

COMMON SENSE



VOICE OF THE AMERICAN ACADEMY OF EMERGENCY MEDICINE

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A Sad But True Story

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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 quality 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.

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Boldly Moving Forward: Learning to Be Proactive Rather than Reactive

David A. Farcy, MD FAAEM FCCM — President, AAEM



In the past several months, I have been traveling and lecturing to students, residents, and attendings, at both community hospitals and at academic programs. While speaking with people on my travels, I often am asked “Why should I join AAEM?” “What do I get for my money?” “I am content, I am happy

where I am!” But in the same sentence, I also hear, “What are you doing about wellness?” “What are you doing to support women in emergency medicine?” etc. As I respond to these questions, filling them in on the great work the Academy is already doing through our Wellness and Women in EM Committees, and many other initiatives, this is usually met with, “Wow, really?! You’re not marketing yourself well, we had no idea.”

Based on this feedback, I surveyed my own program and asked a room of over 30 people if they had read my last president’s message, and I regret to report that only two hands rose. (And, yes, one was mine!)

When people are passionate about something, it drives them to become engaged, to learn, to educate, and to want everyone else to listen too. However, most often the reality is that we are “too busy,” or have “no time” to take up just another concern in our already busy personal and professional lives. I am deeply passionate about the work AAEM is taking on and my wish is for all of our members to be passionate as well.

We as doctors, are too often reactive instead of being proactive. We’re too often afraid that we might cause waves by taking a stand or we might be viewed as having too politically charged of a stance on issues. But when the NRA attacked physicians with their “stay in your lane” tweet last November, we all came together, social media blew-up, and AFFIRM research was created (American Foundation for Firearm Injury Reduction in Medicine). I am sure we have card-carrying NRA members amongst our membership and we might have upset some of them or even worse had some resign from our Academy. But, this was the proactive step we took – we must solve this problem by investing in research and devising a better process. We could not ignore the problem anymore.

Last year, our RSA (Resident and Student Association) leadership approached us with concerns they were hearing from their colleagues regarding the future of emergency medicine and particularly the role of Advance Practice Providers (APPs). Again, AAEM had to be proactive on this issue rather than being reactive. The board formed a task force to explore this issue and set a goal to draft a position statement. The task force worked hard and diligently to come up with a statement and the board agreed to take the proactive steps of issuing the statement and eliminating the allied health category of membership.

We published the statement and wrote an article explaining our stance. Again, social media blew-up in response, mainly positive responses from our students, residents, and attendings. Some APPs were concerned that we were attacking their titles, attacking them. Even APPs at my own program were concerned. What did it all really mean?

As AAEM outlined in our message to members, “These actions are not a statement against the great value of the properly supervised use of APPs in the emergency department, but a statement against the possibility of APPs being utilized to replace board certified emergency physicians.” It comes down to an issue of profits.

The first place they look to maintain profitability is in the composition of their workforce. An ABEM/AOBEM board certified attending physician on average makes over \$190/hour as an independent contractor, an APP makes \$50-\$60/ hour. In terms of dollars, that is about the cost of three APPs to one attending.

We’ve seen this play out already — I’ve heard of CMGs replacing physicians with APPs or having one doctor supervising a staff of all APPs. In my conversations with APP colleagues, I’ve also heard the sentiment that, “We don’t want to practice alone, we want to practice together.”

I agree, when we practice together using a board certified physician-led team, it’s for the benefit of everyone. When we look at our flow, APPs practicing on their own: they see less patients, order more, and patient complaints rise. Especially when the patient received a \$5,000-\$7,000 bill for a cough and claim they were never seen by a doctor.

On this issue of APP independent practice, we have seen many states are either sponsoring a bill, have already passed a bill, or are attempting to pass one. These bills are not limited to granting independent practice to nurse practitioners or physician assistants, but also pharmacists, psychologists, chiropractors, etc. This is just plain dangerous and this is a patient safety issue.

The doctors who are sponsoring those bills, such as in my home state of Florida, claim no conflicts of interest, despite having an ownership stake in practices that would benefit.

AAEM does not oppose a joint team effort, what we do oppose is the independent practice of APPs without direct supervision by a board certified EM physician. One of our pharmacists recently said, “Wait does that mean I am out?” No you’re not out, rather you are a valuable member of the team, led by the board certified EM doctors.

Wait ... did I say “doctor?” We should be more inclusive and all be “practitioners,” right? Wrong. Physicians earned our MD/DO after four years of medical school and the residency training that occurs after medical school cannot be substituted or lumped with any other group in the medical field.

On the topic of the title “doctor,” I’ve heard our Women in Emergency Medicine Committee saying, “what can we do to break the gender bias?” For far too long, women physicians are still mistakenly identified as nurses only and we often see our male nurses identified as the doctors. What do we need to do to change this? We all need to correct everyone



PRESIDENT'S MESSAGE and say that is Dr. Moreno not nurse Moreno. We need to be proactive and search out women speakers for our conferences, encourage women to join EM committees, and encourage more women to run for leadership positions. Yes, I am a He-for-She.

I invite all AAEM members to join me in this call to action — to shift our focus to being proactive rather than reactive to the issues that affect our day-to-day practice as emergency physicians. When we are passionate it drives us to become engaged, to learn, to educate. I encourage you to find your passion and join in advocating for the specialty we all love.

Addendum: In the Aftermath of the El Paso and Dayton Mass Shootings

In the aftermath of the mass shootings in El Paso, TX and Dayton, OH, on the same weekend there were multiple instances of gang violence paralyzing Chicago. Foremost, our condolences go out to all the victims, their loved ones, their families, and to the communities affected. Our thoughts are also with all the first responders, police, emergency department staff, EM physicians, trauma surgeons, surgeons, and the entire medical community.

"A grandfather was shot yesterday. A son was shot yesterday. Yesterday, a mother was shot. And the day before that, five other people were shot that were connected to Americans in this country."

- Dr. Roger A. Mitchell Jr. on CBS Sunday Morning 8/4/19
Guns and public health: Applying preventive medicine to a national epidemic



#PreventGunViolence #StandAFFIRM #ThisIsOurLane

In Florida, there were 18 deaths were related to hepatitis A and a health crisis was declared, providing vaccinations and mandating vaccination changes. Yet, we have no funding for research for gun violence, the FBI does not even have a definition of what constitutes a mass shooting. People are still arguing if this is a public health crisis. It is not only a public health crisis, but an epidemic and with every epidemic, physicians are at the forefront. It is time to demand action, regulation, license, restriction, stricter background checks, and funding to study gun violence. Together we can fix this devastating epidemic and save lives. Thinking you cannot or will not be affected by this is just ignoring the problem until it is too late. ●

This is a public health crisis and it is time that we all unite, despite our personal beliefs, and come up with actions. At this rate we are not safe anywhere! The common theme of sending prayers without action are just motions to makes us feel better.

"The only thing worst than a death is a death that could have been prevented. To go and talk to a mom about a child who was normal at breakfast and now is not here is the worst possible thing. Honestly, it drives us to address this problem."

- Dr. Ronald Stewart on CBS Sunday Morning 8/4/19
Guns and public health: Applying preventive medicine to a national epidemic



#FundResearch #StandAFFIRM #ThisIsOurLane

There are over 40 ways to get involved with AAEM

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Visit the AAEM website to browse the 40+ groups you can become a part of today.

Get Started!

www.aaem.org/get-involved

The Fox and the Hedgehog

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



How We Respond to Stressors

We all know that an emergency department is a stressful place to work. During any shift we can see, and personally experience, an array of responses to stress and challenges. Many emotional styles can be seen, and it is important to try and understand where these responses come from in order to accurately interpret what the individual is trying to accomplish. Responses to stress range from the valued team builder who creates a sense of accomplishment and value, to the angry provider who creates turmoil. We can become leaders and survivors, or the burned-out physicians who really need collegial help. All individuals come to the table with their own set of strengths and weaknesses. All of us must understand our individual abilities and challenges if we are to survive and prosper. Learning how others respond to the same stresses at the same time is just as critical for our success as mastering our own response. If we do not notice or appreciate the way others are dealing with the same challenges, we are setting ourselves and our department or group up for failure.

One way to categorize the way we think is to divide people into foxes and hedgehogs. Originating with the ancient Greek poet Archilochus, this idea has been discussed by many authors, including most famously by the philosopher Isaiah Berlin in the 1950's.

The Hedgehog

Hedgehogs know just one technique for survival: curling into a ball when threatened, with spines directed outwards. Foxes use many tricks to survive. The hedgehog way of thinking tries to make all problems conform to one overarching guiding principle. This thinking is usually much more direct and single minded and can appear to be dogmatic or uncompromising. The hedgehog, however, can be inspirational and lead a department to success by his overriding belief in one big thing, which at times is exactly what is needed to steady a sinking ship. Rallying around the flag may be just the thing a department needs in times of crisis.

Do you recognize any hedgehogs in your life? In the emergency department, you can identify those people who seem to emphasize one formula or "best practice." This is the consultant who is brought in to fix things by teaching you the importance of patient satisfaction scores, flow models, or whatever else their perceived magic bullet is. They



are stubborn and seek conformity to their model of success, and to many seem overconfident in their idea. If you think like a fox then this approach can seem dogmatic, and many foxes will try and undermine the director, administrator, or consultant who is trying to convince you that this "one big thing" will right the listing ship.

The Fox

The fox faces each day as a new challenge and tries to plug whichever hole is letting water in the ship that day. The fox may seem distracted, but is often trying to figure out a plan or tactic that will work today. They don't have one formula but see the world as a complex mess that needs different responses on different days. That may mean anything from setting yourself up for a procedure because the tech called in sick, to seeing patients in the triage room to get things going, as there is no physical space to see a new patient anywhere else. The hedgehog sees only the forest while the fox sees only the trees.

Do you have foxes in your emergency department? These individuals can appear to be scatter-brained and unfocused, because they are not concentrating on what you think is important. Maybe they are calling the lab to see if there is something going on with the chemistry machine that day, instead of monitoring the average turn-around time for chemistry over the last year. It is a different way of thinking. Obviously, both can be very useful on a particular day with a particular problem.

Which One Are You?

So which one are you, or do you think you are a hybrid? Which do you think would work better in your emergency department and what style does your director or administrator fit into? Some situations definitely call for a firm hand, directing people down a definite path.



“
A FOX
knows many
things, but a
hedgehog one
important thing.
— Archilochus
”

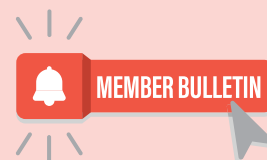


FROM THE EDITOR'S DESK Other situations call for a more adaptive and improvisational approach. What is important is that we recognize how we are thinking and how the people around us are thinking, and how those may be at odds. These different styles lead to conflicts, and not just in the emergency department. During a conflict we need to stop and think about why there is a problem. The key is to understand the other side's method of dealing with problems.

Our answer to suggestions cannot be that our patients are "the worst," so the consultant's ideas will never work in our ED. Both being too rigid and too reliant on improvisation have pros and cons, but the interaction of people with different styles needs to be recognized and made productive.

Please think about these two worldviews, and consider how the other side is thinking before you act and respond. ●

Introducing the AAEM Member Bulletin



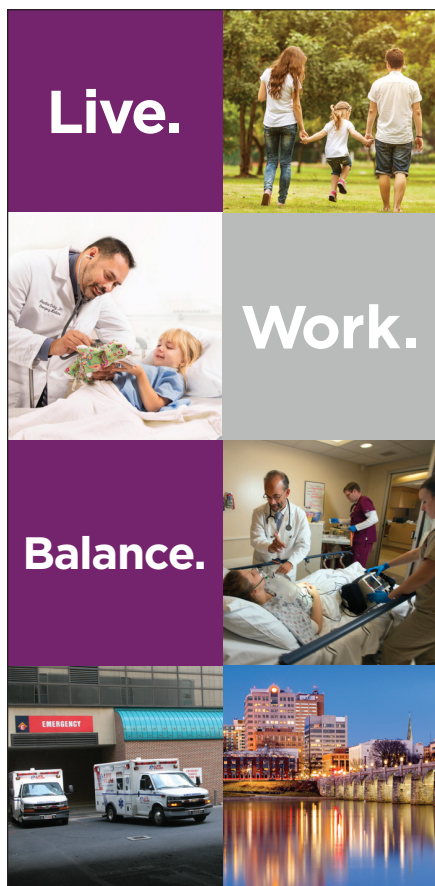
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The Kevin G. Rodgers Fund and the Institute will LEAD-EM just like Dr. Rodgers did. The funds will support important projects such as development of leadership qualities, and clinical and operational knowledge of emergency physicians with a view toward improving and advancing the quality of medical care in emergency medicine, and public health, safety and well-being overall. LEAD-EM would like to thank the individuals below who contributed from 1-1-2019 to 7-15-2019.

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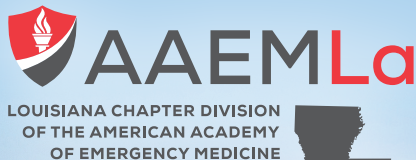
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September 11, 2019



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AAEM Conferences

September 5-6, 2019

ED Management Solutions: Principles and Practice
New Orleans, LA
www.aaem.org/education/events/ed-management-solutions

September 7-8, 2019

Oral Board Review Course – Fall 2019
Dallas, TX and Philadelphia, PA
www.aaem.org/oral-board-review

September 14-15, 2019

Oral Board Review Course – Fall 2019
Chicago, IL and Orlando, FL
www.aaem.org/oral-board-review

September 22-25, 2019

Xth Mediterranean Emergency Medicine Congress – MEMC19
Dubrovnik, Croatia
www.aaem.org/MEMC19

September 25-26, 2019

Oral Board Review Course – Fall 2019
Las Vegas, NV
www.aaem.org/oral-board-review

April 19-23, 2020

26th Annual Scientific Assembly – AAEM20
Phoenix, AZ
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AAEM Jointly Provided Conferences

September 11, 2019

2019 AAEMLa Residents' Day and Meeting
New Orleans, LA
www.aaem.org/AAEMLa

November 5-9, 2019

Emergency Medicine Update Hot Topics
Oahu, HI
www.aaem.org/education/events/emergency-medicine-update-hot-topics

AAEM Recommended Conferences

September 13-15, 2019

The Difficult Airway Course: Emergency™
Seattle, WA
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October 4-6, 2019

The Difficult Airway Course: Emergency™
Chicago, IL
<https://theairwaysite.com/>

December 9-11, 2019

2019 ACMT Total Tox Course
Washington, DC
<https://www.acmt.net/TotalTox.html>

December 11-14, 2019

Emirates Society of Emergency Medicine Scientific Conference (ESEM19)
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WELCOME TO MEMC 2019!

Lisa Moreno, MD MS MSCR FAAEM FIFEM
President Elect, AAEM; Executive Chair, MEMC 2019



On behalf of the Executive and Scientific Committees, it is my pleasure to welcome you to the Xth Mediterranean Emergency Medicine

Congress (MEMC), jointly organized by the American Academy of Emergency Medicine (AAEM) and the Mediterranean Academy of Emergency Medicine (MAEM), to be held in Dubrovnik, Croatia on the 22-25 of September 2019.

“

IN ADDITION

to our cutting edge updates on pain, cardiac emergencies, pediatrics, geriatrics, infectious disease, EMS, critical care and so much more, we will also feature a Women's Empowerment session...

”

AAEM is the specialty's strongest proponent of board certification as the standard for the emergency medicine specialist. Our members know that for years our Executive Board has worked closely with ABEM to make the maintenance of certification and life-long learning requirements relevant to patient care, protective of patient safety, and reflective of what we do

in the ED as skilled, committed specialists. This year, the theme of specialty training and board certification will be front and center at MEMC. Dr. Terry Kowalenko, the immediate past president of ABEM, will give the Keynote address on the importance of board certification to the development of the specialty internationally. While many countries struggle to provide essential emergency care at the same time as the specialty is developing, growing the specialty the right way from the start is the only way to insure that patients everywhere get the highest standard of emergency care. Dr. Kowalenko has worked both nationally and internationally to develop standards for both residency training and board certification, and his experience will inform the important theme of his Keynote.

MEMC will also feature plenary speakers who have worked diligently to establish residency programs and board certification criteria in their respective countries. This year's Founders Award winner, Dr. Saleh Fares, is the President and Founder of the Emirates Society of Emergency Medicine. Dr. Fares sought residency training outside of his country so that he could bring those skills back to the United Arab Emirates and work with colleagues to establish residency training and certification criteria for this new specialty. Although he readily tells you that he did not do this alone, Dr. Fares

“

THIS YEAR,
the theme of specialty
training and board
certification will be front
and center at MEMC.

”

provided the leadership and direction essential to making EM a board certified specialty in the UAE, and his work serves as an example not only in the Arab world, but globally.

Dr. Melanie Stander presents the next step in that process. Dr. Stander was a member of the first class of residency-trained physicians to qualify as an EM specialist in South Africa. She is a Past- President of the African Federation of Emergency Medicine and the current Vice President of the International Federation of Emergency Medicine. Dr. Stander has worked diligently to advance the specialty both in South Africa and in the world. She is this year's winner of the Dr. Cristina Costin International Emergency Medicine Award, given annually to a female physician who has made a profound and sustained contribution to the development of emergency medicine in her country. Dr. Stander will speak about women's leadership in EM.

>>

Xth MEDITERRANEAN EMERGENCY MEDICINE CONGRESS



MEMC19

www.aaem.org/MEMC19
#MEMC19

REGISTER NOW

Dubrovnik
CROATIA
22-25 SEPTEMBER 2019



WELCOME TO MEMC 2019!

Dr. Ian B. K. Martin is a longstanding member of both AAEM and SAEM, and he was recently in-

stalled as President of SAEM. Dr. Martin is only the second African American to hold that position, the first being Dr. Marcus Martin. While the two Dr. Martins are not related, Dr. Marcus Martin has been an inspirational mentor to Ian, me, and so many of our friends and colleagues throughout our careers. Dr. Ian Martin is himself an inspiration, bringing together support of residency training and board certification and the global expansion of our specialty in one career. His plenary presentation will focus on leadership in emergency medicine.

Collaboration is another of the themes featured at every MEMC. This year, Dr. Vikas Kapil, Chief Medical Officer and Associate Director of Science at the Center for Global Health at the Centers for Disease Control and Prevention, will focus on the theme of global health needs and global development. Dr. Kapil is board certified in Emergency Medicine and Preventive Medicine, and has been a colleague and advisor to many of us as we seek to develop culturally competent, locally empowering emergency care in various countries around the world. Dr. Kapil is a strong supporter of the accreditation of residency training programs in order to insure uniformity of training and the best standard of care for every patient.

The best care has to be based on rigorous, accurate research. Another of our plenary speakers, Nishant Kishore, links high quality research and the role of emergency physicians in disaster response. Mr. Kishore is a doctoral candidate at the T.H. Chan School of Public Health at Harvard University. He performed groundbreaking research on the impact of

“
DUBROVNIK
is ready to
welcome us.
”

Hurricane Maria, which was published in the New England Journal of Medicine. AAEM consistently seeks to develop the careers of young investigators and physicians, and we are proud to present a plenary speaker who has done excellent work while still in training.

Last and most certainly not least, Dr. Billy Mallon, a professor of emergency medicine, is well known to emergency physicians for combining humor and hard facts in his engaging lecture style. Dr. Mallon will update us on trends in marijuana use turning up in our EDs.

In addition to our cutting edge updates on pain, cardiac emergencies, pediatrics, geriatrics, infectious disease, EMS, critical care and so much more, we will also feature a Women's Empowerment session, headed by Drs. Judith Tintinalli, Eveline Hitti and Meagan Healy, and an International Panel of experts from around the world sharing their winning strategies for tackling problems in emerging EM systems.

Take advantage of our popular pre-con courses before they sell out. Dr. Susan Torrey's Advanced EKG, Dr. Wood and Lambert's

Ultrasound, and Dr. Terry Mulligan's LEAD ED Management are always fast sellers. New offerings include a Chemical Warfare course with Dr. Ziad Kazzi, and workshops on publishing your research and on board airplane emergencies.

Dubrovnik is ready to welcome us. The city where many segments of *Game of Thrones* were filmed offers archeological gems from the Roman Empire and the medieval period, pristine beaches, and the most natural and freshest fish and produce, harvested within hours of the time it's served. Our Sun Garden Resort features four pools, two gyms, saunas, tennis courts, a regulation basketball court, several restaurants, bicycles, a climbing wall, table tennis, pool tables, playgrounds, water aerobics, a spa, yoga, a meditation room, and even more. Following our Opening Reception (free with your registration), we will host you at the resort's nightclub for an evening of dancing with a cash bar. Our Gala Dinner, replete with music and typical Croatian cuisine, will be held at an ancient fortress featured on *Game of Thrones*. Tickets are on sale on our website. Feel free to roam the Old City. Croatia is one of the safest and most inexpensive places in the world. Sign up for a *Game of Thrones* walking tour, scout the shops for unique Croatian jewelry and handicrafts, network with old friends and make new ones, relax with your family. MEMC is the place to be in September. I want to greet you personally and thank you for making the conference everything it would not be without you. Be in Croatia for the Xth MEMC! ●

Dr. Lisa Moreno Receives the Order of the INTERNATIONAL FEDERATION FOR EMERGENCY MEDICINE

AAEM President-Elect, Lisa Moreno, MD MS MSCR FAAEM FIFEM, was awarded the "Order of IFEM" in recognition of her contribution to the development of emergency medicine internationally. The award ceremony was held during the 18th International Conference on Emergency Medicine in Seoul, Republic of Korea, June 12-15, 2019.

CONGRATULATIONS TO DR. MORENO FOR THIS AWARD AND HER ACCOMPLISHMENTS.



Can Simulation Give Us Objective Data to Help Overcome Implicit Bias?

Elizabeth Rubin, MD



In the March/April 2019 issue of *Common Sense*, Dr. Danya Khoujah discussed the role of bias in performance evaluations. She posed a challenge

to her readers to identify a solution. Embracing simulation as a means for evaluation is one such viable solution.

In 1998, three scientists founded Project Implicit, a non-profit organization that aims to reveal, examine, and educate the public about hidden biases and evaluate the way those biases impact the way that we see the world and make judgements on a daily basis.

The implicit bias test has dramatic, if not uncomfortable, results. The comprehensive tests reveal the subconscious way we as individuals judge others based on gender, ethnicity, race, or other external factors, and have subconscious preferences and expectations of career roles or ability. These results can be extrapolated to the way program directors and faculty evaluate physicians in training.

In a comparison of male vs. female emergency medicine resident milestone evaluations, a study in 2017 showed that males consistently scored higher than female residents throughout residency, despite starting at the same levels during the first year. The study looking at resident evaluations and milestone achievement showed that female emergency medicine resident physicians were not achieving milestones as quickly as the men in their cohort. This measure of “achievement” however, may be more as a result of evaluator bias than a measure of clinical skills or ability. By having a standardized milestone assessment via simulation, clear

feedback can speak to areas of improvement and skill level, as well as provide unbiased data on the management of complicated, rare, and even more common medical ailments that present to the emergency department.

A comprehensive Simulation Assessment experience may be the answer to begin to address these issues. In 2014, a group of emergency medicine residencies collaborated for a simulation based assessment of ACGME milestones in order to overcome challenges that arose from the lack of standardized assessment instruments. With a binary grading system and reliance on a checklist to evaluate tangible criteria, the results have a lower risk of being influenced by implicit bias. In addition, a standardized assessment allows for a comprehensive evaluation, which is an improvement over end of shift evaluations that can be clouded by bias, interrater variability, and other confounding factors. A recent study published August 2018 showed no statistically significant difference in score between male and female residents when using a simulation experience to evaluate residents. By controlling the assessment environment, resident competency was evaluated in a manner that excluded implicit bias and can help add an objective assessment to the multiple factors that play a role in annual and semiannual competency evaluations.

As the interdependence of the practice medicine and technology continues to develop, it is time to bring that technology into the resident evaluation process. Adding more objective data can only help close the gap that results of the societal biases that are covert and hard to overcome. ●

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BIAS

“As the **INTERDEPENDENCE** of the practice medicine and technology continues to develop, it is time to bring that technology into the resident evaluation process.”

A Sad But True Story

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



The issue of the appropriate role of advanced practice providers (APPs) in our emergency departments has been recently analyzed by a task force of AAEM and a new position statement has been approved. AAEM recently published this position statement and AAEM and this editor also submitted contributions to other emergency medicine publications (*EM News*, April, 2019) related to this issue. *Common Sense*

has recently been contacted by a member of AAEM related to the impact of the increasing use and role of mid-levels in our emergency departments.

This member has recently been told by the new contract management company which took over her hospital's emergency department staffing contract that there would no longer be any shifts available for her and the other part-time physicians, as the company would be bringing in midlevel providers to take these shifts. *Common Sense* thought an interview with her would be a good way for our members to understand the risks to our practices by the expanded use of midlevels. Will we be replaced by Doctors of Nursing Practice (DNPs)?

Andy Mayer, MD FAAEM
Editor, *Common Sense*



Dr. Mayer: So, please tell us a little about yourself, where you went to school, your path to emergency medicine and training.

MEMBER: I am an emergency physician in Louisiana. I went to LSU Medical School in New Orleans, and originally wanted to be a pediatrician. During my third year of pediatric residency, I did a rotation in a pediatric ED and loved it. It was then that I decided to do EM. My initial plan was to do Peds EM, but when I did a second residency in emergency medicine, I found out that I really like adults too!

Dr. Mayer: How did you end up in in practice in Louisiana?

MEMBER: I am from Louisiana and I decided to stay home to be around my family after residency. My first real job was with my current hospital system, and have been with them for around 15 years (other than a brief time at another local hospital to help them start their pediatric ED).

Dr. Mayer: Tell us about the group you joined and the working conditions.

MEMBER: The physician group here has been great to be a part of for many years. It really has been a family-type of atmosphere. We have over 30 ED physicians, and have been providing good care in our region. In fact, we are the only hospital in our area with all board certified emergency physicians working in our emergency departments. I went to part-time work when my daughter was in kindergarten, and she is in 4th grade now. I was an older mom, and wanted to enjoy being a mom. I could be flexible and work more when there was a need and could work less when needed less. Interestingly as a side note, part-time work has been advocated as one avenue to help physician burnout, and I agree. Being part-time has helped me enjoy work more.

Dr. Mayer: Your group sounded great and a place many of us would have been proud to work with. Please tell us what happened? How did the changes to your group by the new contract holder affect you and the other board certified emergency physicians working there?

MEMBER: The hospital was in the process of rolling out a new contract for the ED physicians. In fact, I had just signed the new contract two weeks before that day in August when we were told on a group text that an outside contract management group would be taking over our contract effective November 1. We were blindsided. It was a surprise even to the directors. The corporate management group said that the pay would not change significantly. They gave the staff information on new changes in March.

One change they planned on implementing was to bring on advanced practice providers. Board certified emergency physician hours would be decreased to make room for these midlevel providers. I was told that this was because the labor cost for these midlevel providers was cheaper. This meant that the part-time doctors would no longer be needed as their shifts would be filled with the midlevels, and many of the full-time doctors would have their hours cut. We were all board certified emergency physicians, most with 19+ years of experience. One has been a loyal ED doctor in our system for almost 40 years. Many of us are doctor moms (who work full-time at home, too). Others are also employed at our VA hospital and supplement their income for their families with part-time shifts at our hospital. No more work for us in the hospital system we have been serving for years. We will not be needed, as non-doctors will be replacing us on the schedule.

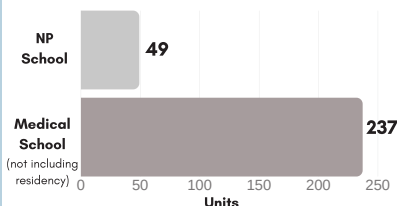
My residency advisor, who is now one of the administrators at the CMG, had to tell me in April (ironically the day after Doctor's Day) that there will not be any more shifts for me or the other part-time doctors when the APPs will be implemented. I told her that it stinks. She said it was business. So emergency medicine is just down to business now. How will patient care suffer? I do understand the business part, but replacing doctors



WHAT IT TAKES TO MAKE A DOCTOR

The Educational Differences between Medical Doctors and Nurse Practitioners

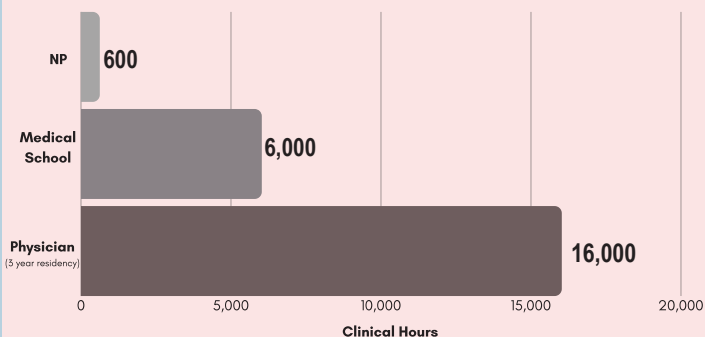
CERTIFICATION BY UNIT REQUIREMENT^{1,2}



- Even without accounting for residency, which is an additional 3-7 years of training, physicians who just graduated medical school had to take nearly 5x the amount of units for their degree compared to NPs.

* Example programs are listed that state their specific unit requirements for graduation. These sources closely resemble other programs of their same degree.

CLINICAL HOURS REQUIRED FOR CERTIFICATION



- While some nurse practitioner degrees can be completed 100% online in as little as 5 years including college, physicians must complete at least 11 years and more than 16,000 hours of hands-on training before treating patients independently.⁵
- An NP has less than 4% of the clinical hour training of an MD/DO (with the minimum 3 years residency training).⁴
- **A medical student, who is not allowed to treat a patient independently, would have undergone nearly 5x the amount of unit requirements and 10x the amount of clinical training that a fully licensed NP has.**



With the vast amount of education, training, and clinical hours required to produce a single physician (the most of any healthcare team member), physicians can rely on a much larger breadth of knowledge in each of the medical decisions they make. This is why we at AAEM/RSA believe that all healthcare team members, including nurse practitioners, should be under the supervision of a physician in order to ensure the safety and proper health care of our patients.

#ASKTOSEEYOURPHYSICIAN



1 https://www.samuelmeritt.edu/nursing/ftp_nursing/curriculum
 2 <http://med.stanford.edu/medhandbook/section-4-curriculum-overview.html>
 3 <https://tftp.org/media/default/downloads/advocacy/scope-education.pdf>
 4 <https://www.tatp.org/Media/Default/Downloads/advocacy/scope-ramas.pdf>

A SAD BUT TRUE STORY with non-doctors is not right. Also, the physicians who remain with the system will be required to work with APPs. It would be different if you have

a midlevel provider in an office setting, where you can hire and train them to work as you do. However, in the ED there are so many different doctors to work with and different individual approaches to patient care. The ED doc has no voice in whom to hire or who they will work with on shift. They can be required to work with them even if they would have treated a patient differently, and this opens the physician up to more risk of litigation. True point, there are now malpractice lawsuits where this has happened and the doctor was sued — and lost.

Dr. Mayer: Where are you working now?

MEMBER: I still love emergency medicine. I am blessed to be in a field where I can work on a part-time basis. I have been working some at our VA and in rural emergency departments lately. The work is good, and I have time to talk and visit with my patients. For Doctor's Day, the rural hospital gave all the docs a nice engraved mug with candy. (I was told that even the pharmacists were involved in helping with the Doctor's Day gifts!) That is definitely a different experience. Yes, there is a physician shortage in the rural areas. Part of the solution was to have midlevel providers in these areas. Weren't they originally started as an entity to help doctors, not to replace them? Ironically, they are taking my job in the city, and now I drive out to the rural areas to work.

Dr. Mayer: Tell us what you are looking for and what message you have for your fellow emergency physicians in this changing work environment.

MEMBER: Please know that there are many advanced practice providers who I think are excellent — and they can be of great assistance to doctors in many fields. However, I do not think they should take the place of a board certified physician in the ED just because they are less expensive labor. Less expensive does not always equal similar quality. Would construction companies stop using steel to make buildings because it is too expensive? They might use aluminum because it is cheaper, and looks the same, but there will be detrimental long-term effects.

I have contacted ACEP and AAEM — it would be great if our societies could work together on this issue. Do board certified emergency physicians want full independent practice for advanced practice providers at the risk of making ourselves obsolete and diminishing patient care? If we can be replaced by a nurse with an online degree what message would that send to the medical students and emergency medicine residents who are spending years and huge sums of money to reach the goal of board certification? Does this mean that our training is not that important during medical school and residency? Do the number of hours required to become a midlevel compare in any way to the sacrifices required to become an actual emergency physician? The depth of knowledge is not the same. The recent exponential rise of online NP programs with their clinical hours of shadowing doctors should not replace the years of clinical training and experience of a physician, but it has. They use our education and board certification and dilute its value. How can I recommend to my pre-med niece to be an emergency physician, when we are so easily replaceable? Also, how could it be recommended to be ABEM



A SAD BUT TRUE
STORY

board certified, to jump through all of the hoops we have to, like MOC, when someone who has DONE NONE OF THIS can take your job?

My message to our ED docs is this — we need to be proactive with our contracts because our jobs and patient care are at stake. We might talk to our anesthesia colleagues, as they have been working against full independent practice of their APPs/CRNAs for years before us. We need for the public to be aware of this shift in medical care so they can have a voice in who treats them in the ED. We could refuse to cosign charts of patients we have not been consulted on, or chart a disclaimer that the patient was not independently evaluated by the MD while they were in the ED. We need for ACEP and AAEM to help speak for physicians who are afraid to do so on this issue for fear of job loss. The contract management groups have become too powerful, but we also need to realize this is not just a CMG problem. It is also going on in academic centers, hospital based departments, and smaller partnership groups. We also need to become more business oriented, maybe depending less on

CMGs and more on working together with administration to form our own groups. I understand that it is a business, but our patients should be the first priority. In a post from April, Dr. Edwin Leap talked about things we can do as physicians to improve our situation and satisfaction. He said, “I hope that over time we can push back, steadily, against bad ideas. ...To start by calling them out in the light so that physicians aren’t bullied into thinking that they’re alone, or that they’re complainers. Shine the light on the demons and they scatter. And look smaller than we thought when we stand together.”

In Louisiana, we love our Saints football. To use a football analogy, we don’t need another blown call while those with the power to change things look away and say “It’s not my problem.” This is a blown call for patient care in the ED. Our founding EM physicians fought hard to make our specialty separate and valuable for patients in emergency situations, not to give our specialty away to the lowest bidder. Job security is a thing of the past.

Editor’s Note

“ Board certified emergency physician hours would be decreased to make room for these midlevel providers. I was told that this was because the labor cost for these midlevel providers was cheaper. This meant that the part-time doctors would no longer be needed as their shifts would be filled with the midlevels, and many of the full time doctors would have their hours cut. ”

The really sad truth of this whole story is the courage it took for this emergency physician to come forward to share her story. When did we subjugate the practice of medicine to corporate management groups and hospital administrators? There are many emergency physicians who have been adversely affected by the increasing role of mid-levels working in our nation’s emergency departments. AAEM cares about this issue and wants to hear your story. AAEM has created a form where you can submit ways the increasing role of advanced practice providers has affected you. We want to hear your stories and we understand if you want to be anonymous. The fear of retribution by CMG’s and the like is sadly a real and increasingly oppressive force in modern emergency medicine. AAEM wants to clarify the role of mid-levels in our emergency departments and support the practice of emergency medicine led and controlled by board certified emergency physicians. Please submit a concern or send a letter or comment to the editor.

Submit a concern here: <https://www.aaem.org/get-involved/committees/committee-groups/em-workforce>

— Andy Mayer, MD FAAEM
Editor, Common Sense ●

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Beyond Acute Care

Priya E. Mammen, MD MPH



Renegades. Champions for marginalized peoples. Cowboys. All names I've heard used to describe emergency physicians in academic centers, it is commonplace to hear residents and others grumble about the ED and the perception of work generated from within. We all have our stereotypes of other

specialties within the house of medicine, but sibling-like taunting aside, we act as colleagues who ultimately work together for the good of our patients.

What has surprised me is how little others, outside the world of medicine, seem to understand the emergency department and the work emergency physicians do. Yet all have an opinion if the ED and expectations of what emergency physicians should be able to do. As my public health advocacy work took me to higher and larger tables, it became clear that policy makers, high powered decision makers, and federal/state/regional funders did not have a clear understanding of how EDs fit within the health system as a whole, but neither how the ED fits in the venn diagram of public sector services nor public health infrastructure. They fail to recognize that not only do we serve as the safety net of the populace, but we act as the safety net to the health system as a whole.

Emergency physicians and departments function at the interface of the medical system and the communities they serve. This vantage allows us to act as vigils of population health issues and serve as a barometer of policies in action. This is perhaps no greater reflected than the role of EPs in the current opioid epidemic. Emergency physicians were among the first to draw attention to unsafe opioid prescribing practices within the medical system at large and to develop safer strategies in our own practice. We were successful in advocating on behalf of our patients and communities to policy makers on the local and national levels to bring large scale attention to the epidemic as it developed and to inform population level interventions. Many of us have independently



worked to implement the tri-pronged approach the CDC suggests to combat the opioid epidemic - Prevent, Reduce, Reverse - well before the CDC chimed in. With a heightened awareness of the consequences of Substance Use Disorders (SUD) and IV drug use in particular, and as more EDs engage in population health initiatives such as HIV screening and HCV screening, emergency physicians transcend acute care needs alone and function at various points on the healthcare continuum.

Consequently, I learned that in order to advocate on behalf of my patients to those who could impact upstream improvements, I would also have to educate on the role of the emergency department. I would have to illustrate how EDs meet the needs of individuals and the community we serve. I could show how emergency departments are universally accessible to any and all who need us or want us. And as a result, not only were uniquely positioned to identify and address public health issues, but could serve as a tool of health equity and social justice for our most vulnerable patients. This message resonated with many and I was invited to share it on the bigger stage of TEDx.

I share it now with you - my colleagues and co-diplomates of emergency medicine. My advocacy is not only for our patients, but for the dedication and tireless efforts of all emergency physicians who meet our patients' needs where others fail.

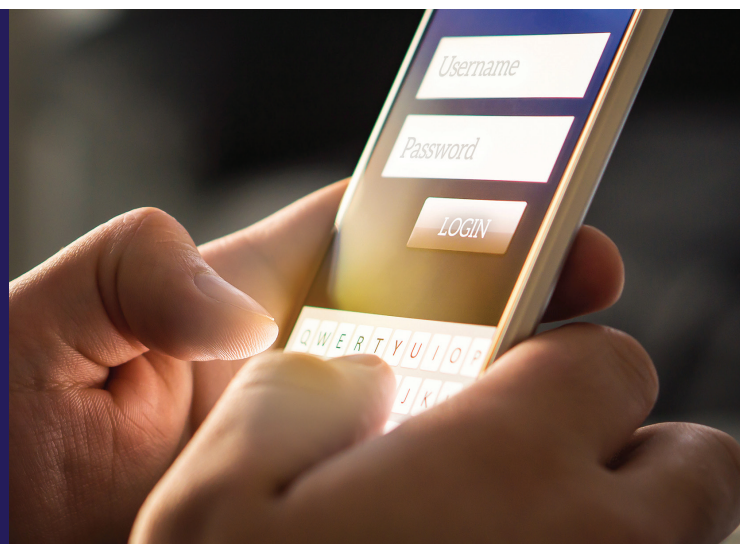
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CEN Challenge Update

Tom Scaletta, MD FAAEM MAAEM — Emergency Department Chair, Edward Elmhurst Health



In 1980, emergency physicians began taking ABEM examinations. That same year the Certified Emergency Nurse (CEN) exam was initiated by the

Board of Certification for Emergency Nursing (BCEN). This is a comprehensive, challenging test that nurses generally take after two years of emergency department experience.

AAEM members recognize the importance of specialty board certification and so we should be aware of and support the credential that measures competence in emergency nursing. Start noticing and acknowledging the pin that many CENs wear.

My 2006 AAEM President's message, Got CEN?, described the program that my group created called the *CEN Challenge*. We provide a \$1,000 honorarium to encourage emergency nurses to obtain their CEN and \$500 to renew it every 4 years. To date, we have contributed \$100,000.

Nurses spend 80% more time with our patients than we do and so it is no surprise that talented nurses significantly increase patient safety and satisfaction. They uncover relevant information and immediately alert us when vitals are deteriorating.

Before we initiated the CEN Challenge, about 15% of our emergency nurses were CENs (consistent with the national rate). Over time,



the number has quadrupled. This factor contributes to our low rate of professional liability claims (according to Willis Towers Watson) and high level of patient satisfaction (over the 95th percentile according to Press Ganey).

So, encourage your nurses to obtain their CENs by recognizing this accomplishment in some manner. Treat it like a big deal ... because it is! ●

“TREAT it like a big deal ... because it is!”

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Presented by the AAEM Operations Management Committee

Stop Injury Lawyers

Gary M Gaddis, MD PhD FAAEM FACEP FIFEM



I was born in the late 1950s. When I was young, just as was the case for physicians, it was considered unseemly for attorneys to advertise their services. Not anymore! Now, it seems that every other bus or taxi has an advertisement for a personal injury lawyer. And, of course, the groups against whom they like to claim injury includes doctors and hospitals.

So, imagine my pleasant surprise, while sitting in a line of stopped traffic, when I saw this vision, right in front of me!

Not only was I waiting for a red light to turn, I was waiting directly in front of the hospital at which I practice, when I noticed this juicy opportunity!

So, I quickly reached in my pocket and turned my phone on, flipping immediately to my photo app. I captured my photo, which I now share with all of you. All of this occurred before the light turned green.

The total justice of it all! A bus, carrying advertising for a personal injury lawyer firm, appealing that we “Stop Injury Lawyers,” right in front of the hospital where I could imagine them actively trolling for clients.

I was thinking to myself not only that I could not agree more with the sentiment on the back of that bus, but that it was just sooooo very very just that this message was broadcast right in front of the hospital at which I work!

Then, to add to the experience of writing this caption, today Missouri Governor Mike Parson signed a bill recently passed by our legislature that provides for some useful tort reform! ●



AAEM News

Western Journal of Emergency Medicine's (WestJEM) Journal Rank and Impact Factor Advance Substantially!

Previously published as a WestJEM Press Release – June 12, 2019

AAEM is happy to share the latest news on WestJEM's journal ranking.

Published by the Department of Emergency Medicine at the University of California, Irvine, WestJEM is one of a few fully open-access EM journals, and now ranks 12/84 worldwide (86th percentile), per the newly released SCImago Journal Rank (SJR) index for 2018. This represents a notable jump from a rank of 16/78 titles in 2017.

WestJEM

Integrating Emergency Care with Population Health

The 2018 Scopus CiteScore also ranks WestJEM at 11/77 EM journals worldwide, up from 16/78 in 2017.

Impact Factors from the two sources improved to 1.75 for two-year, and 1.65 for three-year metrics. These are increases of 33% for CiteScore and 11% for SCImago over 2017.

These place WestJEM as the 4th or 5th ranked general EM journal in the world, and 2nd or 3rd among Open Access EM journals.

WestJEM focuses on the integration of population health with emergency care. The journal is indexed in all major medical databases including MEDLINE and PubMed and a member of the Open Access Scholarly Publishers Association. WestJEM's companion journal, CPC-EM, has also grown with its indexing through PubMed and PubMed Central.

WestJEM's authors, section editors, editorial board, and sponsors are all critical elements to the journals' success. They sincerely thank the entire WestJEM community for its continued support. ●

Thank You

Robyn Hitchcock, MD FAAEM



I began this article after the AAEM Scientific Assembly (AAEM18) in San Diego and I've added to it since returning from AAEM19 this April. Both

conferences were inspiring. I truly wonder if my earlier career would have had a different trajectory if I had gotten involved with AAEM earlier. But looking forward, I am excited about the support and camaraderie I am sharing in this organization.

In 2018, a call went out for student mentors and I volunteered. As a community physician I don't get the opportunity to work with students or residents and thought it might be fun to get a snapshot of the up and coming doctors in the field. The experience has been more fun and rewarding than I could have imagined (shout out to Katie Scholp, my student mentee).

Much of my focus and goals for AAEM18 were centered on resilience and wellness: something I am always striving for but haven't really figured out yet. A common theme I noticed in several of the lectures and committee meetings was the suggestion to reframe potentially negative situations to create positive energy instead of negative. Great idea, tough to implement.

On any woman MD blog, social media channel, or even when two or more of us are in a room together, there are common irritations. One I heard several times was the recurring, "patient mistakes you for a nurse" situation. We have all been there: you walk into the room, introduce yourself as, "Dr____," shake hands with the patient and family and then they ask if you are their nurse. (FYI male colleagues, a day rarely goes by when this doesn't happen at least once. Really.)

This issue was raised at several forums throughout the talk. I sometimes get snarky and reply, "They let girls be doctors now." Others shared similar quotes they find themselves repeating, and we all have to mentally restrain the eye roll. Not really good for anyone in the room: the patient is having to realize they were inappropriate and are embarrassed, we are upset and offended and trying not to show it, and there is just tension, which is never a great way to start a patient encounter .

What if we had a way to empower both ourselves, and the patient/family when this happens?

At the last social event of the conference this issue came up yet again. A series of the usual snarky comebacks to this or similar situations ensued which promote laughter and that always helps lighten the mood. But I was with my mentee at the time and just wanted to do better. For her. For me. For the future of our profession.

So for the first time, in the supportive, healing environment of the conference, I really racked my brain for a better solution.

I kept going back to nursing. My sister is a nurse. My mom was an RN for 20 years and then one of the earliest nurse practitioners for the last 30 years of her career. I have the utmost respect for nurses and simply could not do my job without them. Nor could any of us.

I turned to my mentee and said, "What about 'Thank you.'" "What?" Curiosity and then comprehension in her glance "What if we said, 'Thank you'." Thank you for thinking I have the compassion and patience to be a nurse. Thank you for putting me in the category, without even trying, with my amazing mother. My unbelievable sister, who is back to full time nursing after an MS diagnosis, and the countless dozens of nurses I have been fortunate to work with over the years.



“ A COMMON THEME I NOTICED ... was the suggestion to reframe potentially negative situations to create positive energy instead of negative. Great idea, tough to implement. ”

Of course, most of that is my internal monologue. To my patient, perhaps "Thank you, but I'm your doctor" will suffice. However, inside my head I'm already being lifted up, mentally, by my sister and mother. And all the other nurses I have been fortunate to work with over the years. I can't help but smile a little, and so does my patient. Or their family. Or both.

Because a potentially negative moment was diffused and deflected into an uplifting moment for all of us.

Think about what just happened. Instead of a snarky comment and mental eye roll with patient shaming, we have just created positive feelings for everyone in the room. Just like the Tai Chi class, (shout out thanks to the Wellness Committee) the last morning of the San Diego conference, when we got to practice pulling our assailant's energy towards us then deflecting it, so much more effective than pushing back.

Two simple words to turn a toxic moment into an uplifting one.

Thank you.

Dr. Hitchcock blogs about travel and locum tenens work at: StethoscopesuitcaseMD.wordpress.com ●



Something to Think About: Metacognition and The Cognitive Pause

Keys to Safe Decision Making in Emergency and Ambulatory Care Practice

Michael A. Sequeira, MD and Gregg Miller, MD FAAEM



Making safe medical decisions in emergency and ambulatory care practices is challenging. As emergency medicine (EM) clinicians, we are faced with a constant barrage of interruptions necessitating multitasking and task switching, as detailed in a 2016 article by Skaugset, et al. The ED environment puts extreme pressure on the emergency clinician to constantly make multiple, fast life-and death decisions. Inherent cognitive biases that are part of everyone's normal neurochemistry can further complicate an already complex decision-making process.

Nobel Prize winner Daniel Kahneman, in his book "Thinking: Fast and Slow," explains that our brains are structured to have two ways of thinking: The fast way, System 1, is quick, automatic, algorithmically based, and is the usual default process in most situations. It's our gut reaction. The slow way, System 2, is more systematic, complete, and deals with complex situations and problem solving. It's a thoughtful approach after taking time to weigh the variables.

Ideally, we use fast thinking for easy problems, and slow thinking for the more difficult problems. But in EM, we make many of our decisions in the fast mode using unconscious frameworks to speed up the process. Cognitive biases are short-cuts, also known as heuristics, our mind uses while in the fast mode that can lead to medical errors. Heuristics such as the anchoring bias, availability bias, and confirmation bias, in combination with the tendency of the mind to shift into fast thinking mode, lead providers to make fast, quick decisions and jump to incorrect conclusions.

How can we avoid falling into the trap of fast thinking for a complex problem? The key is in the practice of metacognition, which simplistically, is just the practice of "thinking about your thinking". This awareness of your type of thinking, and the ability to recognize the cognitive traps, is vital to making safe, complex decisions in our practices.

A best practice for metacognition and bringing mindfulness into our practices is to utilize a practice called "The Cognitive Pause." This is based on the work of noted patient safety researcher and emergency physician Dr. Robert Wears, and further described by Dr. Mark Jaben. A "Cognitive

Pause" is the practice whereby the clinician at the point of any important event in patient care, including formulating a diagnosis or disposition, and includes five components:

- Reserves a brief time just to think of the patient, and nothing else.
- Reviews if there is anything atypical or complex in the case
- Questions if any cognitive bias has intruded in their thinking
- Considers "Can't Miss Diagnoses" for the symptoms and signs being considered.
- Considers the best way to document and substantiate their decisions.

In our physician partnership, we teach the cognitive pause in our workshops on medico-legal risk. We emphasize to clinicians the need to consciously run through this mental checklist and slow down their thinking. While we can't yet prove that a cognitive pause and slow thinking truly makes a difference in our medico-legal risk, our gut feeling — using fast thinking! — is that it must. We encourage you to spend some time "thinking about thinking" with your group and discussing whether a cognitive pause is a practice you'd like to adopt.

Dr. Michael Sequeira is the Director of Risk for Vitivity. Dr. Gregg Miller is the CMO of Vitivity.

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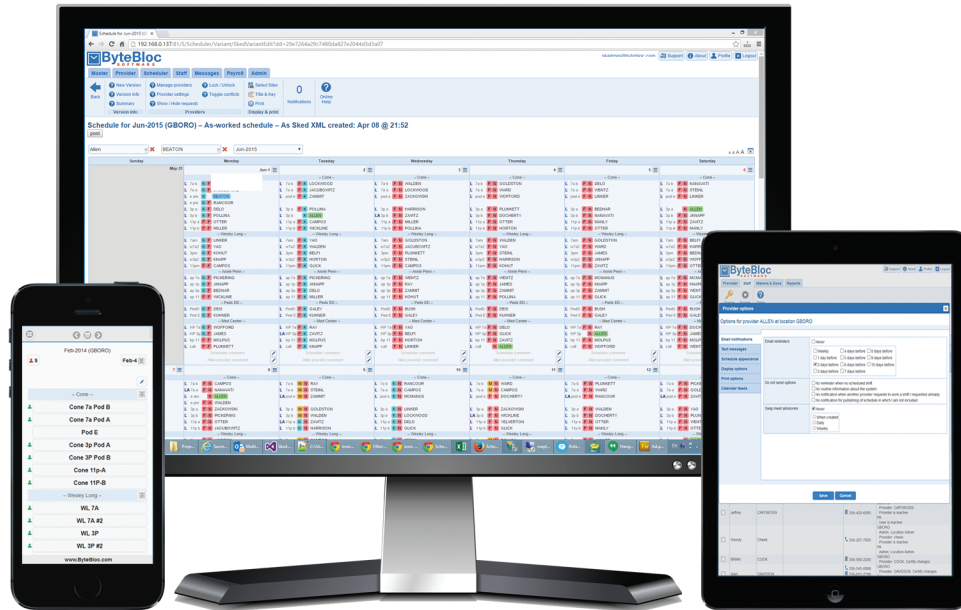
EXAMPLES OF COGNITIVE BIAS	
Aggregate bias (aka ecological fallacy)	Believing that evidence-based (aggregate) data does not apply to your patient. This can lead to errors of commission, such as an increased CT usage when decision instruments such as PECARN are ignored
Ascertainment bias	Seeing what you expect to see, based on preconceived expectations. Includes stereotyping and gender bias, as well as “frequent flyer” bias.
Availability bias	Reaching a diagnosis based on your recent experience with a particular case.
Belief bias	The tendency to accept or reject data based on one’s personal beliefs. For example, individuals may be “true believers” in tPA for ischemic stroke, and therefore reject any evidence that would contradict their belief.
Commission Bias	The tendency towards action rather than inaction, such as over-ordering CT scans for headache.
Confirmation bias	Only noticing data supporting your initial diagnosis and ignoring contrary data.
Diagnostic Anchoring	Prematurely settling on a single diagnosis and ignoring new data which may lead to a different diagnosis. This is closely related to, and made worse by, confirmation bias.
Diagnosis momentum	Similar to anchoring. Once a diagnostic label has been assigned to a patient by another individual, it is very difficult to remove that label and interpret their symptoms with fresh eyes.
Omission Bias	The tendency towards inaction rather than action, such as delaying a surgical airway.
Triage cueing	Diagnosis and treatment is based on initial triage labeling, such as doing less workup on patients placed in a low-acuity ED pod.

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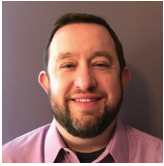


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How Do We Measure Burnout?

Adam Kennah, MD FAAEM and Carie Martin, MS



Burnout. We hear the word in our profession almost daily now. But what is burnout? And more importantly, how do we measure it?

Researchers in the 1970s set out to answer those exact questions. Psychologists began to recognize that individuals in the helping professions would frequently develop emotional exhaustion and cynicism towards their clients. They noticed that individuals in the health services industry were particularly prone to developing a calloused and dehumanized attitude towards their patients. As researchers untangled the various aspects that defined the burnout syndrome, efforts were then directed at creating a standardized measure to assess burnout in providers.

In 1981, Christina Maslach and Susan Jackson published the Maslach Burnout Inventory. The MBI and its variations remain one of the most validated and useful tools in the measurement of burnout. The full survey consists of 22 items (abbreviated versions also exist), designed to measure three specific areas: Emotional Exhaustion (EE), Depersonalization (DP), and Personal Accomplishment (PA). Providers rate how often they experience certain feelings, between never to every day. Examples include:

- I have become more callous toward people since I took this job (DP)
- I feel burned out from my work (EE)
- I don't really care what happens to some patients (DP)
- I feel I am positively influencing other people's lives through my work (PA)

Symptoms of burnout as registered in the MBI have been associated with increased medical errors and malpractice claims, increased physician turnover, decreased level of professionalism, and a lower level of personal wellbeing – including alcohol abuse, suicidal ideation, and even car accidents.

If a 22-item survey seems overwhelming, studies have shown the responses to the first two questions listed above strongly correlate with scores for the entire MBI. Providers who answer “once a week” or greater on those two questions have been shown to report twice as many medical errors and a three-fold increase in suicidality.

While the MBI is the most often used survey in current literature, other surveys are also cited, including:

1. Oldenburg Burnout Inventory – 16-item survey grouped in two subject areas: exhaustion and disengagement from work
2. Copenhagen Burnout Inventory – 19-item survey that measures burnout in three realms: personal, work-related, and client/patient-related
3. Physician Work-Life Study's Single Item – wording varies, but it simply asks, “How would you rate your level of burnout?”

While the various surveys may differ in structure, they draw from the same three indicators of burnout defined in the original MBI. Most of us can likely recognize those same three indicators in either ourselves or our colleagues – loss of empathy and compassion toward our patients, lack of satisfaction in our work, and a consistent feeling of exhaustion.

So..... How much burnout do you feel? ●

“
But What Is
BURNOUT?
And more
importantly,
how do we
measure it?
”



An Update from the Government and National Affairs Committee

Andy Walker III, MD FAAEM – Chair, AAAEM Government and National Affairs Committee



On June 6, the AAEM Resident and Student Association put on an excellent Health Policy in Emergency Medicine Symposium (HPEM).

In my opinion it was the best yet, with both congressmen and state legislators giving talks, along with topical experts from AAEM and private business. The next day AAEM's board of directors, HPEM Symposium attendees, and I spent the day on Capitol Hill educating legisla-

“

MOMENTUM

is building very quickly in Washington for a solution to the balance bill/surprise bill problem.

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tors, staffers, and regulators on issues like due process for emergency physicians, balance billing/surprise bills, medical student debt, and psychiatric boarding in EDs due to the lack of psychiatric resources in our country.

Momentum is building very quickly in

Washington for a solution to the balance bill/surprise bill problem. The good news is that everyone agrees that patients should be taken out of the middle of the conflict between insurers and physicians/hospitals. (I refuse to use the word “provider” in its medical context.) The bad news is that most of the proposed solutions would make the insurance industry's immense and near-monopolistic power truly absolute, and hardly anybody in Washington understands the unique role and vulnerability of emergency physicians and EDs in our nation's medical safety net – even though EMTALA has been federal law since 1986. It is important to the continued health of our specialty – and to the patients we serve – that you **contact your Senators and Representatives before it is too late, and make sure they know what they must in order to avoid destroying America's medical safety net.**

A few years ago AAEM's Independent Practice Support Committee released a paper on this issue, and it is available at the Academy's website: <https://www.aaem.org/UserFiles/BalanceBillingPaper.pdf>. I urge you to read it thoroughly and explore the links it contains to other valuable resources, including Miles Riner's blog posts on the topic (<https://www.ficklefinger.net/>) and Physicians for Fair Coverage (<https://www.endtheinsurancegap.org/>), an organization founded to address this problem that AAEM belongs to. The Academy also has a position statement on the topic (below).

I think these are the top ten points to make to policy-makers, but please exercise your own judgment:

1. Emergency physicians and EDs have special ethical and legal obligations, and carry a charity burden that dwarfs that of any other specialty in medicine, because of EMTALA.
2. Although EMTALA is a federal mandate, it has never been federally funded.
3. Since uninsured, Medicaid, and even Medicare patients don't pay enough to keep an ED open and running 24/7/365, we depend on the minority of our patients with commercial insurance to pay our bills and fund our charity mission.
4. If insurers get away with capping OON fees below fair market rates, which is their goal, they will have no incentive to lure hospitals or emergency physician groups in-network with fair contracts. That will give them the power to dictate terms to both in- and out-of-network hospitals and medical groups, freeing them to pay as little as they want for the emergency care that we are



obligated to give their clients – our patients. That will end the cross-subsidy from commercial

insurers that keeps the ED doors open and funds our charity mission.

If the federal government doesn't then step in to fund America's medical safety net, it will disappear as independent emergency physicians groups and hospitals that don't have the bargaining clout of being an academic medical center or part of a huge hospital chain go out of business and close.

5. Fair market "usual and customary" fee rates should be determined using a charge database that isn't owned and controlled by the insurance industry, such as FAIR Health, since insurers have already been caught falsifying data to defraud physicians and hospitals – that is why FAIR Health was created (see the AAEM paper linked above or "Why was FAIR Health formed?" here: <https://www.fairhealth.org/faqs>).
6. The 80th percentile of the FAIR Health "usual and customary" fee is recommended as the OON benchmark, because setting it lower would remove insurers' incentive to lure hospitals and physician groups into network. Using a percentage of Medicare as a benchmark is inadequate, in part because Medicare reimbursement will be going steadily down in years to come. Using a percentage of the insurer's in-network rate would be disastrous, since that would prod

insurers to lower their in-network rates – thus lowering OON rates at the same time.

7. Mandatory arbitration is **not** the answer, since most emergency physician groups can't afford to arbitrate every OON bill. Insurers would ride roughshod over us.
8. Most emergency physicians would be happy to give up all balance billing, if insurers were forced to pay us fairly. We have no interest in price-gouging our patients, many of whom can't pay anything out of pocket anyway. We just don't want to be victimized by the insurance industry.
9. Most emergency physician groups want to be in-network. That gets us paid faster and more reliably, with less hassle and lower overhead – and with our charity burden, anything that cuts our overhead costs is desirable. But, we have so little bargaining leverage with insurers that they often demand in-network discounts so steep that we can't survive in-network. Staying OON is then our only option.
10. Physician groups and hospitals should be able to waive all out-of-pocket charges for a patient without being liable for insurance fraud. That requires a change in current laws and regulations.

You can identify your Representative here: <https://www.house.gov/representatives>, and your Senators here: <https://www.senate.gov/senators/states.htm>. **Please don't fail to act. Our patients need you.** ●

AAEM Position Statement on Balance Billing and Out of Network Charges

Position

Any regulations or laws that restrict out-of-network fees and balance billing from the emergency department should provide that insurers reimburse emergency physicians for their professional services at rates consistent with "usual and customary charges." The "usual and customary charge" for a service should be defined using a source of unbiased, third party data such as FAIR Health.

Background

EMTALA (the Emergency Medical Treatment and Labor Act of 1986) requires that every patient presenting to an emergency department must be examined and appropriately treated regardless of their ability or willingness to pay for that care, and regardless of insurance status or network. Although completely unfunded, this federal law created a safety net for everyone in the United States who needs emergency medical care.

In fact, the Centers for Medicare and Medicaid Services has determined that it is a violation of EMTALA even to ask a patient about health insurance or warn a patient that the emergency physicians are out-of-network with his insurer, before all necessary emergency medical care has been completed.

Because of EMTALA, insurance companies know their clients – our patients – will receive all necessary care even if their insurer has no emergency physicians in its network, and thus insurers have little incentive to offer contract terms to emergency physicians sufficient to lure them into an insurance network. **Only** the ability of emergency physicians to stay out-of-network, bill an insurer at higher than in-network rates, **and be paid by the insurer at that rate** gives insurance companies a reason to negotiate in good faith with emergency physicians.

America's emergency departments carry a huge charity burden as they deliver care to the uninsured and Medicaid patients, and Medicare doesn't begin to fund that charity mission. If insurers are freed by restrictions on out-of-network fees and balance billing to choose for themselves what they will pay for emergency medical care, emergency physician groups will go out of business, emergency departments and even some hospitals will close, and the medical safety net will unravel. Out-of-network fees and balance billing ensure the strength and adequacy of the safety net for all patients, and cannot be safely restricted unless insurers are prohibited from paying out-of-network emergency physicians less than "usual and customary charges," best defined as no less than the 80th percentile of "usual and customary" according to the FAIR Health database. ●

Tips and Tricks for the Peri-Arresting Patient

Andrew Phillips, MD MEd FAAEM



I have only articles from the “Journal of Anecdotal Medicine” to support the statement that peri-arresting patients are the most difficult, but they are.

No pulse: ACLS

MAP >50: you have a little time

MAP between 1 and 50: you're stuck in Goldilocks zone

Some facilities stock phenylephrine and epinephrine pre-made syringes. Some keep ready-to-hang dopamine, norepinephrine, and/or epinephrine infusions. Some facilities keep intubation boxes and video laryngoscope equipment immediately accessible. Some do not. So, the following are some general principles to give you time to figure out the problem and its appropriate solution.

1. Do NOT intubate.

Nonbreather. BVM if agonal breathing. Maybe noninvasive positive pressure ventilation (NIPPV) if you have a backup rate and are watching carefully; but do not intubate when the MAP is less than 50, and think hard about waiting until the MAP >60. The loss of sympathetic drive with the sedation medication (possible even with ketamine) and the reduction of pre-load with the loss of muscle tone after the paralytic can drop the blood pressure off the cliff. Adjunct airways (oropharyngeal and nasopharyngeal airways) with a BVM provide the most flexibility for the short term. If they are completely nonresponsive you can consider no drugs, but risk aspiration (and the structural integrity of your fingers). Even if it is respiratory failure, strongly consider giving the blood pressure a quick bump while you are setting up to intubate. (It is a lot more difficult to intubate during compressions...)

2. Epinephrine here; epinephrine everywhere.

From the resuscitation bay of a level 1 trauma center to the crash cart in the outpatient clinics, there is epinephrine. The utility of epinephrine in the peri-arresting patient is extraordinary because of its availability and flexibility. If things take a bad turn, you already have the code stick in your hand. If things are in the Goldilocks zone, you can give just 0.5cc or 1cc (50mcg-100mcg) IV push. If you make a little progress but need a quick infusion, you can make a “dirty epi” drip (squirt one code stick of epi (1mg) into a 1L bag of NS or any other crystalloid and pressure bag it in wide open, titrating down to effect). Epinephrine carries the benefit of being the most balanced inotrope/pressor. There is alpha and beta built-in, so whether it is cardiogenic shock, septic shock, spinal shock, etc, it will get you there. It might not be ideal, but it is generally effective and buys you time.

3. Remember calcium.

Calcium is another code cart standard that can give you a good blood pressure boost very quickly. It is calcium chloride, so be prepared to lose the peripheral IV you push it through or place and use an IO. Calcium provides inotropy, peripheral constriction, and is helpful in specific clinical settings such as hyperkalemia that may be causing the hypotension.

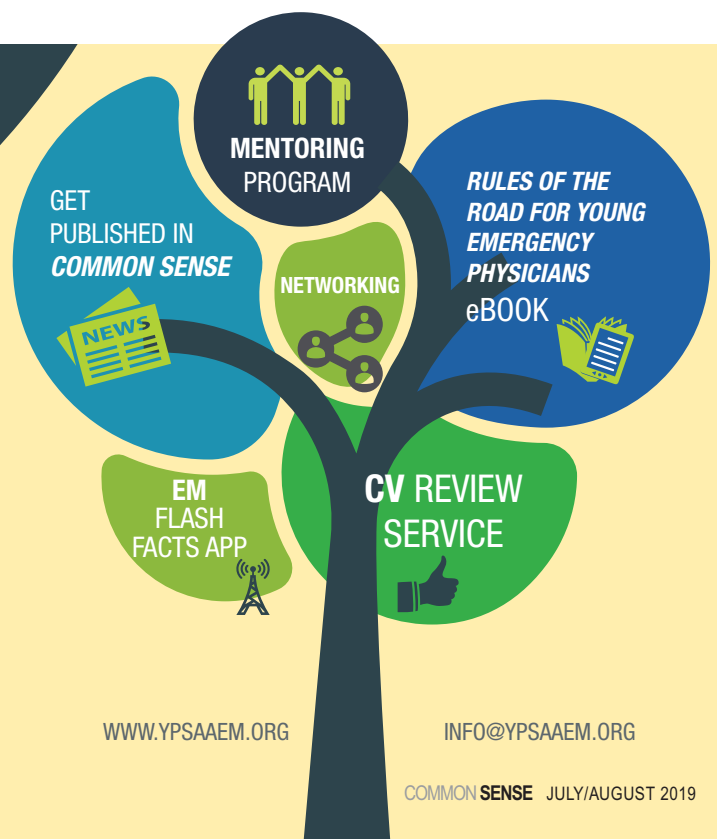
None of this takes the place of working through the differential diagnosis, or starting an appropriate inotrope or pressor for a specific type of shock. Rather, the three points above are relatively safe ways to do something fast that can raise the blood pressure, but not so much as to cause stroke. ●

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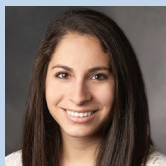


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What's New with YPS

Danielle Goodrich, MD FAAEM — President, Young Physicians Section



Welcome to the Young Physician Section! As I enter my second term as president of YPS, I am very proud of our accomplishments over the last year and I am looking forward to an even stronger year ahead for us.

Above all, YPS is a champion of the young emergency physician with a foremost goal of providing programming and support that is tailored to the needs of physicians at this pivotal step in launching their careers. We know that the transition from residency to independent practice is an exciting, yet daunting time, because of the challenges that come with such an immense transition. During this shift in your career, there are new responsibilities, new tasks, and often, one must learn their way around a new hospital or system all while preparing for boards. Our goal is to try to reduce these stressors through mentorship and education programs for you, our members. Take advantage of our mentorship program or CV review services to start your career off strong.

New Educational Benefits to Check Out

In the past year, we have focused on strengthening our educational content for our members. As medical education is changing, we too want to provide innovative resources for our members to meet their varying needs. For our members who are taking their board exams for the first time or for others who are re-certifying, we tackled the changing landscape by updating our FlashFacts Board Review App. We are very excited about the assistance it provides, especially giving busy physicians the ability to study on the go. With more questions, we want to help young physicians review for the boards whenever it is convenient for them. It can also be helpful as a teaching sidekick for your medical students or residents as well! Intimidated by the process of signing up for boards? We partnered with the American Board of Emergency Medicine (ABEM) to get helpful information to you about registering for the written boards, oral boards, and LLSAs. Check out our three-part article series in the most recent Common Sense issues.

As part of our broader education objective, we are utilizing social media to keep our members informed on important topics. Make sure to follow us on Twitter @AAEMYPS for daily tweets about finance, wellness, and board review. Continuing to utilize the technology that our members interact with, we partnered with the Resident Student Association to develop a series of engaging podcasts that we are eager to share with you all in the near future. Looking to the year ahead, we are forging even more relationships and are currently working with another fantastic podcast program, EM Board Prep Knowledge Bombs. There will be no shortage of great content coming your way!

FREE YPS Membership

We are committed to our members and we are very pleased with our accomplishments that expanded our reach and available programming for our members. We are excited to also announce that our membership is now FREE for AAEM members within the first five years out of residency! There are many opportunities for our members to get involved with, please consider joining our education committee or writing a Common Sense article!

Learn more at www.aaem.org/get-involved/sections/yps

We invite you all to share your thoughts, expertise, and vision for our organization, so that the section will continue to grow stronger! I cannot wait to see all the great things that 2019-2020 has in store for the Young Physicians Section! ●

“

YPS IS A CHAMPION of the young emergency physician with a foremost goal of providing programming and support that is tailored to the needs of physicians at this pivotal step in launching their careers.

”



SVI: The Next Step 2 CS

Haig Aintablian, MD — AAEM/RSA President



I did great on my SVI. The day of, I had just gotten a haircut and shaved my beard. My top half was covered by a nicely pressed navy blue suit jacket my mom bought me 4 years ago but that I hadn't touched since my undergrad graduation. Under the blazer, a white shirt I'd worn twice that week

already, and a baby blue tie I'm pretty sure I've had since high school. Best of all though, my bottom half was covered with a pair of stereotypical grey Hanes boxers – the type you buy in a 6+1 pack because you get one for free. I sat behind a desk in the middle of my half disastrous room (the side not covered by the camera), prayed an Our Father, and I said what had become my motivational slogan at this point, “**** it, we're almost done.” I looked great on camera. My upper body displaying a professional, well-groomed student against a clean room backdrop with undergraduate degrees newly hung on the wall. There were no tight pants to hold me back (away rotations made me gain weight like a CHF off Lasix). Regardless of how I looked on camera, I felt a deep helplessness. During the hardest half year of medical school trying to prove myself on away rotation after away rotation, devoid of family, friends, and proper sleep or nutrition, I was expected to be a robot in front of a video camera for reasons no medical student understood, no administrator could directly answer, and almost no PD would actually care about (let alone watch).

I had just undergone this same scenario too – we all had! Step 2 CS, the money making scheme weighted on the backs of students already in the hundreds of thousands in debt to their name is commonly called the most expensive lunch on earth. And it had scarred my friends and myself significantly already. This though, was a different beast. For this, I had to play a computer game against my will with the threat that if I opted out, it may affect my chances of getting into residency. I sat in front of my computer (the device that usually harbored the good feels of “The Office” now being used to judge my soul) to have an interview with questions it seems no one had filtered, with the goal to convince an “HR employee” with a mystical rubric that was unpublished, that I was perhaps a good interviewer. (I'm actually not sure if that was the point – no one knows). Better yet, this HR employee would potentially be replaced by a computer generated algorithm in the future. “Hasta La Vista Baby.”

I remember finishing the ordeal. My armpits were sweaty underneath my blazer, and my brain was fried. I remember having a shelf to study

“**I WAS EXPECTED**
to be a robot in front of a
video camera for reasons
no medical student
understood...”

“**WE'RE SCARED**
to speak out at the
time given the fact
that any retribution, no
matter how small, could
severely affect our
chances at residency.”

for, but decided that I definitely needed a beer instead. That night I hung out with a few of my co-residents who were also going into EM and we vented. A few weeks later my SVI grade appeared in my inbox, and it made me smile. I wasn't proud of myself for doing well – I was proud that the mysterious program didn't weed me out for being the half-naked, half-messy, half-awake person I was in that “interview.”

Today, I'm the President of the AAEM Resident and Student Association, and a resident in an incredible residency program. I'm a little more professional in my meetings and interviews than what I and many of us did with the SVI (I just add a pair of pants now). Most importantly though, today I can air my grievances with these types of forced loopholes that so much of our medical education contains. We're scared to speak out at the time given the fact that any retribution, no matter how small, could severely affect our chances at residency. For me personally, I feel as though the purpose of my presidency has been to cut out as much bureaucracy from our education as I and the RSA can.

I've heard enough about what stresses this SVI and of course, Step 2 CS are causing. I'm going to highlight a few brief points below as to why RSA specifically chose to call for the end of the SVI, and why we will do everything we can to advocate for our students and residents while on the AAMC SVI work group and elsewhere.

1. Lack of evidence
2. Very few PDs deem the SVI necessary
3. EM is not a small specialty: We don't need more filters
4. EM residency spots are growing
5. Potential for this to be an added cost in the future (cue: Step 2 CS)
6. EM is a team sport requiring human interactions - no computer should grade that

Check out this and other resource for more: https://journals.lww.com/academicmedicine/Abstract/publishahead/Applicant_Reactions_to_the_AAMC_Standardized_Video.97550.aspx#pdf-link

If you agree with our stance, help our efforts and join RSA. Let us represent you in our battles toward making medical education more about the medicine and less about the pointless bureaucracy. ●

The Power of Mentorship

Alexandria Gregory, MD — AAEM/RSA Publications & Social Media Committee Chair



I fell in love with emergency medicine before medical school. Truth be told, I had been hooked on EM since the first time I watched “ER” when I was ten years old. But as I entered college and became pre-med in earnest, I started to wonder if perhaps another specialty might be right for me. That was

until I started working as a scribe in the ED. It was there that I fell in love with emergency medicine all over again, and this time for better reasons than I had seen on television. Above all, though, were the people.

While working as a scribe, I became close with several of the physicians I worked for, and we maintained our relationships when I entered medical school, despite me moving 1,200 miles away. In fact, I had built such a relationship with not only the physicians, but also nurses, techs, and other staff members, that I decided to travel back to work as a scribe while on school breaks. As I progressed in medical school, my mentors continued to help foster my passion for emergency medicine, in ways both concrete and intangible.

“MEDICAL SCHOOL and residency are difficult, so hearing this and knowing you have a support system is incredibly powerful.”

At the same time, I sought EM advisors at my medical school early in my first year so that I could set myself up for residency as best as possible. They were able to help me with the more concrete aspects of my application, such as research and leadership positions. However, because I had sought these relationships early, by the time I entered fourth year, they had also become my second EM family.

While I sought out some of my mentors intentionally, and others fell into place more naturally, all of my mentors share certain key qualities of being a good EM mentor, some of which might be less obvious than the qualities that are typically mentioned:

- **They don't always give you all the answers:** This applies in a couple of ways. Academically, good mentors push mentees to think through decisions so that they are able to develop their own systems of practice. Additionally, they guide mentees in making choices about their careers without forcing their own ideals onto those decisions.
- **Willingness to be your mentor:** This one is a bit more obvious, but it's still pretty important. Some of my mentors have invested countless hours into my personal and professional development, above



and beyond what I could have ever expected. While not all mentors are able to devote such a large amount of time, a great mentor is willing to use the time they do have to truly focus on their mentee's needs and development.

- **They are knowledgeable:** This one may also seem obvious, but it is especially relevant for emergency medicine because of the uniqueness of the specialty. In a practical sense, mentors should be aware of the situations their mentees are facing. For example, a mentor helping a medical student put together their application for residency should be knowledgeable about away rotations and SLOEs. Alternatively, if they are not as knowledgeable regarding specific questions, they are able to help a mentee find the resources they need.
- **They have your back:** A few of my mentors have told me this directly. It may be the most important quality, but it's also impossible to directly seek out. Medical school and residency are difficult, so hearing this and knowing you have a support system is incredibly powerful. I suspect this is something students and residents in other specialties don't hear as often, since it's reflective of the way emergency medicine is practiced.

Looking back, it's clear that my life would be very different if I had gotten any other job during my gap year, or even if I had worked in a different emergency department, because of the impact my mentors had on my development, both personal and professional. As I enter residency, I look forward to continuing my relationships with my current mentors, while also finding new mentors along the way. Most importantly, as I grow in my career, I hope to develop the same qualities so that I can be a mentor to others. ●

Utility of Non-Invasive Cardiac Testing in the Emergency Department Setting

Authors: Taylor M. Douglas MD, Taylor Conrad, MD, Ted Segarra, MD, Rithvik Balakrishnan MD
Editor: Kelly Maurelus MD FAAEM, Kami Hu MD FAAEM

Chest pain is one of the most common complaints in the emergency department (ED), and presents one of the toughest dilemmas to emergency medicine (EM) physicians, as the fear of missing a diagnosis of acute coronary syndrome (ACS) is very real. Today we have high sensitivity troponin assays which allow quick and accurate diagnosis of acute myocardial infarction (MI); many of the guidelines for the diagnosis and treatment of ACS, including those established by the ACC/AHA, suggest that it is reasonable to perform stress testing within 72 hours of an ED presentation for possible ACS, and yet these guidelines were largely established before the aforementioned data were available. Current clinical policy statements from the American College of Emergency Physicians (ACEP) recommend that providers arrange follow-up in 1 to 2 weeks for low-risk patients in whom MI has been ruled out. If no follow-up is available, consider further testing or observation prior to discharge (level C consensus recommendation). Research is ongoing regarding most appropriate diagnostic measures and follow-up to prevent adverse events, leading us to investigate and discuss non-invasive cardiac testing and its role in the ED-based evaluation of chest pain.

1. How effective is non-invasive testing in identifying coronary artery disease (CAD) in low to intermediate risk patients?
2. Does non-invasive cardiac testing in the ED setting improve clinical outcomes in patients that present with chest pain?

Bauters C, Lemesle G. Screening for asymptomatic coronary artery disease in patients with diabetes mellitus: A systematic review and meta-analysis of randomized trials. *BMC Cardiovascular Disorders*. 2016;16(1).

Given that diabetes mellitus is a major risk factor for CAD, there has long been interest in determining if screening this at-risk population would confer any benefit. A major study in 2009, the Detection of Ischemia in Asymptomatic Diabetics (DIAD) study, showed that there were similar rates of cardiac events in the screening and control groups. Since then, it has been accepted that screening this population would not improve clinical outcomes. In recent years, several major trials have been performed to continue to test this theory. In the above study, Bauters et al. aimed to provide a systematic review and meta-analysis of the current data to date with respect to screening this patient population.



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Episode Highlight — Myths, Bias, and Lies My Medical School Taught Me

In this episode, Kenneth Chang and Richard Byrne, MD FAAEM, discuss Dr. Byrne's AAEM18 talk, Myths, Bias, and Lies My Medical School Taught Me. Mr. Chang is a medical student at Western University of Health Sciences and AAEM/RSA Education Committee Member. Dr. Byrne is an Assistant Professor of Emergency Medicine at Cooper University Hospital.

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The authors only included prospective, randomized trials that compared screening (of multiple

different modalities) to no screening in type II diabetics with no known CAD. The follow-up periods were at least 1 year and endpoints were all-cause mortality, cardiovascular mortality and various cardiovascular events, including non-fatal MI. A total of 5 studies were included in the analysis, which included the DIAD study. The pooled results of the meta-analysis showed no detectable impact of screening asymptomatic patients on subsequent risk of all-cause death, cardiovascular death, non-fatal MI, or composite of cardiovascular death or non-fatal MI. Overall, the rate of coronary angiography was relatively low (8%) and even fewer patients received revascularization therapy. Presence of medical therapy (aspirin, statin, ACE inhibitor) between the two groups was found to be similar.

This study provides support that the screening of asymptomatic diabetic patients for CAD confers no significant clinical benefit. An important finding replicated between this study and the prior DIAD is that the overall event rates of mortality and cardiovascular events in the population study are very low. Of course, ED providers are not encountering asymptomatic patients; incidence of ACS varies greatly in different practice environments and many patients we see likely have non-cardiac causes of their chest pain. Important future studies should look specifically at patients seen in the ED who are now symptom free to determine if referral to non-invasive testing is beneficial.

Van Waardhuizen CN, Khanji MY, Genders TSS, et al. Comparative cost-effectiveness of non-invasive imaging tests in patients presenting with chronic stable chest pain with suspected coronary artery disease: a systematic review. *European Heart Journal - Quality of Care and Clinical Outcomes*. 2016;2(4):245-260.

There have been many non-invasive testing modalities developed and subsequently improved in recent years, but no cost effectiveness or preference of test in certain situations has been established. In fact, many society guidelines offer different advice and recommendations based on the country of origin. Currently available testing ranges from exercise electrocardiogram and stress echocardiography to computed tomography coronary angiography (CTCA) and cardiac magnetic resonance imaging. The authors' goal was to perform a systematic review of the literature to establish cost effectiveness of available imaging for the diagnosis of CAD in patients with symptoms of stable angina.

The systematic search provided 70 articles that were included in the final analysis. Studies were excluded that evaluated patients with ACS, and those focusing on detecting left main or triple vessel disease. The authors organized the recommendations based on the studies by pre-test probability of disease as well as looking at preferences between countries. An option of no testing for low probability was evaluated in one study included, but otherwise was severely underrepresented in the data. The authors ultimately concluded that there is no consensus in low to intermediate pre-test probability but that CTCA may represent a role as an

initial gatekeeper test for diagnosis of presence of CAD. When pre-test probability was >50% the initial test tended to be straight to coronary angiography.

Limitations of the study include that there was a definite overrepresentation of CTCA compared to other modalities, and that most studies used coronary angiography alone as compared to angiography with fractional flow reserve, the more current accepted practice for determining clinically significant stenosis. Additionally, as discussed by the authors, the prior probabilities of CAD present before testing are likely grossly overinflated. One study showed that no patient group had an observed prevalence of obstructive CAD >60%, irrespective of age, sex, risk factors, and the typicality of angina (Patel). Additionally, because of the underrepresentation of no testing for lower risk patients, a true comparison of a cost-effective strategy of not testing versus performing CTCA could not be made. Understanding the effectiveness of CAD evaluation modalities can help the EM physician develop a more effective observation plan or outpatient follow-up. Additionally, as CTCA has become more prevalent, its incorporation into algorithms for acute chest pain evaluation has been studied, as in the ROMICAT-II study, for example.

Reinhardt SW, Lin C-J, Novak E, Brown DL. Noninvasive Cardiac Testing vs Clinical Evaluation Alone in Acute Chest Pain. *JAMA internal medicine*. 2018;178(2):212.

The ROMICAT-II trial was a randomized, multicenter clinical trial comparing CTCA with a standard ED evaluation looking at the primary outcome of ED length of stay (LOS). ED physicians could order functional testing for patients randomized to the standard evaluation arm. The original study demonstrated a decreased LOS as well as increased direct ED discharge in patients who had CTCA compared with standard evaluation without any missed ACS or difference in major adverse cardiac events (MACE). They did note increased downstream testing and a trend towards increased invasive testing (coronary angiography and revascularization) in the CTCA group.

Reinhardt et al. sought to reevaluate this data for the purpose of comparing any testing (CTCA or functional) with a clinical evaluation. They performed a retrospective analysis of the ROMICAT-II data with the help of an additional statistical analysis to attempt to account for the fact that their two groups were not randomized, since they took the randomized/matched patients from ROMICAT-II and redistributed them. They demonstrate that there were no significant differences in the baseline characteristics matched in the ROMICAT-II randomization except for the diagnosis of non-cardiac chest pain (91% in clinical alone vs. 97% in testing group) and ACS (0% in clinical alone vs. 9% in testing group).

882 (88%) of the original study received testing during the index ED visit. They also used very similar outcome measures as the original study, and unsurprisingly found a decreased LOS in the clinical evaluation alone group. There was an increase in downstream testing in the testing group as well as percutaneous coronary intervention (PCI) at the index visit but no difference in PCI after index visit or CABG at any point. Importantly, as in the original ROMICAT-II study, there were no missed cases of



ACS in either group and no significant difference in MACE. Overall they concluded there was decreased LOS, cost, and radiation exposure in the clinical evaluation group without any increase in adverse events or missed ACS. Although this study design is not ideal as it is a retrospective re-analysis of another study, it makes good use of a large population of low to intermediate risk chest pain patients and addresses the utility, or lack thereof, of testing in the ED setting.

Natsui S, Sun BC, Shen E, et al. Evaluation of Outpatient Cardiac Stress Testing After Emergency Department Encounters for Suspected Acute Coronary Syndrome. *Ann Emerg Med.* 2019.

As demonstrated above, the guidelines regarding non-invasive testing have been contested given they are mostly based on research before the availability of today's troponin assays as well as studies looking at outcome measures after ED visits for ACS evaluation. This recent retrospective study of a large group of patients in the Kaiser Permanente Southern California hospital system set out to evaluate completion rates of non-invasive stress testing as ordered after emergency department

visits for chest pain, specifically to assess the 2014 ACC/AHA guidelines that this testing should be completed within 72 hours of discharge. As a secondary outcome, they also looked at 30-day MACE.

They started with 24,459 encounters over a two year study period, of which 16,086 were excluded because the non-invasive imaging was completed prior to discharge, leaving 7,988 eligible for their study. They collected and reported various demographic data points as well as medical history and risk factors. Upon analysis of the three groups of patients (testing within 72 hours, testing between 72 hours and 30 days, and no testing within 30 days), only day of the week and medical center were reported as causing significant variation; the comparison of black versus white race also had a confidence interval which did not cross 1 (0.71-0.99) however this was not addressed within the text of the article.

The rate of acute MI was 0.7% and revascularization by any means was 0.3%; there were no deaths within 30 days. Although they list the insufficient power of their study with regards to comparing these outcomes between the three time frames (odds ratio of 0.92, 95% CI 0.55 to 1.54), they still state that the overall low event rate suggests these patients were appropriately discharged and do not benefit from early outpatient testing.



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The outcomes this study set out to measure are ambitious as they are combating the guidelines set out by two major medical organizations. However, they demonstrated that the populations who get early outpatient non-invasive testing are not different from those who are slightly delayed (within 30 days) and suggest that all patients deemed low risk enough to be discharged have low rates of MACE and may not require early testing at all. This last statement is not supported by their study, and requires further investigation to be validated. This study does set a precedent for future studies to demonstrate that non-invasive testing may not have a role in improved clinical outcomes in those patients at low risk of acute coronary syndrome.

Conclusion

Now we return to the questions posed in the introduction:

1. *How effective is non-invasive testing in identifying CAD in low to intermediate risk patients?*

Non-invasive testing may be unlikely to be of utility in screening patients with risk factors for CAD who are clinically asymptomatic. CTCA is likely the best modality for low risk to intermediate patients, although increased costs and testing downstream, and provocative tests may be more appropriate for intermediate risk patients. Studies looking at a methodology of non-testing for low risk patients are needed.

2. *Does non-invasive cardiac testing in the ED setting improve clinical outcomes in patients that present with chest pain?*

Non-invasive testing during the ED visit or early after discharge has not yet been shown to improve clinical outcomes in patients with low to intermediate risk of ACS.

In summary, for patients in the acute care setting with low to intermediate risk, but without evidence of myocardial damage, non-invasive testing has not been studied to show major clinical benefit at this time. Despite its poor test characteristics, non-invasive testing may still play a role in the non-emergent diagnosis and medical management in the evaluation of stable CAD.

Current ACEP clinical policy recommends that providers do not routinely use further diagnostic testing (coronary CT angiography, stress testing, myocardial perfusion imaging) prior to discharge in low-risk patients in whom acute myocardial infarction has been ruled out in an effort to reduce 30-day major adverse cardiac events. Future studies should focus their efforts on determining the usefulness of non-invasive testing (specifically provocative testing methods) for appropriately identifying stable angina more effectively and differentiating myocardial injury related to obstructive CAD versus disease entities that won't benefit from intervention. ●

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Medical Student Council Introductions

David Fine, Medical Student Council President



Hello! My name is David Fine, and it is my greatest pleasure to be serving as the AAEM/RSA Medical Student Council President for the 2019-2020 academic year. First a bit about me, I am from Deerfield, IL best known for its football field from the end of the movie

Breakfast Club. I attended the University of Michigan for my undergraduate education, and am now approaching my M4 year at the Loyola University Stritch School of Medicine.

I am incredibly excited for the opportunity to contribute on the Medical Student Council along with our Vice President Leah Colucci (University of Miami Miller School of Medicine), the four regional representatives Sara Bradley (College of Osteopathic Medicine of the Pacific Western University of Health Sciences), Lauren Lamparter (Loyola University Stritch School of Medicine), Dickran Nalbandian (Florida International University: Herbert Wertheim College of Medicine), and Bryan Redmond (University of Rochester School of Medicine and Dentistry), and our International Ex-Officio representative Chris Phillips (Ochsner Clinical School). For more information about the board's interests and hobbies check out this AAEM/RSA leadership webpage: <https://www.aaemrsa.org/about/leadership#msc>

“ IT WAS ELECTRIC
to be surrounded by students
of every year, residents, and
program directors all discussing
how to reach our ambitions. ”

In setting goals for this year, I have been reflecting on what originally drew me to this organization. My experience as an M1 student at the Midwest Medical Student Symposium was phenomenal. It was electric to be surrounded by students of every year, residents, and program directors all discussing how to reach our ambitions. Soon after I joined AAEM/RSA with a one year trial, because I was drawn in by the direction that the organization was able to provide not only with that symposium

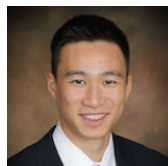


but also with access to resources such as the *Rules of the Road* career guide and the EM:RAP podcast. When I was looking to get more involved, committee applications were conveniently being advertised via emails so I became a member of the Publications & Social Media Committee. There is not a single path to success, but for me this was a great way to build-upon my passion and take on new responsibilities. In summary, the leadership opportunities and resources have been what I find to be most significant about my experience.

On behalf of the Medical Student Council, we are excited to get started adding to outstanding work of previous boards whose efforts are the reason that we were encouraged to participate in AAEM. We aim to increase outreach to Emergency Medicine Interest Groups interested in expanding their programming. We will create guides to facilitate conference planning and provide a medium for the various regional conference committees to share ideas. Throughout the year we will be addressing new ways to encourage medical student participation. For these goals and more, we are enthusiastic and grateful for this opportunity. Please do not hesitate to reach out with any suggestions, concerns, or questions. We look forward to working with everyone this coming year! ●

CPR Induced Consciousness – An Important Phenomenon to be Aware Of

Jake Toy, DO — Harbor UCLA Medical Center



In a recent resuscitation of an unconscious elderly woman in ventricular fibrillation, my team observed that upon initiation of cardiopulmonary resuscitation (CPR), she began to make purposeful movements with her arms and legs. During compressions, she

batted at the mechanical CPR device and reached for her endotracheal tube. When attempting to place a femoral line, she withdrew to pain from the needle on that side. Through these periods of seemingly purposeful movements, her eyes remained closed and she was not responsive to voice commands. Upon pulse checks, these movements abruptly ceased. Many questions arose during this resuscitation for my team: Should we physically restrain the patient? Should we chemically sedate? What was the level of the patient's awareness?

CPR induced consciousness is a rare and slightly alarming phenomenon that is important to be aware of lest it catch you off guard. With high quality compressions, this may theoretically produce sufficient cerebral blood flow to induce varying states of consciousness. This may manifest as spontaneous eye opening, jaw tone, speech, or spontaneous body and extremity movements.^{1,2} The incidence was approximated at 0.7% in a prehospital registry study completed in 2014.² It was further noted that CPR induced consciousness was associated with improved survival outcomes and that the number of recorded cases increased over the course of the six-year study period. I can clearly remember two cases of CPR induced consciousness during the first six months of my residency. Though little evidence exists in current literature, anecdotally, the frequency of this seldom discussed phenomenon appears to be rising.

One of the most impressive reports to date describes how a patient was awake, alert, able to speak, and engaged in purposeful movements during mechanical chest compressions.³ On interviewing this patient prior to hospital discharge, he was able to clearly recount events during his own cardiac arrest up until the moment IV ketamine was administered. Though these cases are rare, patient interference during critical moments of a resuscitation as well as the unintended emotional and psychological impact on patients, families, and providers, necessitates early management of CPR induced consciousness by prehospital providers and emergency physicians.

At present, the management of CPR induced consciousness is not well defined. Reports document interventions ranging from no intervention, verbal instruction, physical restraint, chemical restraint (including ketamine, benzodiazepines, opiates, muscle relaxants), or a combination of strategies.^{1,3} To date, limited sample size in the only large-scale observational study precluded any significant association between chemical agent choice and survival outcomes.² Yet practically, extra consideration

should be taken before using opiates or benzodiazepines given their potential to induce hypotension. Similarly, paralytics carry the risk of "paralysis while conscious" which warrants additional medico-ethical consideration. In 2016, a letter from the Nebraska Office of EMS shared their prehospital protocol for CPR induced consciousness. It was initiated



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after a reported rise in cases, seemingly after the introduction of prehospital mechanical CPR. The protocol delineates that the first-line therapy is an IV or IM ketamine bolus with possible co-administration of IV or IM midazolam.³ Further research is needed to better evaluate the best medication regiment.

Despite the rarity of CPR induced consciousness, I feel that general awareness of it is essential. In the case of my patient, after much deliberation during the code, no physical or chemical intervention was taken. CPR induced consciousness may have prolonged the overall time that we ran the resuscitation, but it did not appear to impact its eventual termination. In hindsight, quick and appropriate management of CPR induced consciousness in this case may have helped reduce our cognitive load through limitation of distractions, as well as decrease the potential psychological stress on the patient, her family, and the providers involved.

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