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EMERGENCY MEDICINE

COMMONSENSE

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INSIDE

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COMMONSENSE

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AAEM Mission Statement

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

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

Membership Information

Fellow and Full Voting Member: $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)
Resident Member: $60 (voting in AAEM/RSA elections only)
Transitional Member: $60 (voting in AAEM/RSA elections only)
International Resident Member: $30 (voting in AAEM/RSA elections only)
Student Member: $30 or $60 (voting in AAEM/RSA elections only)
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*Fellows-in-Training membership includes Young Physicians Section (YPS) membership.

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President's Message

Where Are We Going?

Kevin Rodgers, MD FAAEM
AAEM President

Every two to four years the AAEM board of directors holds a strategic planning session, to determine the future direction of the Academy. This is often accomplished following the election of a new president. In May we held such a session in Milwaukee, and we were fortunate enough to coax one of our past presidents, Tom Scaletta, into joining us to facilitate what turned out to be a very successful session. I would like to review AAEM's strategic plan, and in turn, ask your assistance in helping us accomplish some lofty goals.

- **Increase AAEM's advocacy efforts and impact on federal legislation affecting emergency medicine.** The specific goals are to increase AAEM's presence in D.C. as the go-to organization in EM, to develop new strategies to attain our "Due Process Guarantee" agenda with CMS and Congress, and to increase our involvement with non-governmental agencies on EM issues. Williams and Jensen, our D.C. representative — in conjunction with AAEM's Government/National Affairs Committee, led by Kevin Beier and Terry Mulligan — will be developing specific strategies to accomplish these goals. Terry Mulligan will also be investigating the development of a day-long conference on Health Policy and Advocacy, which will be held in conjunction with our Advocacy Day on the Hill each year.
- **Define AAEM's image — what makes us different?** We've created a Marketing Task Force chaired by Megan Healy, whose primary goal is to formulate recommendations for a marketing plan. This plan would potentially include creating a new AAEM slogan as well as developing an AAEM marketing video. Another layer of this effort will be led by Bob Stuntz and the Social Media/Communications Committee. It will focus on improving AAEM's social media presence on a more consistent basis, with the goal of enhancing collaboration and education for AAEM members as well as the EM community in general.
- **Retain and recruit, and increase membership.** The Membership Committee, led by Chair Andy Mayer, and that committee's liaison to the board of directors, Brian Potts, are exploring strategies to attract new members and retain current members. They would love to hear your suggestions, specifically aimed at converting RSA and YPS members to full voting members. Other areas for investigation include the impact of providing "swag gear" during residency visits, the development of incentive programs such as a new-member-referral dues discount and free membership for program directors who sign up their entire residency, as well as strategies to identify and attract emergency physicians who feel disenfranchised in their current practice setting.
- **Improve emergency physician wellness and resiliency.** The recently established Wellness Committee, under the direction of chair Robert Lam and board liaison Jonathan Jones, is actively recruiting members to research strategies aimed at improving the wellness and resilience of emergency physicians. Their efforts, in conjunction with The EP Wellness and Resilience Summit to be held in February 2017, will direct future AAEM programs focused on preventing physician burnout. A number of board members will also be designing and implementing a research study to examine EM workplace parameters that might impact physician wellness.

- **Maintain and expand efforts to make AAEM the go-to organization for emergency medicine education.** The Education Committee, led by Kevin Reed and board liaison Jonathan Jones, as well as the Scientific Assembly Sub-Committee, led by Evie Marcolini and Chris Doty, are spearheading efforts to create novel methods to deliver quality education during the Scientific Assembly, thus maintaining its position as the number one conference for the board certified specialist in emergency medicine. Also in development are workshops to mentor up-and-coming new speakers, opportunities to mentor our medical student ambassadors, and our Leadership Development Track for members interested in leading the Academy in the future. The Education Committee and the Social Media/Communications Committee are investigating avenues to provide free member access to all AAEM content. You may already have noted their first efforts via AAEM Online, with member access to Scientific Assembly videos and links to a variety of PK talks. A task force led by Andrew Phillips is hard at work, developing a new Comprehensive Written Board Review Course and App that will use a variety of content delivery formats, meeting the needs of every type of learner.

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- **Develop, refine, and implement strategies that will allow AAEM to positively impact the development of EM as a specialty internationally.** The International Committee, chaired by Ashley Bean with board liaison Terry Mulligan, will lead efforts to create a tool kit to help countries establish emergency medicine as a specialty, create an EM System, and set up board certification and fair practice environments. Other goals include the creation of new international chapters of AAEM, similar to the Mediterranean Chapter, and the development of an "International Audit" aimed at assessing the needs of countries developing emergency medicine.
- **Market and grow the AAEM-Physician Group.** You may have noted the recent ground-breaking news from the AAEM-PG, which proudly announced that Greater San Antonio Emergency Physicians (GSEP) joined as the inaugural physician group. The AAEM-PG seeks to improve the environment for emergency physicians and their patients by creating a large, national group that adheres to the values of AAEM. Emergency physicians under the AAEM-PG umbrella practice in a setting based on the equal partnership of professional colleagues, where each member is an owner. This will allow them to more fully enjoy the practice of EM and better tolerate its stresses. Patients will in turn be better served by these more professionally satisfied physicians. Success of the AAEM-PG is obviously a primary goal for the Academy!

These are lofty but attainable goals. Mostly we need your input, ideas, direction, and hard work. The success of the Academy has always been built on the tremendous efforts of our members. Looking for an opportunity to make a difference? Looking to develop a niche? Join a committee or a task force, or just send me your ideas. ■

This is life as an AAEM member — 2017 Renewals begin Oct. 1!

You are connected.

AAEM is over 8,000 members strong and growing. We offer multiple ways for you to get involved with the topics that matter most to you through engaging committees & projects plus multiple ways to network with fellow members in the U.S. and around the globe.

You have an advocate in your corner.

For over 20 years we have been committed to your personal and professional well being. Our primary concern is supporting you: your practice rights, your autonomy, your relationship with your patients. That's the AAEM difference.

You have access to top-tier benefits.

From our extraordinary education to exclusive discounts on the best EM products – AAEM brings you a high-quality membership experience. As always, we offer FREE registration to our Annual Scientific Assembly for members with a simple fully-refundable deposit – an outstanding value among EM professional associations.

You have a strong voice.

Your concerns reach the ears of our leaders in Washington. AAEM actively works to ensure the needs of EPs are being addressed on the national and state levels. We offer support & legal assistance to members whose rights are threatened. The strength of the Academy is in your corner.

Crossing the Line

Andy Walker, MD FAAEM
Editor, *Common Sense*

First, my thanks to Asst. Editor Dr. Jonathan Jones for editing this issue with little or no help from me. After 23 years in our home in Nashville my wife and I moved to Chattanooga this summer, and Jonathan saved me by taking on a lot of extra work. Second, and once again, the column below is my personal opinion — nothing more and nothing less — and not a statement from the American Academy of Emergency Medicine. And finally, I would love to hear from some of you who are members of both the Academy and the College. Why did ACEP elect someone from EmCare's upper management to its presidency? Am I a paranoid lunatic for seeing a conflict of interest in the two roles?

As perhaps the most honorable of the learned professions, medicine has had a stringent code of ethics for millenia. At some point during our entry into the profession, almost all of us swear an oath to assume ethical obligations that go far beyond those of businessmen and tradesmen. Whether it's the Oath of Hippocrates or some other pledge, we agree to put the health of our patients above our own self-interest and to maintain confidentiality, among other things. Among those other things is something that is becoming more and more forgotten or widely ignored: the pledge to treat our colleagues as family. In fact, the World Medical Association's Declaration of Geneva specifically says, "My colleagues will be my sisters and brothers." Traditionally, the most common and concrete example of that was not charging other physicians for our services, or not charging anything beyond what insurance pays, known as "professional courtesy." I still follow this custom (and extend it to all employees of the emergency department — physicians, nurses, clerks, janitors, etc.).

Does our ancient code of professional ethics mean anything in this day and age? Patients hope so. I hope so. I certainly believe it does, and I hope you do too. Which brings me to the issue I want to address: does it violate medical ethics to work for a contract management group (CMG) like EmCare, TeamHealth, the Schumacher Group (and its recently acquired ECI), ApolloMD, US Acute Care Solutions (and its subsidiary, EMP), and others? Before trying to answer that question, let's look at why I ask it at all.

It seems clear to me that CMGs prey on and exploit emergency physicians for the benefit of their managers and shareholders. If you doubt that you should go back and read Bob McNamara's article on page eight of the Jan/Feb 2010 issue of *Common Sense*, "Give a Shift a Week to the Company: An Analysis of the TeamHealth IPO" (http://www.aaem.org/UserFiles/file/commonsense0110.pdf). Or read Mark Reiter's analysis of EmCare on page 41 of the Nov/Dec 2013 issue, "EmCare Goes Public — Again" (http://www.aaem.org/UserFiles/NovDec13CommonSense.pdf). You will see that after charging emergency physicians for services provided, such as coding/billing and malpractice insurance (both usually provided by a subsidiary of the CMG, rather than shopped to outside vendors), CMGs then take another 20-25% of an emergency physician's collected professional fees — and that's on the average contract. That adds up to between one and two million dollars over the course of a physician's career. Even worse from a patient's point of view, CMGs routinely force physicians to waive their rights to due process and peer review as a condition of employment — meaning an emergency physician can be

fired and stripped of medical staff privileges for any reason, or for no reason at all — making it impossible for us to be the strong advocates for patients that our ethical code demands. If you find that hard to believe, reread the President's Message from Kevin Rodgers in the recent May/June issue of *Common Sense,* or Google "Wanda Cruz" and see what comes up. Emergency physicians are fired every day in this country, not for being bad doctors, but precisely because they are good doctors who are fighting for their patients. In addition, many CMGs still put restrictive covenants in their physicians' employment contracts — a practice considered unethical even by the legal profession.

So, is simply working for a CMG unethical? In my opinion, absolutely not. After all, if you are an ordinary emergency physician (a "pit doc") taking care of patients in a CMG's ED, you are the victim of unfair and unethical behavior — not the perpetrator. Besides, CMGs control so many jobs in our specialty — in some regions, practically all the jobs — you may have little or no choice but to work for one. But what if you are a traveling doc for a CMG, part of that group of emergency physicians called different things by different CMGs (special ops, the hit team, the strike team, the staffing support team, travel ambassadors, etc.), whose main mission is to staff newly acquired EDs for the CMG? This is more troublesome,

Continued on next page

because these travel teams help the CMG acquire and keep new contracts, often destroying independent, democratic emergency physician groups in the process — groups that didn't unfairly exploit their docs, deprive them of peer review and due process, or bind them with post-employment restrictive covenants. I believe that does cross the ethical line, and violates our profession's ethical demand that we treat our colleagues like family. I admit, however, that it's a close call and reasonable physicians of good will might disagree with me.

On the other hand, what about the doctors who are owners of or upper level managers in CMGs? What about the CEOs, chief medical officers, regional directors, etc. who are responsible for acquiring new contracts, growing the CMG, and increasing shareholder value — those who enrich themselves with the labor of their colleagues who actually take care of patients in the ED? I think those people have definitely crossed the ethical line. Money and self-interest have blinded them to how unfairly they are treating their fellow physicians. They have forgotten our ancient ethical code. They have abandoned the ethical legacy of our profession, adopting the role and ethics of a businessman who thinks anything short of fraud is acceptable. They should be ashamed, and in my opinion such doctors should be sanctioned by their professional societies for violating medical ethics — for exploiting their fellow physicians, depriving them (and their patients) of the protection that comes with peer review and due process, and binding them with contractual non-compete clauses.

I know AAEM would never tolerate having such a doctor in a leadership position. I wish that were true of ACEP too. However, I just received an email announcing:

> "Registration is now open for the EmCare sponsored CME Conference to be held in Atlantic City, NJ. We are extremely proud to announce that this year's conference will include lectures/presentations from both [sic] the current, past and future Presidents of ACEP:
>
> Jay Kaplan, MD FACEP
> *President, American College of Emergency Physicians*
>
> Michael J. Gerardi, MD FACEP FAAP
> *Immediate Past-President, American College of Emergency Physicians*
>
> Rebecca Parker, MD FACEP
> *President-Elect, American College of Emergency Physicians"*

Ignoring for the moment how close this makes the two organizations look, despite one supposedly existing to serve emergency physicians and the other to serve shareholders who profit from the professional fees of emergency physicians, consider ACEP's president-elect. According to EmCare's website, Dr. Parker:

"Serves as Senior Vice President of Practice and Payment Integration for Envision Healthcare and Executive Vice President for Leadership Development and Education for EmCare […] Dr. Parker has served in numerous ACEP leadership positions over her 20 years of membership including chair of the ACEP Board of Directors, chair of the ACEP's formidable Coding and Nomenclature Advisory Committee, editorial board member for Vital Care and as a member of the finance committee. She has been a leader in the Illinois College of Emergency Physicians, serving as president elect, secretary/treasurer and chair of the Educational Meetings Committee and also served on the Board of Directors of the Texas College of Emergency Physicians." (For those who don't know, Envision Healthcare is EmCare's parent company.)

"Destroying independent, democratic emergency physician groups … groups that didn't unfairly exploit their docs, deprive them of peer review and due process, or bind them with post-employment restrictive covenants. I believe that does cross the ethical line, and violates our profession's ethical demand that we treat our colleagues like family."

For more on Dr. Parker's activities in Illinois, I once again urge you to go back to the Nov/Dec 2013 issue of *Common Sense* (http://www.aaem.org/UserFiles/NovDec13CommonSense.pdf), especially Dr. Carol Cunningham's article, "Lake Emergency Services and the Road Less Traveled." Dr. Cunningham describes the end of her independent EM group and Dr. Parker's role in it as EmCare's Regional Director at the time. What makes her story relevant to ACEP, or at least ought to make it relevant, can be seen in this excerpt from the article:

"At the request of Lake Health's CEO, I met with her in January of 2011 to discuss Lake Health's emergency medical services, since I had served as EMS medical director since 1995. During our conversation she expressed surprise that nearly everyone in LES refused to work for EmCare. She thought that working for a corporation whose regional medical director was on ACEP's board of directors would be attractive to us."

Though it may have been completely unintentional, Dr. Parker's leadership role in ACEP helped EmCare acquire a contract and wipe out an independent, physician-owned EM group.

As Bob McNamara said in the editorial immediately following Dr. Cunningham's article:

"A leader of ACEP helped destroy an independent, democratic emergency medicine group. What purpose did that serve? What these emergency physicians built and nurtured over the course of 25 years was ruined. Dr. Parker was a principal agent in disrupting the careers of the LES emergency physicians. Can any EmCare bonus justify that?"

In October, Rebecca Parker will become ACEP's president. Since the interests of individual emergency physicians so often conflict with the interests of CMGs, that looks like a conflict of interest to me. But what do I know — right? ■

Letters to the Editor

An Issue that is Not Addressed by Either AAEM or ACEP

Whether you work for a mega group or a democratic group, ED physicians are not afforded the same due process as the rest of the medical staff. It takes a horror story to get a staff physician removed from the medical staff of a hospital. Not so with ED physicians. Without cause, and if the CEO tells the contracting group that he wants Dr. X off the schedule, no reason has to be given. There is no due process. All the CEO has to do is wave the group contract in the groups face and it is all over. The ED doc is off the schedule.

ABEM has been the leader in continuous certification, which although it may be cumbersome at times, it does keep us current with the literature and changes in the practice of EM.

We will never be respected, except perhaps in a hospital with an EM residency, as long as we are not treated as true peers of the rest of the medical staff of the hospital we work at. Please forward to the AAEM president. I lost my job at the end of March. Without being egotistical, I was the best physician in the group, and the highest paid. It turns out hearsay from the nurse manager of the department (too slow?) was enough to get me removed. I was never actually removed from the staff, but I am not permitted to work there.

Until ED physicians are treated with due process, we will never gain the respect for the lifesaving work that we do.

— Evan B. Tow, DO FAAEM

AAEM Works for Due Process

Thank you for writing, and I couldn't agree more. More importantly, AAEM agrees too. Our Academy has been working hard for quite some time to assure due process for emergency physicians, mainly by making it impossible for any physician to be deprived of peer review and due process by an employment contract with a third party such as EmCare, Team Health, or other contract management group. For more on this issue, see the article by Dr. Larry Weiss (attorney and former president of AAEM) in this issue of *Common Sense*. ■

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

Strength in Numbers
AAEM 100% ED Groups

■ AAEM 100% ED Group Membership

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

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

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

For a complete listing of 2016 100% ED Group members, go to **www.aaem.org/membership/aaem-ed-group-membership**.

Zika Fight Headlines End of Summer Health Agenda; Work Continues on MACRA Implementation and 21st Century Cures Legislation

Williams & Jensen, PLLC

Zika Funding

As over three million U.S. citizens are at risk of Zika in Puerto Rico and non-travel related cases have begun to emerge in the continental U.S., Congress has recently focused on public health and the Zika virus. The headlines have placed Congressional leaders and the White House under pressure to respond quickly this September. The Administration and Congressional Democratic leaders have backed a plan for $1.9 billion in funding for Zika, while the Senate approved a $1.1 billion package earlier this year. The House agreed to allocate $1.1 billion to combat Zika, but negotiators proposed restrictions on the role of Planned Parenthood in Zika prevention efforts and proposed to repeal certain ACA provisions, which caused the bill to stall upon its arrival in the Senate. Each party blamed the other for playing politics with a serious public health issue.

Amid efforts to strike a compromise, the Administration has shifted existing funds from several sources including the Department of Health and Human Services (HHS) to bolster Zika research, vaccine development, and efforts to contain the spread of the virus. The Vaccine Research Center at the National Institute of Allergy and Infectious Diseases estimates that they will have initial trial results by January 2017, months after the end of peak mosquito season for the U.S.

During the August recess, in a show of bipartisanship, the entire Florida delegation sent a letter to Centers for Disease Control and Prevention (CDC) director Tom Frieden requesting that he reconsider the current allocation formula for Zika-specific funds. Under the current formula, Florida will receive $720,000 in new funding for detecting and monitoring microcephaly and other adverse effects of Zika infection from a pot of $16 million that will be divided among 40 states and territories.

Zika has also commanded the attention of the Presidential campaigns. Democratic Presidential nominee Hillary Clinton responded by proposing a Public Health Rapid Response Fund, which she said would set aside funds annually to allow public health agencies such as HHS, the Centers for Disease Control and Prevention (CDC), state and local public health departments, and hospital systems to "quickly and aggressively respond to major public health crises and pandemics." She cited Congress' failure to enact an emergency funding request and suggested that Zika infections may have been preventable. House Republicans have backed a similar idea, proposing a new reserve fund that would include $300 million to address emergency health issues such as Zika and Ebola. Republican Presidential nominee Donald Trump has also pressed Congress to approve funding to combat Zika.

Some lawmakers urged Congressional leaders to cut short the recess to approve funds for Zika. While this did not happen, discussions have continued in an attempt to send a Zika package to the President's desk quickly after returning to DC in September.

MACRA Implementation

Members of Congress and health policy experts are also closely tracking the implementation of HHS' proposed replacement policy for the Medicare Sustainable Growth Rate (SGR), set forth by the Medicare Access and CHIP Reauthorization Act (MACRA) that was signed into law in 2015. The Centers for Medicare and Medicaid Services published a proposed rule this year, outlining the details of the Merit-Based Incentive Payment System (MIPS) and the Alternative Payment Model (APM) that will allow providers to earn bonus payments beginning in 2019.

Under the law, HHS will begin measuring performance through MIPS on January 1, 2017. Some lawmakers have urged CMS to delay implementation until 2018, citing the need for providers to gain a greater understanding of the options to earn bonus payments. A number of industry stakeholders have supported the delay, expressing concerns over new regulatory burdens on providers and the concern that it will be impractical or impossible for many physicians to participate in advanced APMs. To qualify for the 5 percent bonus under MIPS, a provider must achieve high value care across four performance categories: quality, advancing care information, cost/resource use, and clinical practice improvement activities. Of these four categories, HHS proposes to apply a 50 percent weight in year one to the quality category.

In a joint letter that is being circulated for signatures on Capitol Hill, Members cite concerns that the reporting requirements would make it too complex for providers to qualify for MIPS, and that independent practices are disadvantaged by the proposed rule and could be under further pressure to join larger practices or hospitals.

AAEM, along with other specialty groups and state medical societies, has encouraged HHS to work with stakeholders to design quality measures that make sense for emergency physicians. AAEM also highlighted the importance of providing emergency physicians with robust options to participate in APMs, so that they are not excluded from achieving bonus payments through the use of these models. Participants in AAEM's Advocacy Day received an in-person briefing from CMS officials on the law. At a Congressional hearing this summer, CMS Acting Administrator Andy Slavitt signaled CMS' openness to a delay while the agency's interim final rule is under consideration, increasing the possibility that the law's implementation could be postponed beyond January 1, 2017.

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21st Century Cures

The 21st Century Cures Initiative, led by House Energy and Commerce Committee Chairman Fred Upton (R-MI), has been the subject of renewed efforts to get a bill passed and signed into law before the end of the 114th Congress. The legislation, which would increase funding for the National Institutes of Health (NIH) and streamline the U.S. Food and Drug Administration's (FDA) drug and medical device approval process, was approved by the House last year. Key House and Senate policymakers agree that an amended version could win Congressional passage later this year, but it would require agreement on billions of dollars of pay-fors that could cut spending in other areas of the federal health care budget. This money would be used primarily to pay for additional NIH spending which is a central element of the bill.

Upton's term as Chairman of the influential panel which has much of the nation's health care system under its jurisdiction concludes at the end of this Congress.

ACA and House GOP Health Care Blueprint

The attention to Zika has shifted the focus away from several major Affordable Care Act (ACA) related storylines developing over the summer, including the proposed Anthem-Cigna and Aetna-Humana mergers, and double digit health insurance premium rate increases in states across the country. As more insurance companies have pulled out or suggested they may exit the exchanges, Members of Congress in both parties are keenly aware of the larger impact on the ACA going forward into 2017.

In June, House Speaker Paul Ryan (R-WI) unveiled House Republicans' plan to replace the ACA and reform the nation's health care system. The plan, which was developed by four House Committees, seeks to provide greater flexibility and portability of health insurance by simplifying regulations put in place by the ACA. Speaker Ryan has acknowledged the goal is "not to show that we can send a bill and watch it get vetoed by the president," but that instead it would demonstrate a path forward on legislation should Republicans gain control of the White House in 2017.

The plan proposes a broad set of changes, including a refundable tax credit which would enable Americans who do not have employer-provided health insurance, Medicare, or Medicaid to purchase health coverage. It would also expand the use of health savings accounts (HSAs), institute medical liability reform and place caps on non-economic damage awards, strengthen Medicare Advantage, and provide greater flexibility for states on how they spend their Medicaid dollars.

HHS Agrees to Implement PROP Act

In July, HHS announced that it would administratively implement the policy changes proposed by the Promoting Responsible Opioid Prescribing (PROP) Act. The PROP Act was introduced by Rep. Alex Mooney (R-WV) and Senator Ron Johnson (R-WI) and was supported by AAEM. During the 2016 Advocacy Day, Members described the need for this legislation based on their experiences in emergency departments across the country.

The bill removes the link between patient satisfaction questions and pain management, aiming to mitigate the pressure on doctors to prescribe narcotics. As a result of HHS' decision, pain-related measures are now excluded under the value-based purchasing program (VBP). The sponsors of the legislation hailed the announcement as a common sense change that will help deter opioid abuse. ■

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AAEM Antitrust Compliance Plan:

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

www.aaem.org/publications

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Recognition Given to Foundation Donors

Levels of recognition to those who donate to the AAEM Foundation have been established. The information below includes a list of the different levels of contributions. The Foundation would like to thank the individuals below who contributed from 1-1-2016 to 8-2-2016.

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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All contributions are voluntary and the suggested amount of contribution is only a suggestions. The amount given by the contributor, or the refusal to give, will not benefit or disadvantage the person being solicited.

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Join the AAEM Critical Care Medicine Interest Section!

- **Open to any AAEM or AAEM/RSA member** with an interest in critical care, including students, residents, fellows and attendings. We are looking to gather 50 charter members to kick off this new section.
- **What will the section do for you?** Critical care is an ever revolving field with major advances, and the goals for this section are to keep you up-to-date by writing guidelines or position statements, networking, developing a job database, and providing mentorship.
- **Dues for AAEM members are set at $50** and dues for international and RSA members will be determined soon. Watch the fall membership mailing for more information.

Sign-up with your interest at:
www.aaem.org/forms/critical-care-application.php

AMERICAN ACADEMY OF EMERGENCY MEDICINE

CRITICAL CARE MEDICINE
Interest Section

Upcoming Conferences: AAEM Directly & Jointly Provided and Recommended

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

September 17-18, 2016
- AAEM Pearls of Wisdom Oral Board Review Course
  Chicago, Dallas, Orlando
  www.aaem.org/oral-board-review

September 24-25, 2015
- AAEM Pearls of Wisdom Oral Board Review Course
  Philadelphia, Los Angeles
  www.aaem.org/oral-board-review

September 28-29, 2016
- AAEM Pearls of Wisdom Oral Board Review Course
  Las Vegas
  www.aaem.org/oral-board-review

March 16-20, 2016
- 23rd Annual AAEM Scientific Assembly – AAEM17
  Orlando, FL
  www.aaem.org/AAEM17

AAEM JOINTLY PROVIDED CONFERNCES

September 30, 2016
- PreGameCME: Pediatric Emergency Medicine
  Ann Arbor, MI
  www.pregamecme.com/event/pediatric-emergency-medicine-2016/

October 5, 2016
- AAEMLa Emergency Medicine Resident Conference and Annual Meeting
  New Orleans, LA

November 14-16, 2016
- The Teaching Course
  New York City, NY
  www.the teaching course.com

AAEM RECOMMENDED CONFERENCES

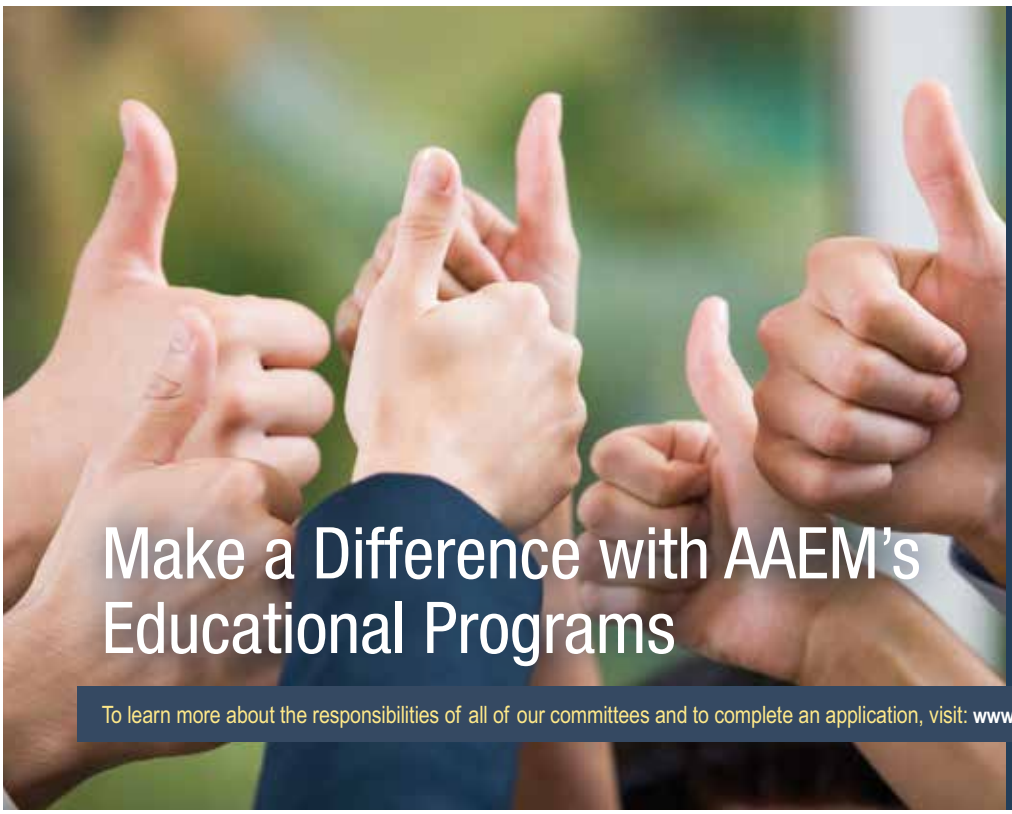
September 30-October 2, 2016
- The Difficult Airway Course: Emergency™
  Boston, MA
  www.theairwaysite.com

November 4-6, 2016
- The Difficult Airway Course: Emergency™
  Las Vegas, NV
  www.theairwaysite.com

December 4-9, 2016
- 37th Annual Current Concepts in Emergency Care
  Maui, HI
  www.emergenciesinmedicine.org

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**

Call for 2017 AAEM Board of Directors Election Nominations
Nomination Deadline: December 17, 2017 — 11:59pm CT

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

Open Positions for the 2017 Election:
- Five At-Large positions
- YPS director

Nominations

Any Academy member may nominate a full voting or YPS member (for the YPS director position only) for the board. Self-nominations are allowed and encouraged. You must be a YPS member to be eligible to run for the YPS director position.

In order to nominate yourself or another full voting member for a board position, please go to www.aaem.org/about-aaem/elections to provide the following information and complete the nomination form and attestation statement.

1. Name of nominee. Each nominee may have only three individuals as nominators/endorsers.
2. Name of nominee's medical school and year graduated.
3. Board certification status of nominee, including Board and year completed.
4. Number of ED clinical hours worked each week by the nominee.
5. A candidate statement (written by the nominee, 500 word max.) listing recent AAEM contributions, accomplishments, activities, or any other information detailing why the nominee should be elected to the board. A photo for publication may accompany the statement if the nominee wishes.
6. Any emergency medicine related business activity in which the nominee has a financial interest.
7. A current CV for the nominee.
8. AAEM Attestation Statement filled out by the nominee.
9. **Conflict of Interest Form must be completed by the nominee prior to the nomination deadline**.

The information listed above must be submitted to the AAEM office before 11:59pm CT, on December 17, 2016. The nomination form and required information is the same as that for a board position.

The candidate statements from all those running for the board will be available online and also featured in the March/April 2017 issue of *Common Sense*.

Online Voting

New for 2017 voting will occur online only. The online ballots will be available prior to Scientific Assembly and online voting will be available onsite. WiFi will be available in the meeting space and we encourage members to bring a device or computer to cast their ballot.

Elections

Elections for these positions will be held at AAEM's 23rd Annual Scientific Assembly, March 16-20, 2017 in Orlando, FL. Although online balloting arrangements will be made for those unable to attend the Assembly, all members are encouraged to hold their votes until the time of the meeting. Online voting will be available leading up to Scientific Assembly and onsite

The Scientific Assembly will feature a Candidates Forum, in which members will be able to directly question the candidates before casting their ballots. Winners will be announced during the conference, and those elected will begin their terms at the conclusion of the Assembly.

These nomination and election procedures are what set AAEM apart from other professional medical associations. We believe the democratic principles that guide them are one of AAEM's greatest strengths and are an integral part of what makes us the organization of specialists in emergency medicine. In AAEM, any individual, full voting or YPS member can be nominated and elected to the AAEM board of directors. ■

DEADLINE: December 17, 2016 – 11:59pm CT

CALL FOR AAEM Award Nominations!

DEADLINE:
DECEMBER 17, 2016
11:59pm CT

AAEM is pleased to announce that we are currently accepting nominations for our annual awards. Award presentations will be made to the recipients at the 23rd Annual Scientific Assembly to be held March 16-20, 2017 in Orlando, FL.

Complete nomination criteria and the required online nomination form are found at www.aaem.org/about-aaem/awards. Self-nominations are not accepted. The AAEM Executive Committee will review the nominees and select recipients for all awards.

Individuals can be nominated for the following awards:

Administrator of the Year Award — AAEM encourages members to nominate an administrator deserving special recognition for their dedication to emergency medicine and patient care.

David K. Wagner Award — As an organization, AAEM recognizes Dr. Wagner's contributions to the specialty by offering an award named in his honor to individuals who have had a meaningful impact on the field of emergency medicine and who have contributed significantly to the promotion of AAEM's goals and objectives. Dr. Wagner himself was given the first such award in 1995.

Young Educator Award — Nominees must be out of residency less than five years and must be AAEM members. This award recognizes an individual who has made an outstanding contribution to AAEM through work on educational programs.

Resident of the Year Award — Nominees for this award must be AAEM resident members and must be enrolled in an EM residency training program. This award recognizes a resident member who has made an outstanding contribution to AAEM.

James Keaney Award — Nominees for this award must have 10 or more years of experience in EM clinical practice and must be AAEM members. Named after the founder of AAEM, this award recognizes an individual who has made an outstanding contribution to our organization.

Robert McNamara Award — Nominees for this award must have 10 or more years of experience in an EM academic leadership position and must be AAEM members. This award recognizes an individual who has made an outstanding contribution to AAEM in the area of academic leadership.

Joe Lex Educator of the Year Award — This award recognizes an individual who has made an outstanding contribution to AAEM through work on educational programs. Nominees must be AAEM members who have been out of their residency for more than five years.

Master of the American Academy of Emergency Medicine (MAAEM) — Active members of AAEM may also recommend nominees to the AAEM executive committee for the Master of the American Academy of Emergency Medicine (MAAEM). Full criteria for this designation are available on the AAEM website.

Program Director of the Year Award — This award recognizes an EM program director who has made an outstanding contribution to the field of emergency medicine and AAEM. The winner of this award will be chosen by the AAEM Resident and Student Association (AAEM/RSA). Nominations will be accepted for all awards until 11:59pm CT, December 17, 2016. All nominations should be submitted in writing and include:

1. Name of the nominee.
2. Name of the person submitting the nomination.
3. Reasons why the person submitting the nomination believes the nominee should receive the award.

Dollars & Sense: The $121,500+ Guest Room

Joel M. Schofer, MD MBA CPE FAAEM
Commander, Medical Corps, U.S. Navy
AAEM Board of Directors

I have a wife, two children, two dogs and the need for three bedrooms and two bathrooms. In March 2015, I purchased what I consider to be a modest 4 bedroom, 3.5 bath, 3,000 square foot house in a nice neighborhood with quality public schools. The fourth bedroom is largely unnecessary, but like many people we occasionally have visitors and feel that it is nice to offer them a bedroom as opposed to a hotel. This is the story of how that fourth bedroom cost me over $100,000, far more than it would cost to provide our visitors with a hotel room … a REALLY NICE hotel room.

The Guest Room

The guest room and its accompanying full bathroom are approximately 600 square feet. The house sold for $140/square foot, meaning that this extra room and bathroom cost me $84,000. Where I live, you can get a decent hotel room for $100/night. In other words, I could have purchased 840 nights in a hotel room for any guests we have and I don't think we'll ever have 840 guest-nights unless we stay in this house for a very, very, long time. In addition, we have a quite comfortable queen size Lazy Boy sleeper couch that could have substituted for the guest room.

Running total: $84,000

The HVAC Incident

"The way they installed this, I don't even think I can fix it." That is not what I wanted my HVAC repair man to say, but that is what he said. The guest room did not have its own HVAC zone and because it is above the garage and the insulation is not what it could be, the guest room is always too hot or too cold. And what's the point of a nice guestroom if it's not comfortable? After spending $5,000, the guest room had its own wall mounted HVAC unit and zone.

Running total: $89,000

The Exchange Student

Since we have an $89,000 extra room with a bathroom and its own HVAC, we are hosting a Spanish exchange student during the upcoming school year. Hosting an exchange student will likely be a great experience for us all, as I assume it will expand our horizons and hopefully forge a lasting relationship with someone for us to visit in Spain.

I suspect this student, like most humans, will eat and drink and cost some money, so I'm adding that to the running total.

Running total: $89,000 plus whatever a 16-year-old boy eats and drinks during a school year. Despite the fact that he is of driving age, he is not allowed to drive in the U.S. This, of course, led to…

The Manny Van

Sometime in August, I will have a wife, two kids, two dogs, and an exchange student. It is (was) going to be tough to get around and do the traveling we'd like to do in our Toyota Prius and Ford Fusion Hybrid. Having a 12, 15, and 16-year-old in the back seat, while technically feasible, was not going to be fun for anything other than the shortest of trips. Plus, we like to bring the dogs.

Enter the $32,500 2015 Toyota Sienna minivan, which I like to call the "manny van" when I'm driving it. I can now haul all living beings for whom I am responsible in the manliest of vans.

Running total: $121,500 plus whatever a 16-year-old boy eats and drinks in a school year

> "One of the classic financial mistakes that almost all physicians make (including me apparently) is that they spend too much money, buying too expensive a car and too large of a house."

The Moral of the Story

One of the classic financial mistakes that almost all physicians make (including me apparently) is that they spend too much money, buying too expensive a car and too large of a house. Sometimes something as simple as wanting a guest room can lead to unintended and expensive consequences. If we didn't have a guest room, I would probably have an extra $100,000 and I wouldn't be driving a "manny van."

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. ■

ADVERTISEMENT

WHAT IS CULTURE AND WHY DO I NEED IT?

CULTURE IS TRENDING

You can't open a magazine or read an article lately without a reference to culture. But what is it, really, and why do organizations need it?

WHAT IS CULTURE?

Like an iceberg, culture is largely invisible. If you ask your nursing or medical staff to describe your hospital's culture, they'd probably have a hard time. However, it's likely that everyone in your organization shares an unspoken understanding of the rules and their place in the pecking order.

> "Culture represents your organization's core, its true self."

It's expressed continuously by what your people do and say. For this reason, it can't be faked or changed through directives. It has to be changed through hearts and minds.

CULTURE IS MISSION CRITICAL

Developing and maintaining a positive culture probably isn't in your job description as a leader. But make no mistake, it's one of the most important things you can do.

Culture touches everything in your organization. It influences behavior, relationships, decisions and ultimately, effectiveness. A survey of top supply chain executives found that they viewed culture (or lack thereof) as the number one barrier to business success. Culture has elevated many ventures — and crushed many more. On the positive side, the best and the brightest minds compete to work for culture-conscious companies like Google, Twitter, Facebook and even the fully unionized Southwest Airlines. On the negative side, we have the culture of unchecked greed that tanked Enron. Glaring cultural differences made the $35 billion Sprint Nextel merger a disaster.

CULTURE & HEALTHCARE

Let's talk about what this all means for hospitals and health systems.

As a vice president and former regional director of CEP America, it's been enlightening to work with dozens of hospitals over the years.

BY DAVID BIRDSALL, MD
VICE PRESIDENT & EMERGENCY MEDICINE PARTNER

Very often, when a department is struggling, team members will point out why their department is different. Maybe they're in a part of the country where recruiting top-notch providers and staff is difficult. Maybe the facilities are outdated, cramped and uncomfortable. Or maybe they have high patient volumes, high acuity or a challenging population.

Granted, these difficulties are real. But I also think these departments are underestimating the role culture plays.

In my day, I've seen hospitals with every advantage struggle with staff retention, patient satisfaction and quality. And I've seen hospitals with stark disadvantages excel at all of the above.

Performance areas directly impacted by culture include:
Patient Satisfaction, Provider Satisfaction, and Medical Staff Alignment.

To read more about the importance of culture and how CEP America enacted change, visit:
go.cep.com/your-culture

CEP America®

Freestanding Emergency Departments: What Can We Learn

Joseph Guarisco, MD FAAEM
Operations Management Committee

Free-standing emergency departments (FSEDs) usually generate patient satisfaction scores above the 90th percentile, have a left-without-being-seen (LWBS) rate of virtually zero, and extremely low door-to-provider times. And these are EDs in every sense — they provide acute care; they have unscheduled, uncontrolled demand; and they have admission rates only slightly below the national average for hospital emergency departments in the United States. It is important to acknowledge that these *are* emergency departments *and* they achieve operational excellence. What can FSEDs teach us about operational management?

> "Both traditional EDs and freestanding EDs (whether hospital outpatient departments or independent) see similar types of patients, operate in an unscheduled/variable demand environment, and generate similar fees — but provide vastly different patient experiences and operational outcomes."

A FSED is defined as a facility that receives patients for emergency care and is structurally separate and distinct from the hospital. Freestanding EDs were initially established by hospitals in the 1970s in medically under-served, rural areas. However, FSEDs have proliferated over the past decade in suburban areas with more affluent patients. There are now approximately 500 FSEDs in 45 states. For simplicity, we can categorize FSEDs as either a hospital outpatient department (HOPD), owned or operated by a hospital but separate from the hospital's main campus; or as a completely independent FSED. Hospital-based FSEDs are subject to the same federal rules and regulations as hospitals, are bound by EMTALA, and account for 75% of all the FSEDs in the United States. Some states require that freestanding EDs be hospital-based, and that they obtain a certificate of need before being opened. An independent FSED does not require a certificate of need, is not recognized by Medicare and is not subject to CMS rules and regulations, and may choose not to serve Medicare or Medicaid patients. Independent FSEDs represent the remaining 25% of FSEDs. It is important to note that both types of freestanding EDs are allowed to charge *both* a facility fee *and* a professional fee.

There is a great debate as to whether FSEDs make financial sense for both the payer and the patient. From a billing standpoint, hospital outpatient department FSEDs are generally in-network and independent FSEDs are out-of-network with insurers. Regardless, the argument is that most of their patients would be better served by urgent care facilities, at lower cost. However, that's the same argument made against traditional EDs. Both traditional EDs and FSEDs, whether hospital-based outpatient or independent, generate facility fees that urgent care facilities do not. That is an important distinction between urgent care facilities and EDs of all kinds, and the primary reason for debate.

Both traditional EDs and freestanding EDs (whether hospital outpatient departments or independent) see similar types of patients, operate in an unscheduled/variable demand environment, and generate similar fees — but provide vastly different patient experiences and operational outcomes.

A recent article in Common Sense, "Operational Margin: The Critical Final Pathway in Patient Flow," explored operational margin as the defining element in any successful ED and explained why FSEDs generally outperform traditional EDs.

What defines operational excellence? Every emergency department's goal is to see patients quickly (minimizing LWBS numbers) and complete the patient's care in a reasonable amount of time (minimizing length of stay). If these goals are achieved, other important outcomes such as quality, safety, and excellent patient satisfaction will follow. There is one operational concept that determines whether an ED of any kind achieves these goals. It is known as operational margin. It's analogous to a savings account or a personal line of credit, in that it's similar to money one has available to manage variance in personal spending, commonly known as liquidity (easily and quickly available cash). Without liquidity, there is a risk that one will spend too much and run out of cash — not a good thing. If one spent the same amount every day, every month, and every year, a savings account or line of credit would not be needed. Demand and supply would always be perfectly matched. The same principle applies to emergency departments. Liquidity for an ED is its surge capacity. It is essentially a line of credit or savings account on physician, nursing, and space availability that can be drawn on when needed. If the ED always saw the same number of patients per hour per day and per year, we wouldn't need to have extra capacity available. But in ED patient flow, as in your personal spending, there is unpredicted variation. This can only be managed by creating liquidity of critical resources — surge capacity — the essential definition of operational margin.

Now, let's look at how freestanding ED's create operational margin. Figure 1 below shows the relationship between utilization (patient intake) and response time (patient wait time), and shows that as one approaches

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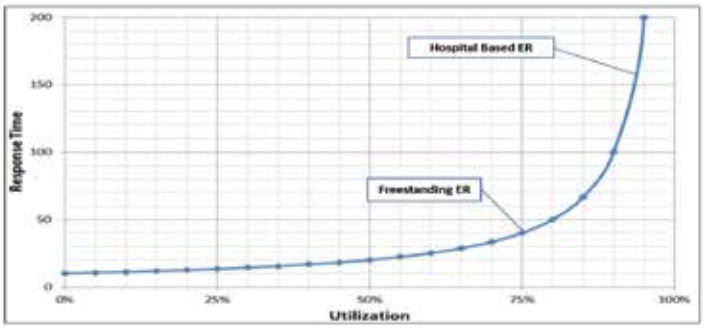

extreme utilization response time degrades exponentially because of depleted operational margin. It also shows where on the curve traditional EDs and FSEDs generally fall.

Figure 1 – Service Response vs Utilization

Provider productivity in independent FSEDs is approximately one patient per hour. The average provider productivity in traditional EDs is approximately two patients per hour. Freestanding EDs, as stated earlier, generally report fairly immediate door to provider times and essentially 0% left without being seen, yet this is accomplished with approximately half the average productivity (patients/provider per hour) of emergency departments nationally. Furthermore, there are hospital EDs with productivity of three patients/provider/ hour that achieve operational metrics similar to FSEDs, and EDs that average one patient/provider/hour that are operational disasters. The point is that operational excellence is unrelated to productivity — it depends on operational margin — the available capacity of provider, nursing, and space resources to meet demand with high probability. To be clear, the interplay of productivity and efficiency are important to throughput, as long as the utilization of resources is kept on the flat part of the curve in Figure 1. Operational excellence does not exist without operational margin — the ability to do the next thing *now*.

Whether productivity is at one patient/provider/hour or three, the ED must have the surge capacity to manage the inevitable variation in patient arrivals that exists in emergency medicine, just like any other service industry. Theoretically, this capacity can be created by supplying the necessary resources (physician, nursing, and space) in sufficient quantity to manage demand in all its variation, or by improving efficiency at any given level of productivity. That explains why some EDs succeed and some fail at identical levels of productivity — whether it's one patient/provider/hour or three.

Freestanding EDs provide excess capacity, implementing low-utilization staffing models and space plans, guaranteeing that sufficient resources are *always* available to manage demand — even with extreme variability. When demand begins to creep up, efficiency becomes increasingly important to maintaining the low utilization of resources. Freestanding EDs have essentially eliminated this requirement by creating resources for extreme levels of demand, guaranteeing that a room, a nurse, and a provider are always available.

How do they do it? Remember that every ED generates both a provider fee and a facility fee. The key difference between FSEDs and traditional EDs is how these fees are distributed. FSEDs keep both the provider fee and the facility fee in the FSED, whether the patient is discharged or transferred and admitted to a hospital. The result is fairly healthy financial margins. The hospitals that house traditional EDs sweep some of those fees into DRG-bundled payments for the admitted patient, and don't return those fees to the ED where they were generated. The result is a fairly unhealthy financial margin for the ED. From an accounting point of view, freestanding EDs look much better than hospital-based EDs — even though the care, costs, and fees for an identical patient would be essentially identical. Neither accounting system is inherently right or wrong. Subsidizing other hospital operations with ED income is the reality some hospitals face. The point is that FSEDs have the ability to invest more of their revenue in higher levels of resources — in themselves — and thus better manage variation in demand.

Whether you support or oppose the concept of freestanding EDs, you surely agree that quickly seeing, treating, and dispositioning every patient who presents with a potential emergency is a worthy goal. Generally, FSEDs are getting that done, and the emergency physicians who work in FSEDs are proud of what they do and have high levels of job satisfaction.

Traditional, hospital-based EDs that properly value the financial and non-financial contributions of their EDs, and adequately invest in them, can achieve the same operational excellence as freestanding EDs. Again, whether you agree with the concept of FSEDs or not, it is important to recognize that they have created an operational model that our specialty should learn from, and for many reasons, embrace.

Further Reading

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3. Dissecting the Cost of a Freestanding Emergency Department Visit. Alan A. Ayers, MBA MAcc Board of Directors and Content Advisor, Urgent Care Association of America Associate Editor, *Journal of Urgent Care Medicine* Vice President, Concentra Urgent Care.
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10. Overview of Existing Freestanding Emergency Departments (FEDs). https://dch.georgia.gov/.../Freestanding%20ER%20Overview%20-%20V2%2... Georgia Corporate. • Governmental Unit. • Partnership, etc. – Not all states allow a FED. Draffin & Tucker, LLP P.O. Box 71309 Albany, Georgia 31708-1309. ■

Who Cares About Due Process?

Larry D. Weiss, MD JD FAAEM MAAEM*
Past Presidents Council Representative

DISCLAIMER: *Nothing in this article constitutes legal advice, as the facts of individual cases vary, and you should seek legal counsel if you have a problem regarding your practice rights at a hospital. This article was written only for the purpose of continuing medical education in the area of practice development.*

In the hospital setting, *due process* for physicians means that a hospital cannot take an adverse action against a physician's medical staff privileges without affording the physician access to a fair hearing. In my many years of visiting residency programs and some large practices, physicians occasionally ask why their due process rights are so important, if their employer or contract-holder can still terminate their employment with or even without cause.

So, let's review the various steps of the credentialing process, your rights as a member of the organized medical staff, the source of your rights, and the importance of protecting your rights. One of the most important reasons AAEM was founded 22 years ago was to advocate for the personal practice rights of emergency physicians. This remains a central focus of our Academy, and our directors and officers spend a considerable amount of time in activities relating to due process advocacy.

Due Process Rights

Due process rights protect your membership in the hospital medical staff. These rights do not protect your contract. Virtually every court in this country recognizes a "freedom of contract," allowing parties to agree to almost any legal activity. A notable exception is any activity that violates "public policy." Public policy represents what is good for society. When a contract includes a due process waiver, requiring you to give up your fair hearing rights, AAEM takes the position that this violates public policy because emergency physicians require due process rights in order to be vigorous advocates for our patients. I am not aware of any court that has agreed with this argument. The lesson here is not to waive your due process rights.

Our due process rights have multiple sources. For those of us who work in government hospitals, our due process rights come from the Fifth and Fourteenth Amendments to the U.S. Constitution. Therefore all physicians, including emergency physicians, have due process rights at government owned or operated hospitals. It doesn't matter whether the hospital is owned by the federal, state, or local branches of government.

Physicians who work at non-government hospitals have other sources of due process rights. The Joint Commission requires all medical staff bylaws to guarantee physician due process rights. The Health Care Quality Improvement Act of 1986 (HCQIA) provides antitrust immunity to hospital peer review committees if they conduct hearings in a fair manner[1] The statute provides specific details on what constitutes a fair hearing. Finally, the AMA Code of Medical Ethics, as well as policies of AAEM and the American College of Emergency Physicians, require physician due process rights. However, in emergency medicine only AAEM is actually active in this area.

Medical Staff Membership

After you sign a contract to work in a hospital emergency department, you then sign a clinical credentials form. This form usually includes a long list of procedures and interventions, requiring you to check off every activity which you feel comfortable performing. Your ED director or department chair will then sign the form and submit it to the hospital credentials committee. When that committee approves your application, you then become a member of the organized medical staff. The medical staff bylaws of virtually every hospital in the country guarantee every physician a fair hearing before taking any adverse action against his or her medical staff membership. The only routine exception allows a hospital medical staff to temporarily suspend the privileges of a physician when an immediate danger to patients exists.

In many community hospitals, emergency physicians are the only members of the medical staff who do not have due process rights. (In most academic medical centers, emergency physicians have due process rights.) A scientifically valid survey published in 2013 showed that 62% of emergency physicians did not have due process rights.[1] Many emergency physician contracts require the physician to waive or forfeit their due process rights as a condition of employment. Once physicians agree to this waiver it becomes difficult to demand a fair hearing, and litigation will often fail when the hospital shows evidence of the waiver.

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"One of the most important reasons AAEM was founded 22 years ago was to advocate for the personal practice rights of emergency physicians. This remains a central focus of our Academy, and our directors and officers spend a considerable amount of time in activities relating to due process advocacy."

Waiver of Due Process Rights

The systematic waiver of due process rights has had devastating results for emergency physicians. In the survey previously cited, 18% of emergency physicians stated they had already been terminated from at least one job without a hearing. The figure for all other physicians must approach 0%. Perhaps the absolute number is not zero, but rounded off to the nearest percentage it must be 0%, because such terminations are very rare in other specialties. Almost all other physicians have fair hearing rights. In very recent years, however, this problem has started to spread to other specialties.

We developed this pernicious problem due to the unfortunate early history of emergency medicine. Prior to the development of residency programs in emergency medicine, hospitals scrambled to meet the needs of rapidly increasing numbers of patients who were coming to EDs in the 1960s. Some hospitals required every member of the medical staff to occasionally work a day or night in the ED. Other hospitals began to hire full time physicians to work in their EDs. In some cases hospitals hired physicians who turned out to be impaired, as successful physicians in private practice were rarely willing to give up their practices to work in an ED. Many hospitals wanted to have an efficient mechanism for getting rid of these physicians. This denial of due process has stubbornly persisted, even in current times when we graduate outstanding emergency medicine residents.

Why is Due Process so Important?

Why do we care so much about due process rights if an employer or contract holder can simply terminate your contract, and such termination will result in your inability to work in the emergency department? We care about due process rights for at least two important reasons. First, you will never be more than a second class citizen of your hospital medical staff if you do not have basic practice rights. No right is more basic than the right to a fair hearing. If a hospital wants to violate the rights of physicians who work in the ED, then perhaps they should hire untrained or impaired physicians. If they want to hire outstanding, well-trained physicians who graduated near the top of their medical school classes, then they should treat such physicians as equal members of the medical staff. Your professional life will improve if you are treated like an equal member of the medical staff.

The other important reason why we need due process rights is because of the threat of a report to the National Practitioner Data Bank (NPDB) when a hospital terminates your privileges. The HCQIA requires such a report if a hospital terminates you "for cause" — meaning the hospital terminates you based on an aspect of your performance or behavior. A report to the NPDB will haunt you for the rest of your career. Every time you renew hospital medical staff privileges, apply for privileges at a new hospital, or renew a state medical license, the form will ask if you have ever been terminated from a hospital medical staff. You will then have to provide a long and detailed narrative to explain. This painful process will recur on a biannual basis for the rest of your career. Such a termination may also make it difficult for you to find another job.

How AAEM Advocates for You

When emergency physicians lose their medical staff privileges and call our home office for help, there are a number of things we do to try to help these physicians. First, we conduct a thorough investigation. Our president usually conducts these investigations, reflecting the importance of this issue to AAEM. We routinely advise the physician to obtain legal counsel. Even in cases where physicians waived their due process rights, hospitals often makes mistakes when they terminate physicians from the medical staff. For example, your contract should require the hospital to provide you with adequate notice if you are terminated for cause. This means they must tell you specifically why they want to terminate you, tell you the exact nature of your alleged misconduct, and give you an opportunity to cure the cause of your termination. Hospitals often fail to provide physicians with such notice, giving the physician a cause of action against the hospital. Hospitals often fail to fulfill other obligations as well when they terminate physicians.

In many cases we try to discuss the matter with the hospital administrator and send a letter of concern to every member of the hospital governing board. In some cases we provided interviews to local media, discussing the danger to the public if physicians in the local emergency department cannot adequately advocate for patients due to a lack of fair hearing rights. In a handful of cases where we thought the physician had a sound basis to sue the hospital, we have provided funds to support the litigation.

We have also lobbied Congress and CMS (the Center for Medicare/Medicaid Services) for statutes and regulations that would support emergency physician due process rights. Here we are playing the long game, as results on this level will take many years. When we explain these issues in Washington we usually get sympathetic and supportive feedback, but we are often told to be patient before seeing any results. In all these ways, AAEM actively advocates for the personal practice rights of emergency physicians.

Above all, to improve our practice environment **you** must care about **your** practice rights. You should not agree to due process waivers. The demand for well-trained emergency physicians has never been stronger. You have more negotiating power than you imagine. In a case where a hospital or a contract management group stubbornly insists on violating your practice rights, just look up or down the road and you may find a fair practice that will respect your rights. The systematic abuse of our practice rights persists because we let it persist. If 62% of emergency physicians lack basic practice rights at hospitals, then this might be our most important professional problem. We will have persistent difficulties in our clinical work until we resolve this problem.

*Dr. Weiss was a founding fellow of the Academy, a founder and President of AAEMLa, the Louisiana chapter of AAEM; has written multiple amicus briefs, policies, and white papers for AAEM; and served on the AAEM Board of Directors from 2003-2012, including a term as president from 2008 until 2010. Dr. Weiss currently serves on the AAEM Board of Directors as the Past-President Council representative, the Legal Committee, and the Government Affairs Committee. He is a past recipient of the David Wagner Award for leadership, and a designated Master of the American Academy of Emergency Medicine (MAAEM).

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AAEM/RSA President's Message

Reflections on Mentorship

Mary Haas, MD
AAEM/RSA President

Mentorship has played a crucial role in my brief EM career. Perhaps, more importantly, it has also contributed to my personal and professional wellness. Realizing this, I asked myself a few questions. Why does mentorship matter? What makes a good mentor?

The term *mentor* originated from Homer's *Odyssey*, as the name of the man entrusted by Odysseus, the king of Ithaca, to care for his son and household while he fought in the Trojan War. Following that example, a mentor is one who guides a junior colleague. Specifically a mentor should teach, advise, and share wisdom with their colleague. A mentor may provide personal advice, professional advice, or both. One useful definition of mentorship is "a process for the informal transmission of knowledge, social capital, and psychosocial support perceived by the recipient as relevant to career or personal development."[1]

Research has proven that mentorship works. A 1977 study of executives found that ones with mentors earn more money at a younger age, are better educated, are more likely to follow a career plan, and are more likely to mentor others.[2] Perhaps more importantly, the same study found that the executives with mentors reported greater career satisfaction. With the help of good mentors I have been able to increase my academic productivity, connect with other professionals, identify useful resources for achieving my goals, and develop my leadership and clinical skills through role-modeling.

What makes a good mentor? One study identified that good mentors are active listeners who can analyze their mentee's strengths and assist with setting and achieving goals.[3,4] I've found that my most effective mentors are those who are accessible, knowledgeable, honest with constructive feedback, respected in their field, eager to share new opportunities for scholarship and leadership, and most importantly, care about me on a personal level. I have benefited from having mentors who were family, friends, former teachers, physicians from other specialties, and colleagues with both more and less experience than me. Finally, I've learned that one mentor is not enough. Mentors have their own strengths and areas of expertise and so I've used different mentors to work towards goals in the various areas of my professional and personal life.

Having benefited from the mentoring process, I have recently started serve as a mentor. I have found great joy knowing that I have helped my mentees progress and succeed. And I am not alone, as research corroborates my feeling. One meta-analysis found that serving as a mentor was associated with greater perceived career success, job performance, job satisfaction, and more perceived connectedness to one's organization.[5]

Both having effective mentors and serving as a mentor to others may be one way to improve resilience and decrease physician burnout. Seeing the excitement in the eyes of a mentee starting their career in emergency medicine helps me realize that it is a great privilege to be an EP and reminds me of how much I have grown through mentoring.

"With the help of good mentors I have been able to increase my academic productivity, connect with other professionals, identify useful resources for achieving my goals, and develop my leadership and clinical skills through role-modeling."

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AAEM/RSA Editor's Message

Standardized Residency Video Interviews: Benefit or Burden?

Mike Wilk, MD
PGY-1, Brown EM

Forward: *Please note that after submission of this article, the Standardized Video Interview Project was put on hold this year for further review by the AAMC. However, its implementation remains expected at a later date.*

> "Much like assessing patients, EM residency programs are looking for more efficient ways to rapidly evaluate future residents even before they are invited for an in-person interview."

We are trained as emergency physicians to start evaluating patients from the moment we lay eyes on them. Sometimes referred as the "door test," we assess, determine workups and consider possible dispositions from the moment we step through the door to lay eyes on our patient. Much like assessing patients, EM residency programs are looking for more efficient ways to rapidly evaluate future residents even before they are invited for an in-person interview. This year, medical students bound for an EM residency will have a new option to complete on their residency applications: the AAMC Standardized Video Interview.

What exactly will this video interview involve? When I first heard of the concept, I initially envisioned it to be a "personal branding" video where each student would have a minute or two to sell themselves. While this idea is exciting, I also envisioned medical students spending many hours perfecting this video, and even more burdensome, spending hundreds of dollars for professional videography. Basically, I imagined something similar to YouTube high school football recruiting videos, complete with pump-up music and special effects.

However, upon further research, I learned that the video interviews would actually consist of students answering on the spot questions involving topics on professionalism and interpersonal and communication skills. Much like an in-person interview, there is no pause or reset button and students will not know the exact question until the video begins. While not as burdensome as making your own personal branding video, it still sounds stressful.

So, what is the good news? At least for this year, the videos will be completely optional and only used for research purposes. Plus participating students will receive a gift card. The videos will be scored and incorporated into a research study to assess for correlation with the ranking of students after in-person interviews. Residency programs will not have access to the videos nor know who participated.

It will certainly be interesting to see how residency programs and medical students receive the videos. For medical students, it is yet another task they must complete to make it through the match process. For programs, it may alter who is selected for in-person interviews which has the potential to save time and money for the programs and also students. For the vast majority of applicants, I imagine it will not have a major impact as USMLE scores, clinical grades, and SLOEs will likely still reign supreme in selecting who is invited to interview. However, it may give programs better insight into the more subjective aspects of the medical student such as their personality, general demeanor, and "fit" with the residency program. Only time will tell if it becomes a required component of residency applications. ■

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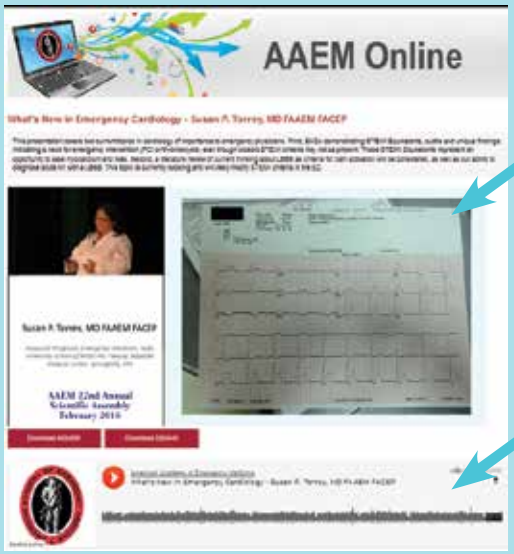

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Committee members plan and organize the resident educational track at the AAEM Scientific Assembly, which will be held March 16-20, 2017, in Orlando, FL. You will also assist with the medical student symposia that occur around the country.

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The International Committee will have the opportunity to contribute to international medicine projects and resource development that are helpful and beneficial to students and residents.

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The Membership Committee promotes our mission by building AAEM/RSA membership through recruiting, developing valuable member benefits, and communicating with residency program directors and chief residents. You will be involved with one of the most critical and exciting committees within AAEM/RSA.

Social Media Committee

The newly formed Social Media Committee will concentrate efforts from the previous Communications and Publications committees. Members will contribute to the development and content of RSA's four primary media outlets: the RSA Blog Modern Resident, the AAEM/RSA website, Facebook and Twitter. The committee also oversees development and revisions of AAEM/RSA's multiple publications including clinical handbooks and board review materials. You will have numerous opportunities to edit, publish, and act as peer-reviewers, as well as work from the ground-up in developing AAEM/RSA's expansion to electronic publications.

www.aaemrsa.org/leadership/opportunities-for-involvement/committees

Is a Central Venous Catheter Actually Required in Order to Administer Vasopressors or Can Peripheral Venous Catheters Suffice?

Authors: Mark Sutherland, MD; Robert Brown, MD; David Bostick, MD; Erica Bates, MD; Megan Donohue, MD
Editor: Kelly Maurelus, MD and Michael Bond, MD FAEEM

Introduction

Vasopressors are instrumental in resuscitating critically ill patients. Administration of vasopressors through a central venous catheter (CVC) as opposed to peripheral intravenous access (PIV) has traditionally been preferred in order to minimize the risk of extravasation injury. However, CVCs have other potential complications as compared to PIVs including unintentional arterial puncture, pneumothorax, and blood stream infections. This edition of the Resident Journal Review reviews four articles concerning peripheral vasopressor administration and the timing of administration in shock states.

Beck V, Chateau D, Bryson GL, et al. Timing of vasopressor initiation and mortality in septic shock: A cohort study. *Critical Care.* (2014) 18:R97.

Acknowledging the importance of maintaining end organ perfusion, this cohort study evaluated the mortality benefit of early initiation of vasopressor therapy, as opposed to specific agent selection, in fluid-refractory septic shock.

The study group developed the Cooperative Antimicrobial Therapy of Septic Shock Database of adult patients treated in the USA, Canada, and Saudi Arabia from 1996 to 2008. Patients were selected from all types of intensive care units (ICUs) and met the 1991 Society of Critical Care Medicine/American College of Chest Physicians consensus definition of sepsis. Included patients had no other clear cause of shock and had failed fluid resuscitation, defined as SBP <90mmHg, SBP decrease >40mmHg, or MAP <65mmHg after a 2L fluid bolus but prior to vasopressor administration. Patients were excluded if vasopressors were initiated within 6 minutes of presentation. Adjustments were made for independent predictors of mortality, specifically, AIDS, hypertension, liver failure, neutropenia, malignancy, metastatic disease, APACHE II score, and delay in antibiotics. Ultimately, 8,670 patients were identified. After excluding those with unclear vasopressor start time or other inadequate data acquisition, 6,514 were included.

After adjusting for other causes of mortality, a weak association was found between delay of vasopressors and in-hospital mortality (OR=1.02, 95% CI 1.01-1.03, P <0.001). When the data was further examined, this effect was mainly due to patients with delays of vasopressor initiation of >14 hours (OR=1.34, 95% CI=1.03-1.76, P=0.048). The pattern was similar for secondary outcomes including renal, respiratory, hematologic, central nervous system, coagulation, and metabolic failure. Delay in vasopressor initiation was not predictive of length of stay in the ICU or hospital.

The authors acknowledge that a major limitation of the study is that time to fluid resuscitation was not controlled, which is quite relevant for the EP. However, this study may suggest that there is a period of time after the diagnosis of septic shock before vasopressors are emergently needed. If true, this window of time could alter the perspective on whether a CVC is indicated, and allow time for consideration of CVC vs PIV risk, resource utilization, and safety. Similarly, if a delay in vasopressor administration is not detrimental, the EP could feel comfortable in taking the time to place a CVC in order to avoid the risks associated with PIV vasopressor administration. Another limitation of the study was the exclusion of nearly 2,000 patients due to inability to determine the timing of antibiotic initiation. Given the large number of patients excluded, this may have changed the results of the entire study by limiting the power to detect statistical significance between study groups.

Ricard JD, Salomon L, Boyer A, et al. Central or Peripheral Catheters for Initial Venous Access of ICU Patients: A Randomized Controlled Trial. *Critical Care Medicine.* (2013) 41:2108-2115.

This prospective, multicenter, non-blinded, randomized controlled trial compared the advantages and complications of PIVs and CVCs in ICU patients from 2004-2006. Inclusion was limited to adult ICU patients predicted to stay more than 48 hours who did not have a CVC. Patients were excluded if they were under age 18, pregnant or breastfeeding, refused to be in the study, had a contraindication to PIV or CVC or needed specific venotoxic drugs. One hundred thirty five patients received a CVC and 128 received a PIV. However, greater than half of the PIV group were crossed over to receive a CVC due to a need for increased vasopressor dose or inability to insert or maintain the PIV. Patients were analyzed by intention-to-treat. Major complications were more frequent in patients randomized to the PIV group than to the CVC group (1.04 vs. 0.64 complications per patient respectively, p<0.02).

Major mechanical complications differed between groups. The major complications in the CVC group included: necessity to change site insertion, more than two attempts to insert the CVC, failure to insert a CVC after trials at two different sites, arterial puncture, vessel injury requiring surgical repair, pneumothorax or hemothorax, local or mediastinal hematoma, gas embolism, and embolism of the wire. The major complications in the PIV group included: inability to place a PIV, more than five attempts to insert the PIV, inability to maintain the catheter, and subcutaneous diffusion ≥5x5cm, necrosis, or blister formation ≥3x3cm.

Complications included three pneumothoraces in each group; however, all pneumothoraces in the PIV group were patients who received the pneumothorax after crossover to the CVC group. The majority (54%) of major mechanical complications in the PIV group were difficulties with PIV insertion. No differences in minor complications or mortality was found between the groups.

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Ultimately, the authors of this study recommend more frequent placement of CVCs, as there are seemingly less complications. However, due to intention-to-treat analysis, some of the serious complications recorded for the PIV group were a result of CVC placement in those patients after crossover. Because more than half of those originally placed in the PIV group were crossed over, it is difficult to draw conclusions about the safety of one procedure over the other. Another limitation is that complications such as pneumothorax and arterial puncture were counted similarly to seemingly less severe complications such as difficulty placing a PIV.

Concerning the safety of administering vasopressors peripherally, subcutaneous diffusion occurred in 2 patients in the CVC group, but in 19 patients in the PIV group. Data regarding whether tissue damage or necrosis occurred in those with extravasation was not available. Therefore, it is difficult to draw conclusions concerning safety of PIV vasopressor use. To truly evaluate the safety of peripheral vasopressor use, a large randomized control trial examining the complications related to PIV versus CVC vasopressor administration is needed.

Loubani OM and Green RS. A systematic review of extravasation and local tissue injury from administration of vasopressors through peripheral intravenous catheters and central venous catheters. *Journal of Critical Care.* (2015) 653.e9-653.e17.

Much of the evidence for the adverse effects of peripheral administration of vasopressors such as local tissue ischemia or necrosis is derived from case studies, case series, and observational data. In an attempt to determine the true incidence, the study authors identified 85 studies for inclusion in this systematic review. Twelve of the 85 studies were published more recently than 2000. Of note, 68 (80%) of the studies were published between 1950 and 1989.

They identified 325 events of local tissue injury or extravasation as a consequence of vasopressor administration in 270 patients. The majority (97.8%) of these events occurred in patients receiving vasopressors through a PIV. Of the 318 events involving a PIV, 204 were a result of local tissue injury and 114 were secondary to extravasation. Of the 204 local tissue injury events involving a PIV, 179 (87.7%) were skin necrosis, 20 (9.8%) were gangrene, and 5 (2.5%) were tissue necrosis. Of the 114 extravasation events, 86 (75.4%) were associated with no injury, while 23 (12.8%) resulted in skin necrosis events and 5 (25%) in gangrene.

Seventy-seven (37.7%) of the patients experiencing an adverse event from vasopressor use experienced no long term sequelae, while 36 (17.6%) experienced a minor disability defined as the patient returning to prior level of function with minor deficits, and 9 (4.4%) experienced a major disability defined as severe deficits with the patient being unable to return to prior level of function. Four (2.0%) patient deaths were attributed to an adverse event from vasopressor use, while 56 (27.5%) of the patients died from other causes. Data was not reported for 22 (10.8%) of the events.

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In the CVC group, 4 complications were reported with 3 extravasation events. None of these extravasation events were associated with local tissue injury. Three of the incidences of local tissue injury were skin necrosis and one was gangrene. Two of the four were left with minor disability, one had no long term sequelae, and one died of reasons not attributed to the local tissue injury.

Two other important variables were identified as potential causative factors of complication from PIV vasopressor administration: location of the IV and duration of infusion. The majority (89.7%) of the local tissue injuries involved a PIV placed at a site distal to either the antecubital or popliteal fossae. As for duration of infusion, 102 (50%) of the local tissue injuries occurred with infusions longer than 24 hours, 18 (8.8% occurred with infusions between 12 and 24 hours, and 9 (4.4%) occurred with infusions between 6 and 12 hours. Duration of infusion was not reported for 66 (36.8%) patients. Considering only patients with a known duration of infusion, 93% of those with tissue injury had a vasopressor infusion of at least 6 hours.

Local tissue injury in the form of tissue or skin necrosis, or gangrene is more likely to occur when vasopressors are administered through distal extremity PIVs or for longer durations. While this paper reviewed case reports and case series, data suggests that vasopressor administration via a PIV may have some initial benefit in the critically ill, hemodynamically unstable patient until central access is obtained. This review suggests that PIVs should be placed proximal to the antecubital or popliteal fossae and used for less than 6 hours. Such PIV use may afford the EP time to stabilize the patient until a CVC can be inserted done non-emergently.

Cardenas-Garcia J, Schaub KF, Belchikov YG, et al. Safety of Peripheral Intravenous Administration of Vasoactive Medication. *Journal of Hospital Medicine.* (2015) 00(00):1-5.

The authors of this study attempted to determine the feasibility of PIV administration of vasopressors. The study was a single center, observational, non-randomized, non-blinded feasibility study, conducted in an 18 bed medical ICU between 2012 and 2014. They observed the incidence of tissue injury in patients with PIV vasopressor administration. The first phase of the study began with a 13 month prospective safety analysis to determine the rate of extravasation as well as the rates of local tissue injury in patients receiving vasopressors via PIVs. This was followed by a 7 month retrospective quality assessment project.

Requirements for PIV use of vasopressors included a vein diameter >4 mm as measured via ultrasound, ultrasound documentation of PIV catheter position the vein prior to infusion, upper extremity use contralateral to blood pressure cuff, use of an 18-20 gauge PIV, no use of hand, wrist, or antecubital veins, 72 hour maximum duration of use, and reassessment of PIV function via nursing every 2 hours. Any patients found to have evidence of extravasation received immediate treatment with local phentolamine injection and topical nitroglycerin paste. Tissue injury was defined as any erythema, blistering, skin breakdown, or necrosis at the site of extravasation.

The study included 953 cases of vasopressor use, 783 (82%) were via PIV, and 170 (18%) were via CVC. Vasopressor infusion duration via PIV was 49 +/- 22 hours with placement of a new PIV in any patients

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requiring an infusion duration greater than 72 hours (49 patients). Norepinephrine was administered 506 times (concentration 8-16 mg/250 mL NS), dopamine administered 101 times (concentration 400-800 mg/250 mL D5W), and phenylephrine administered 176 times (concentration 80-160 mg/500 mL NS).

Extravasation was noted in 19 (2%) patients in the PIV group (16 norepinephrine, 3 dopamine, 0 phenylephrine), but no tissue injury was identified in any of these cases. Based on these results, the authors concluded that PIV administration of vasopressors is both feasible and safe. Limitations of the study include that it was a single center and that the process may not be feasible outside the medical ICU as it required significant resources. Specifically, a multidisciplinary team, including pharmacists, residents, fellows, attendings, and nurses all received extensive training. It also relied heavily on rigorous nursing PIV checks every 2 hours. Furthermore, the study was observational, with inclusion determined by non-blinded physicians, and with data read by non-blinded researchers, thus leading to the potential for internal bias. Due to the lack of randomization and control groups, it is also impossible to determine the relative risk involved with PIV versus CVC administration. Finally, the use of immediate dual treatment for all extravasation events limits the ability to determine the true incidence of tissue injury.

The results of this feasibility study are promising as it involved a large number of cases of PIV vasopressor use with very few extravasation events and no observed tissue injury. However, more rigorous studies will need to be performed to better characterize the relative risks of PIV versus CVC pressor use, the efficacy and necessity of their strict treatment and monitoring protocols, and the broader applicability of these early findings to other settings, particularly in the ED.

Conclusions

While these articles suggest that PIV use for vasopressor infusion may be an alternative to the standard of CVC use, there is still more to learn. Specifically, for patients with septic shock, delay of vasopressor initiation to allow for careful CVC placement may not be detrimental. However, CVC placement continues to carry both mechanical and infectious risk for the patient. Furthermore, use of a distal PIV or prolonged use of a PIV for vasopressor infusion are important risk factors for tissue injury and extravasation. Much of the data on tissue injury and extravasation in PIV vasopressor use is from case reports and cases series from before the 1990s, coincidentally, before the widespread adoption of ultrasound-guided placement of PIVs. The study by Cardenas-Garcia et al. demonstrates that developing protocols and interdisciplinary cooperation between nursing and medical staff can lead to safer PIV vasopressor administration with corresponding avoidance of CVC risks and complications. As such, any ED protocol for PIV use of vasopressors would also require ultrasound guidance as well as strict monitoring by nursing. In most ED scenarios, use of a PIV for vasopressor administration may be appropriate in order to allow for CVC placement in a controlled, non-hectic, sterile work environment that would limit complications. ■

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An Electronic Resource Guide to the EM Clerkship

Stephanie Cihlar
AAEM/RSA Medical Student Council President

Smartphones and tablets have changed the way we practice medicine. They help us make informed medical decisions and offer a practical way to keep us up to date on the latest research. Apps and podcasts are increasingly popular tools used to help us achieve these goals, both inside and outside of the ED. For students striving to do well in EM clerkships, the ability to stay organized and access to the right resources is critical for success. However, in this rapidly changing world of medical apps, podcasts, and seemingly endless amounts of available information, it can be difficult to know where to begin. After evaluating some popular EM resources, I developed this guide of apps and podcasts to help students ensure success in their EM clerkships.

Apps:

EMRA Basics – Students from another medical school first recommended this to me and as soon as I downloaded the free app I was blown away with how helpful it is. The app opens with a list of common chief complaints. Clicking any one then provides useful information on important aspects of the history, differential, pertinent algorithms and criteria, documentation, and treatment. If used as a quick reference while on shift, this app is sure to help you shine on your EM clerkships and away rotations.

Journal Club – An internal medicine attending recommended this app to me and it has proved to be very valuable throughout most of my clerkships. Journal Club is a physician-maintained app that summarizes and breaks down landmark trials in a wide-variety of specialties. While EM articles make up a small section of the app, it is modestly priced and very useful for many clerkships, especially for critical care and internal medicine.

PreTest Emergency Medicine – The app version of the popular text offers a 500 question Q-bank. It is a valuable tool for exam prep with the added benefit of avoiding the bulkiness of a textbook. Download the free version to try out the interface and sample questions prior to purchasing for $29.99.

AAEM Tox Handbook – This newly released app from the AAEM Young Physicians Section offers an easily accessible reference of common toxicological emergencies and their management. The app content was authored primarily by toxicologists and places special emphasis on "tricks of the trade" that you will not find in other resources. The Tox Handbook app is especially useful for those with a particular interest in toxicology.

Podcasts:

EM Basic – Created and hosted by Steve Carroll, EM Basic is a must-listen for students starting their EM clerkship. The podcasts break down broad chief complaints into key components of the history, physical, basic workup, and treatment. I found this podcast extremely helpful. And it's free! Be sure to check out the episode, "How to Give a Good EM Presentation" before jumping into your first shift.

EM:RAP – This well-known podcast is geared more towards residents, but is still an engaging and worthwhile listen for students familiar with the basics of EM. EM:RAP offers a wide breadth of content and is especially useful for staying up-to-date on the latest developments in the field. Normally $95/year, this app is completely free with your AAEM/RSA membership!

AAEM/RSA Medical Student Council Podcast Series – This newly-released series features leaders from emergency medicine residency programs across the country speaking on topics essential to medical students with the goal of helping student land the residency of their choice! Get the inside scoop on how to excel during your EM clerkship, how to match into EM, and more. Visit aaemrsa.org or download from iTunes®.

As medical education continues to be supplemented with useful and informative electronic resources, don't be left in the dust. Check out these apps and podcasts, and rock your EM clerkships this year! ■

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