 8 patients in that study were diagnosed with SA. Also, there exists a large variation in the results of the studies examined. For instance, the authors conclude that synovial WBC counts >50,000/microL had a respectable +LR of 7.7; however the actual five LRs reported from each study range from as low as 2.2 up to 19.0. This wide range makes it difficult to rely on this cutoff for clinical answers. Lastly, studies conducted outside the ED were included so results may not be directly applicable to patients presenting only to the ED.

This study still demonstrated some important findings. Specifically, recently post-operative patients or those with a previous prosthetic joint with overlying cellulitis have high odds of SA. History, physical exam, and serum blood tests, while helpful, cannot alone rule in or rule out SA. Synovial fluid analysis is vitally important when evaluating for SA. It may be prudent to empirically treat patients with high synovial WBC counts or with a high percentage of PMN cells on the differential count prior to availability of culture results. Synovial LDH may be very helpful in single-handedly ruling out the disease, but like all the data presented here, stronger, prospective, ED studies need to be performed before it can be relied upon for this highly morbid diagnosis.

### Carpenter CR, Schuur JD, Everett WW, and Pines JM. Evidence-based Diagnostics: Adult Septic Arthritis. *Acad Emerg Med.* 2011. 18(8):781-796.

In this systematic review of adult SA, Carpenter and colleagues reviewed data from 32 diagnostic trials in order to identify characteristics of history, physical exam, and bedside laboratory tests which may correctly identify non-gonococcal (NGC) SA in patients presenting with a complaint of monoarticular arthritis.

Trials including patients with the presenting complaint of monoarticular arthritis were included as long as they contained sufficient detail to reconstruct partial or complete 2x2 contingency tables for the determination of diagnostic test characteristics using an acceptable criterion standard for SA. Studies were excluded if they did not include ED patients or focused primarily on gonococcal arthritis, pediatric patients, or therapy. Case reports and narrative reviews were also excluded.

The authors determined the prevalence of NGC SA in patients with monoarticular complaints to be 27%. Analysis revealed that very few aspects of history, physical exam, and serum testing had any significant effect on post-test probability. However, most of the analysis was limited by incomplete data in the original studies. The historical components found to be significant predictors of SA were prior joint surgery (+LR 6.9) and presence of a skin infection overlying a prosthetic hip/knee (+LR 15.0). Although joint pain was fairly sensitive (85-100%), none of the studies included adequate data for calculating specificity, and so LRs could not be calculated. From physical exam, most studies only described joint tenderness (sensitivity 100% in one study) and fever, but none had complete information for calculation of LRs. In addition, the cutoffs for fever differed greatly among studies, and most studies did not describe timing of the fever.

Lack of data also prohibited many conclusions concerning serum markers. Only two studies calculated the sensitivity and specificity of leukocytosis, but no studies found an acceptable sensitivity of overall diagnostic accuracy for diagnosing SA. ESR and CRP were assessed but the sensitivities varied widely among all studies. Procalcitonin, tumor necrosis factor, and multiple cytokines were also assessed but they showed only modest specificity, and very poor sensitivity. Blood culture sensitivity ranged from 23-36%, but no specificity data was available.

For synovial fluid analysis, the authors determined that a synovial WBC (sWBC) count >50,000/microL had a summary +LR of 4.7 and a -LR of 0.52. Further, for a sWBC count >100,000/microL, the summary +LR is 13.2 and the -LR is 0.86. However, there was significant heterogeneity (I^2 >25%) between the trials when comparing the sensitivities and specificities for these ranges, and this heterogeneity could only be reduced by excluding certain data sets. LR intervals were also calculated, but the data was calculated using only the four trials that reported sWBC counts with an adequate degree of information to allow for the calculations to be completed. They identified the following sWBC interval LRs: 1) 0-25,000/microL with +LR 0.33; 2) 25,000-50,000/microL with +LR 1.06; 3) 50,000-100,000/microL with +LR 3.59; and 4) >100,000/microL with +LR 13.2. One trial determined that a synovial lactate dehydrogenase level less than 250 units/L may be adequate to exclude SA. In addition, four trials revealed high +LR for synovial lactate levels >10mmol/L (+LR 21, -LR 0.16). However, the remaining markers, including the percentage of synovial polymorphonuclear cells, synovial glucose, synovial protein, and presence of positive Gram stain did not significantly affect the likelihood of having SA.

There are several major limitations of this review. The majority of the studies were retrospective, so the patients that were studied and the tests they received were possibly affected by verification bias, thus falsely increasing the sensitivity and decreasing the specificity within the study. Similarly, these studies were limited by spectrum bias, as the majority of the patients screened were skewed toward higher-severity illness, leading to false elevation of sensitivity. The authors conclude that history, physical, and serum testing do not significantly alter post-test probability. However, the majority of their data points did not include adequate information to calculate complete sensitivity and specificity and the studies had high degrees of bias and heterogeneity, thus making it unclear whether the lack of significant findings reflected a type II error.

Despite these significant limitations, the authors note the importance of determining a clinical decision rule for SA that might be able to incorporate some of the aspects of history and synovial fluid analysis that they

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identified as having higher LRs. This study does a good job of demonstrating a statistically sound method for determining when to continue testing (test threshold) and when to begin treatment (treatment threshold). Nevertheless, its actual calculations are significantly limited by the quality of the studies that it incorporated, and further prospective studies will be needed in order to ascertain the true sensitivities and specificities of all these markers.

### Conclusion

Acute monoarthritis is a common chief complaint encountered in EDs and SA is a do-not-miss diagnosis. However, its exclusion is very challenging, with few data points possessing sufficient sensitivity to rule it out. Arthrocentesis is essential when the diagnosis is suspected. While focusing on single variables from the history, physical examination, blood work, radiography, and synovial analysis is limited in terms of making the diagnosis, incorporating several of these features in the right clinical context can significantly increase the probability of disease.

In particular, a history of prosthetic joints, overlying skin infection, grossly purulent synovial fluid, elevated sWBC, positive Gram stain, and synovial lactate >10mmol/L can increase the probability of disease. A logistical factor in the inclusion of synovial lactate in the work up is that oftentimes, the synovial fluid can be too thick to allow for accurate measurement by the analyzer, so the lab can add hyaluronidase to the sample to digest the proteins to liquefy it, making for easier analysis, and without affecting lactate levels. Given the significant +LRs in these studies, eliciting these features in the history and examination, ensuring adequate examination of the synovial fluid by obtaining a gram stain, sWBC, and synovial lactate, should be essential components in the work up of a suspected septic joint. ■

# Thank you to our 2016-2017 100% Residency Groups!


The following residency programs have registered all of their residents as AAEM/RSA members for the 2016-2017 year. We sincerely appreciate the enthusiastic support of these physicians and their programs.

Advocate Christ Medical Center
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Medical Student Council President's Message

# Reflections on the Fourth Year: Finding Your Fit

Stephanie Cihlar, MS4

Congratulations to all the fourth year medical students who will soon be graduating and moving on to the next phase of their training! As we approach the end of the academic year, I have been reflecting on the tough decisions that the final year of medical school brings. For most of my fourth year, I was not sure what I was looking for in an EM residency. As I progressed through away rotations and into interview season, my idea of the best residency fit changed almost weekly. Luckily, I got a lot of great advice along the way and would like to pass on three tips I found especially helpful. I hope the next class of students finds this advice useful as they begin the exciting but grueling process of finding their best residency fit.

### 1. Choose Your Away Rotations Purposefully

Thinking about what you want in a residency should start when you apply to away rotations. I applied and chose my aways based on the reputation of the residency program, but in retrospect I suggest taking a different approach. EM is a diverse field with practice environments that range from academic to community and urban to rural, with so much in between. Unless you are sure of the practice environment you want in residency, it is helpful to choose rotations that reflect the variety of the field. Aways can also be a useful tool for students trying to match in some of the more competitive regions such as the east coast, California, and Texas – so apply and choose thoughtfully!

### 2. Think Long Term

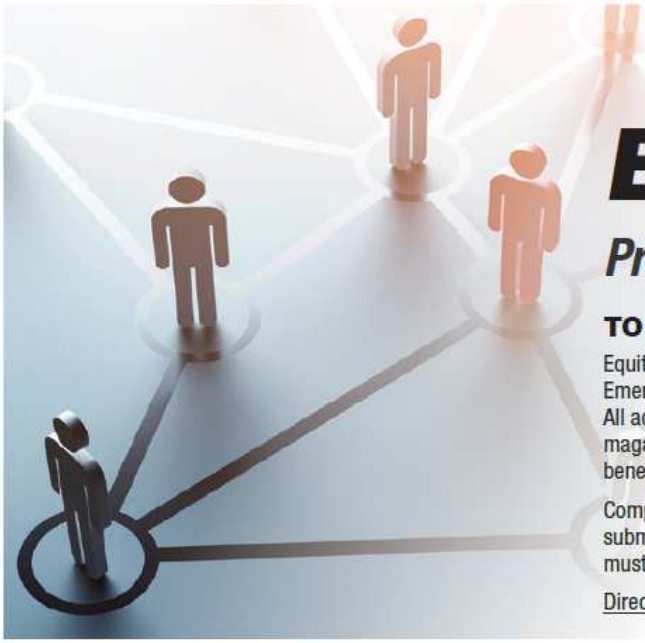
There is a lot to think about when comparing programs. As I struggled to come up with a rank list, an advisor suggested I think about where I would like to be five years down the road. If you are better suited to a career in academics, you may find a better fit with an academic program. Likewise, if you see your future in community EM, you may benefit from a community program. You can apply this strategy to your special interests as well. Programs have different strengths and differ in opportunities related to particular areas of EM such as EMS, toxicology, ultrasound, critical care, pediatrics, global health, administration, etc. There are many directions you can take a career in EM. Finding a program that has the expertise and resources to support you in developing your interests can help you build the career you envision.

### 3. Go With Your Gut

Early on in my interview season I was hyper-focused on the details of each program. I documented patient volume, salary, meal plans, etc. in an attempt to be as objective as possible. However, I quickly found that a growing spreadsheet did not bring clarity to my rank list. Eventually, I put away the spreadsheet and focused on how comfortable I felt with the people who make up the program. Interactions on interview day and pre-interview social events are the best way to get a feel for a program's culture. Make it a point to talk with a variety of people in different roles, and note your level of comfort and compatibility. At the end of the day, you want to match into a program that is made up of good people you can work with comfortably. While considering the objective factors (academic vs. community, location, patient population, etc.), don't discount the subjective feelings you have about the program or the people, positive or negative. In other words, go with your gut!

Lastly, know that wherever you end up, emergency medicine is an incredible specialty with ample opportunity and great people. Congratulations to the Class of 2017, and good luck to the Class of 2018 in the coming year! ■

> "For most of my fourth year, I was not sure what I was looking for in an EM residency. As I progressed through away rotations and into interview season, my idea of the best residency fit changed almost weekly."



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## August 15-18, 2017

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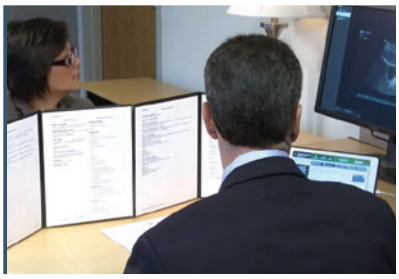
**www.aaem.org/written-board-review 800-884-2236**

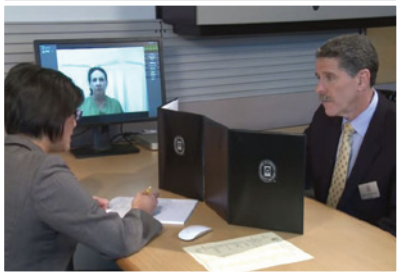
NEW! Hands-On eOral Practice!

AMERICAN ACADEMY OF EMERGENCY MEDICINE

# PEARLS *of* WISDOM FALL 2017

ORAL BOARD REVIEW COURSE





REGISTER TODAY!

We are committed to helping you feel prepared for your Oral Board examination - our course includes the same system that ABEM uses for the board exam.

Practice hands-on with the eOral system including:

- Dynamic vital signs
- An interactive, computerized interface
- Digital images

*AAEM has been granted a sub-license for use of eOral software identical to that used for the ABEM Oral Certification Examination. Case content is entirely that of AAEM.*

PHILADELPHIA
**Saturday & Sunday**
September 16-17, 2017

ORLANDO, DALLAS, CHICAGO
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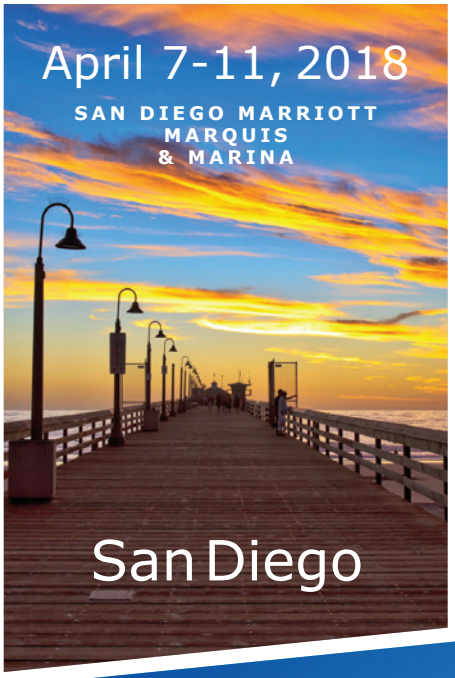
# Call for Educational Proposals

June 1-26, 2017

Share your educational expertise and submit a proposed talk for the 24th Annual AAEM Scientific Assembly!




AMERICAN ACADEMY OF EMERGENCY MEDICINE

24th Annual Scientific Assembly

**Deadline: June 26, 2017**
Submit proposals at:www.aaem.org/AAEM18

Proposals will be accepted June 1-26, 2017. Submissions should include:

- Suggested Title
- Session Type
- Brief Course Description
- Educational Goals and Objectives
- Suggested Speaker

Submitted proposals will be reviewed by the AAEM Education Committee-Scientific Assembly Planning Subcommittee.