

# COMMON SENSE



VOICE OF THE AMERICAN ACADEMY OF EMERGENCY MEDICINE

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## AAEM19 Highlights: What Not to Miss in Las Vegas!

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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.

## Membership Information

Fellow and Full Voting Member: \$425 (Must be ABEM or AOBEM certified, or have recertified for 25 years or more in EM or Pediatric EM)

Affiliate Member: \$365 (Non-voting status; must have been, but is no longer ABEM or AOBEM certified in EM)

Associate Member: \$150 (Limited to graduates of an ACGME or AOA approved Emergency Medicine Program within their first year out of residency) or \$250 (Limited to graduates of an ACGME or AOA approved Emergency Medicine Program more than one year out of residency)

Fellows-in-Training Member: \$75 (Must be graduates of an ACGME or AOA approved EM Program and be enrolled in a fellowship)

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## President's Message

## AAEM Signs On to Support AFFIRM

David A. Farcy, MD FAAEM FCCM  
AAEM President



On November 7, 2018 the National Rifle Association (NRA) tweeted, "Someone should tell self-important anti-gun doctors to stay in their lane. Half of the articles in *Annals of Internal Medicine* are pushing for gun control. Most upsetting, however, the medical community seems to have consulted NO ONE but themselves." This tweet was in response to

the publication of "Reducing Firearm Injuries and Deaths in the United States: A Position Paper from the American College of Physicians."<sup>1</sup> On November 19, 2018, we sadly learned of the death of Dr. Tamara O'Neal, a member of our Resident and Student Association (AAEM/RSA), along with two others at Mercy Hospital, in Chicago. Just one year prior, we lost our own Dr. Kevin Rodgers, AAEM president from 2015-2017, to gun violence. He was a leader, friend, mentor, father, and husband, and is so dearly missed. It is now time for all of us to unite and put our political and cultural differences aside because we are not just treating this epidemic — we are the victims of this epidemic.

Emergency medicine and trauma surgery developed out of lessons learned from war. On the battlefield, no one questions whose lane is whose. Rather, everyone works together to create a common lane focused on saving as many lives as possible. The first emergency system in the U.S. developed during the American Civil War, and it was modeled after the French, who established a system about 100 years earlier during the Napoleonic wars. Triage, first aid, and rapid transport might have been rudimentary, but this was only the beginning. It would take over 70 years for the first hospital-based emergency department to open its door, which was still many years

before emergency medicine became a specialty. In 1946, the Hill-Burton Act provided grants for hospitals, which were required to have emergency departments. At that time, emergency medical services were often run by funeral services.

During the Korean War, helicopters replaced ambulances for more rapid transport times to save lives. Dr. R. Adam Cowley dedicated his life to trauma care and coined the term, the "golden hour."

"There is a golden hour between life and death. If you are critically injured you have less than 60 minutes to survive. You might not die right then; it may be three days or two weeks later — but something has happened in your body that is irreparable."<sup>2</sup> The lessons learned on the battlefield were brought home to advance trauma care in the U.S. "Collaboration between civilian and military health systems started at least 100 years ago," said David B. Hoyt, MD FACS, executive director of the American College of Surgeons. "These partnerships helped advance care both during peacetime and during times of conflict."<sup>2</sup>

Both the Korean and Vietnam Wars brought to light that emergency care back home could not compare to the care provided during those wars. But it was not until 1966, after a landmark report by the National Academy of Sciences, "Accidental Death and Disability: The Neglected Disease of Modern Society," that traffic injury was reported to be an epidemic. That year, after more than 1.5 million citizens died from car accidents, President Lyndon Johnson said "Safety is no luxury item, no optional extra; it must be a normal cost of doing business."<sup>3</sup> And with the help of Congress, he signed the National Traffic and Motor Vehicle Safety Act and the Highway Safety Act into law. The automobile industry did not tell doctors to stay in their lane.

Physicians are a crucial component and integral part of our public health system. In an unprecedented bill that passed in 1996, the Dickey Amendment prohibited the use of the Centers for Disease Control and Prevention (CDC) funds for advocacy or promotion of gun control, thus limiting funds for research. Other states went even further to limit the ability of a physician to even ask about gun ownership. Florida implemented



"At our last AAEM board meeting, your AAEM leadership voted unanimously to partner with AFFIRM."

the Firearm Owner's Privacy Act (FOPA), becoming the first state to actively prohibit questioning, screening, and education by physicians on firearm safety. This NRA sponsored law does not allow physicians to ask questions concerning the ownership of a firearm or to counsel a patient about firearm ownership during an examination. Penalties to physicians for noncompliance included fines of up to \$10,000 and/or risk of having one's medical license revoked. FOPA was eventually overturned in 2017, when a group of physicians who questioned the constitutionality of its legal terms carried a case against FOPA to the Florida Supreme Court.

I am a proud weapon owner — the issue is not about banning guns, the issue is about stopping the bullet. Right now, research is the key for making progress in firearm injury prevention. This is a public health emergency, not a political debate. History has proven over and over that research and then the collaboration of all stakeholders working together saves lives. After motor vehicle deaths were recognized as an epidemic, research along with common sense laws have led to the decline of deaths by motor vehicles by 29% percent in the last 15 years; there has

been a 90% decrease since the 1950's (see table 1).<sup>4</sup> Mandatory seat-belts save lives. Setting alcohol limits for operating a motor vehicle saves lives. Mandatory carbon monoxide detectors in homes and buildings save lives. Research with physician involvement has saved lives through: vaccines, HIV screening, and treatment, and tobacco control just to name a few.

Table 1

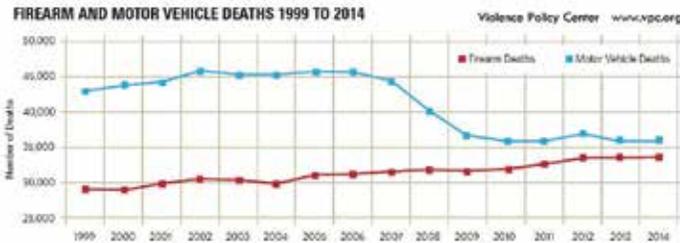
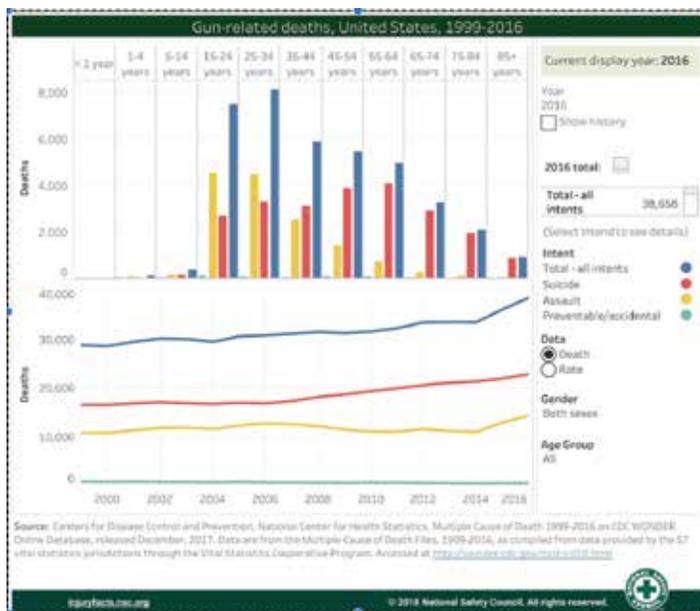


Table 2



In 2016, more than 38,658 lives were lost to firearms, with suicides the highest cause, followed by assaults, and then accidents (see table 2).<sup>5</sup> The problem is multifactorial, and thus, the importance for government and private research to investigate options for injury reduction. Initiatives like #StoptheBleed campaign launched by the American College of Surgery that train lay persons to apply tourniquets in response to mass shootings need further support and funding.

The American Foundation for Firearm Injury Reduction in Medicine (AFFIRM) is a non-profit corporation comprised of health care leaders and researchers who seek to end the epidemic of gun violence through research, innovation, and evidence-based practice. At our last AAEM Board meeting, your AAEM leadership voted unanimously to partner with AFFIRM. We join the clear message being sent to the public and to the NRA that #ThisIsOurLane. We are the front line providers, and we will be at the forefront of the solution. ●

**AFFIRM Key Statistics**

- 38K deaths (13K homicides per year; 23K suicides) per year; 84+K

nonfatal injuries per year

- 200 injuries per day. 100 deaths per day. Deaths are going up.
- 60% of gun deaths are suicide.
- 98% of Americans know someone who has been personally affected by gun violence.
- Many doctors (~40% per non-scientific surveys) are gun owners.

**The AFFIRM Approach**



**References**

1. Butkus R, Doherty R, Bornstein SS. Reducing firearm injuries and deaths in the United States: a position paper from the American College of Physicians. *Ann Intern Med* 2018;169:704-707.
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3. <https://www.history.com/this-day-in-history/president-johnson-signs-the-national-traffic-and-motor-vehicle-safety-act>
4. <http://vpc.org/regulating-the-gun-industry/gun-deaths-compared-to-motor-vehicle-deaths/>
5. <https://injuryfacts.nsc.org/home-and-community/safety-topics/guns/data-details/>

**AAEM Antitrust Compliance Plan:**

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

From the Editor's Desk

# The Gap

Andy Mayer, MD FAAEM  
Editor, *Common Sense*



AAEM completed a membership survey of the active membership in an effort to know what our members are thinking and feeling about emergency medicine and our organization. You may have noticed in the last few issues we have published several of the comments submitted by members. It is always important for an

organization to reflect on what is important to the very members which form it. The board of directors sat and discussed as a group your comments. I believe that the core values for which the Academy was founded are the core values which we still hold. I have carefully read the hundreds of responses to the membership survey and found two which I think should be explored and discussed. One appears to be from a seasoned veteran and the other from a younger member each with different but important perspectives to consider. Here they are:

## Response One

"I'm a 20 year member of the organization. Through the years, the organization has changed and I feel like it's lost its true north in some respects. The battles with the CMG's have been lost. AAEM lobbied and fought and argued and wrote and in the end, look where we're at ... Envision/TeamHealth have massive numbers of EDs and most graduating residents just end up as employees. So now what's left and what differentiates AAEM from ACEP? At this point, I feel like AAEM is the group that a) would stand up for me if I had an issue as an individual physician with my group or hospital and b) does offer amazing, high quality and inexpensive education. But that's it ... SAEM does academic/research better and ACEP does lobbying at the national level better. I'm increasingly finding it difficult to find the gap that AAEM needs to fill besides being another ACEP for people who don't like ACEP."

## Response Two

"I struggle with paying both ACEP and AAEM. I am young in my career and while I understand issues ACEP has from an independent practice perspective I do not know that it is "egregious" enough for me to boycott their membership. I therefore am left paying double membership. I think this is redundant. I'm concerned that at some point in the future that I will have to pick one organization and I am not yet sure which I will choose. It would be best if you would just merge and have one voice speaking for the profession. Infiltrate the higher levels of ACEP so they represent our voice, bring the two together. It "should" be most economical and the most value to the membership."

"I believe that the core values for which the Academy was founded are the core values which we still hold. I have carefully read the hundreds of responses to the membership survey and found two which I think should be explored and discussed."

## So, what do you think?

Has the battle for our profession been lost and should we just throw in the towel and call it a day? Should AAEM just go away and admit defeat in a noble but hopeless cause? Are the corporate bosses really already in charge of our specialty and we should just admit we are just costly line items to be displaced by midlevel's on CMG's books? Does the endless debate and discord between AAEM and ACEP have value? There are many things to consider when we reflect and debate these issues. There are many things which either AAEM and ACEP do and these do have significant value for the membership of each organization but let us look at the points of the two member comments.

The first comment from the more senior member of AAEM is seeking "the gap" that they think AAEM needs to fill to be relevant. They think that we have lost the battle for the control of emergency medicine and that corporate management groups have won. If you look at the number and the geographic penetration of CMG's particularly in certain areas then he would seem to be correct. Try and find a job in a democratic group in Florida for example and it is easy to become discouraged and lose hope for the specialty. Try and ask what is being billed and collected in YOUR name in many places and you can end up being quickly replaced. Now the explosion of corporate sponsored residencies is providing an inbred supply of young graduates who have never even heard of a different way and are eager to fill schedules and replace the old hands who just don't understand that emergency medicine has moved on and we are just "labor." I can certainly appreciate if this member feels the battle is lost but I think there is still hope.

So first, I disagree that the battle is lost. Remember that corporate management groups can only actually make money off of the sweat of others. What do they provide besides a schedule? They have to make money for investors and they have only a limited number of ways to do this and at what cost to our patients? Cutting schedules and replacing

Continued on next page

physicians with Advanced Practice Providers (APP's) can only go so far. There are opportunities to fight back and retake some lost ground. This fight is not easy and I don't think that it is over, but organized medicine should be there to help. Facing the corporate practice of medicine has not, nor will be easy. AAEM has started the AAEM Physician Group to help individual and groups of emergency physicians start fair and equitable groups. Bob McNamara is the champion of this activity and is passionate about helping groups get started. This interest in the emergency physician I think is the main reason to be a member of AAEM. Do you think that an Envision or TeamHealth Executive serving as an officer or president of ACEP can be totally unbiased and care only for the profession of emergency medicine and the well-being of the individual emergency physician? Who do you think is the "Champion of the Emergency Physician?"

The veteran emergency physician does think that AAEM would "stand up for me if I had an issue as an individual physician with my group or hospital." This has always been one of AAEM's key strengths and why we really are the champion of the emergency physician. Individual physicians having a practice issue can call and speak to a board member usually within a day. AAEM has provided expert legal, professional and moral support for a myriad of issues over the years. There are many examples of AAEM showing up and that is enough to stop an action which would have destroyed a long standing group and kept out a CMG simply by publicly shaming the players involved. This is often after being told by ACEP that they cannot become involved in "private business matter." I have always found it to be ironic that many ACEP presidents and board members certainly do work on these very matters on a regular basis except that is in their role at corporate management groups.

The last point of the first comment relates to AAEM's medical education opportunities. If you have never been to the Scientific Assembly then you are missing out on a spectacular meeting. Granted there are not a lot of free shrimp lying about and there are no major galas sponsored by CMG's to enjoy. However, there are fantastic speakers giving relevant talks directed at practicing board certified emergency physicians. There are plenty of social activities to meet and commiserate with "pit docs" who are fighting the same fight as you are every day.

Our second comment comes from a younger emergency physician who is rightly concerned about the cost of paying dues to two separate professional societies and asks if doing so has adequate value to justify the expense. They suggest that the two organization could somehow fuse into a single enlightened organized with the strengths of both. Our younger physician recommends AAEM somehow "infiltrating" the higher levels of ACEP so that our ideals could be represented by ACEP. Certainly, it would be nice if emergency medicine could be represented by one united society where the stakeholders were passionate and sincere in their pursuit of improving all aspects of our specialty. I certainly agree that AAEM does not need to reproduce every aspect of ACEP. ACEP currently has the size and scale of numbers. AAEM is smaller but seems to significantly out shine ACEP in advocating for the best interest of individual emergency physician. AAEM certainly advocates for issues which seem to resonate with our motto as the "Champion of the Emergency Physician." Could and should ACEP advocate more for the value of board certification, due process, etc. and against the corporate practice of medicine and the expansion of the role of mid-levels? I certainly think the vast majority of the membership of both organizations would support this effort. However, in reality if the upper levels of leadership of ACEP are dominated by executives of corporate management groups do you really think this will happen. Do you think that the CMG's want to support the individual physician or small democratic groups? Do they want due process or do they want to keep the ability to arbitrarily fire a troublesome doctor who speaks up for their patients or wants to see what is billed or collected in their name?

My conclusion is that I do not for the foreseeable future predict that AAEM and ACEP will fuse into one organization for several reasons. I do see a value in both. Many will have a moral or philosophical reason for not joining one of the organizations. This is certainly my case with ACEP. Yes, it is hard to be members of both organizations and you may choose to only be a member of one. I chose AAEM and others pick both or only ACEP. I respect all of these choices. The emergency physicians I really am concerned with are those who chose neither and throw up their hands or worse are so burned out that they do nothing and await their future as a simple laborer to a corporate manger until replaced by a mid-level. ●

## Make a Difference with AAEM's Educational Programs

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

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

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

## Letter to the Editor

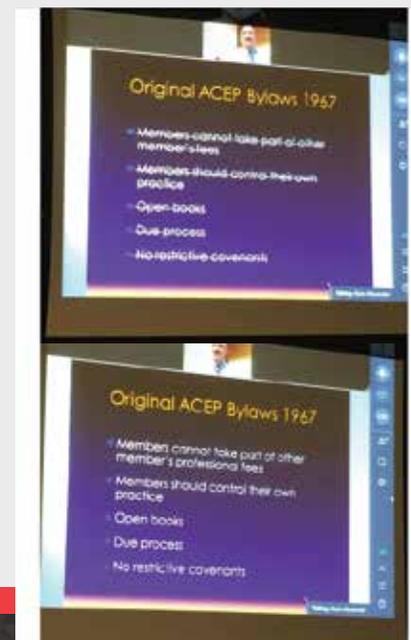


*Common Sense* appreciates members sending in their concerns and comments. Dr. Paul Kivela is a member of AAEM as well as the immediate past-president of ACEP. He sent this letter to the editor. It relates to a slide used during a recent presentation by Dr. Howard Blumstein a past-president of AAEM.

*Common Sense* represents AAEM, which is an open and democratic organization which supports dialogue and discussion related to controversies in emergency medicine and the concerns of its members. The differences between the goals and aspirations of AAEM and ACEP certainly can be seen as one of these issues.

*Common Sense* will print the slide in question, Dr. Kivela's letter to the editor and the responses by Drs. Howard Blumstein and Robert McNamara. The staff of *Common Sense* hopes you will carefully read these and see what you think. We encourage responses to this series.

Andy Mayer, MD FAAEM



## Time to Stop the Fake News

Paul Kivela, MD FAAEM FACEP  
ACEP Immediate Past President

This past month, it has come to my attention that an AAEM board member has been presenting slides with ostensibly false information. A careful review of documents and policies demonstrate the slides appear to be clearly factually incorrect. I reached out directly to that individual. After a prolonged discussion, the individual agreed to remove the slides from his presentation but refused to apologize or correct his misstatements.

He rationalized this was justified because he believed the information was correct. He acknowledged he never checked. He stated he received this information from a former AAEM leader(s) but refused to acknowledge his source(s).

This responsibility to fact check before maligning colleagues or other organizations is amplified with each position of authority that person holds including their position(s) in the professional organization, their title and position of authority at their place of employment, and their role as an educator.

We must take action to decrease or eliminate the proliferation of "fake news." Projecting one's own beliefs onto another organization or culture as the identifiable enemy rather than focusing and weighing the positive and negative qualities results in "splitting" or "all-or-nothing thinking." This proliferation of mistruths creates fear and mistrust amongst physicians, undermines confidence in our professional organizations and damages our specialty. Throughout history, this strategy has been employed by extremists and dictators to unduly influence the public. This proliferation of "fake news" is currently being discussed

in multiple publications including *Anti-Social Media and Weaponized Lies: How to Think Critically in the Post-Truth Era*. Emergency medicine needs to elevate ourselves and stick to actual facts.

I am hopeful that AAEM will investigate incidents of this type and hold its leadership to the same accountability that other organizations do. Indeed, everybody should have "due process." I am hoping the facts will be examined and that no one will be afforded any special treatment.

When leaders engage in spreading untrue statements and remain unchecked, the credibility of the entire organization is undermined. It is difficult to trust someone or work with an organization who won't police their own leadership. It is disturbing when these leader(s) are called out, they don't, can't or won't supply the evidence to support their assertions and refuse to apologize and justify their actions because they thought or wanted their statements to be true.

To me, integrity matters. Perhaps, I expect too much. I was taught to own my actions and when I make a mistake, I should work to correct it. I was also taught that if my mistake was potentially harmful, I should apologize.

Going forward, let this be a call for everyone to check their facts before making public statements about colleagues and other organizations, be transparent to the source of those "facts," and be accountable for their actions.

It is time to end the divisive vitriol and restore integrity, accountability, and unity to our specialty.

Continued on next page

## Response: What About Those Original Bylaws?

Robert McNamara, MD MAAEM FAAEM  
AAEM Past President



Dr. Kivela correctly points out that one of Dr. Blumstein's slides on the content of the original ACEP bylaws is not completely accurate. I find the intensity of the criticism (extremists and dictators?) a bit unusual as the slide presents a favorable view of these bylaws. Of the five bullet points, the first two are largely correct and in comparing them to what was in the original ACEP bylaws we see a specialty gone astray from the vision of the founders.

The first Blumstein bullet says "Members cannot take part of other member's professional fees." The original ACEP bylaws state, "In the practice of medicine a physician should limit the source of his income to medical services actually rendered by him, or under his supervision, to his patients." I see no measurable distinction between these two statements. Clearly this is not the case today where we see EM physicians including national leaders and who derive all or the majority of their income from the labors of ACEP (and AAEM) members. This current division of fees would have been an ethical violation under the original bylaws. Today it raises the issue of prohibited fee-splitting where an EM pit doc is giving up 20% or so of their fees for the right to be put on a schedule to see patients (there is a huge class action sitting out there for the taking).

Let's examine bullet 2, it states "Members should control their own practice." The original ACEP bylaws say "the emergency physician shall not associate himself in any fashion with any institution that permits medical practice by other than a physician." If that doesn't speak against a lay corporation running your practice what does? This statement is the essence of the prohibitions on the corporate practice of medicine that exists in most states. These prohibitions simply state doctors should control their practice to avoid the business interest interfering with the physician-patient relationship.

These concepts have been held forth since the early days even before AAEM was founded in 1993. The 1978 President of ACEP, Karl Mangold, said in the specialty's major journal: "ACEP and other professional societies and many state laws support the policy that earnings derived from physician services belong to the physician." (JACEP 7:245-248). Mangold's statement speaks directly to Dr. Blumstein's first two bullets. That is a referenced fact, not fake news.

The other bullet points are incorrect in that the bylaws did not specifically mention open books or restrictive covenants. Additionally, due process is not specifically mentioned but there is a statement that EM physicians should be medical staff members equal to all other physicians. In case you haven't looked, due process is standard for them and one can deduce the founders valued that. I was in grade school when the original bylaws were written but they look pretty darn good to me. In fact, if we threw in that all full voting members need to be board-certified I deem that original document as true to the principles of AAEM. It has always bewildered me how AAEM is labeled as "radical" when today it is closer to the original intent of the founders of ACEP than ACEP itself.

Certainly, I can agree with Dr. Kivela that unity among the physicians in our specialty would be ideal but that would require ACEP to join us in actively pursuing three of the bullet points Dr. Blumstein listed: no fee-splitting, no corporate control, and open books. The benefit to the pit doc would be huge if that did occur. I have always said simply having every EM doc see what is paid in their name would radically change the practice of EM as the bedside physicians would demand that we regain control of our specialty.

Continued on next page

What stood out to you from this issue of *Common Sense*? Have a question, idea, or opinion? Andy Mayer, MD FAAEM, editor of *Common Sense*, welcomes your comments and suggestions. Submit a letter to the editor and continue the conversation.

Check out the redesigned *Common Sense* online at:  
[www.aaem.org/resources/publications/common-sense](http://www.aaem.org/resources/publications/common-sense)



## Response

Howard Blumstein, MD FAAEM  
AAEM Past President



Since its inception, AAEM has had three core issues. The primacy of board certification in our specialty, economic exploitation of our peers, and unfair employment practices by those who seek to control our medical practice. It is that simple.

When I speak to young physicians, they are quick to grasp these concepts. They understand the financial motivations that drive those issues. They see how our colleagues enrich themselves, and their stockholders/owners, at the expense of those of us working in “the pits.” They feel the outrage that led to AAEM’s founding 26 years ago. It’s easy.

But then comes the hard part — where we must necessarily address how our specialty is dealing with those abuses. In what direction we are headed? And how do we have that discussion without including ACEP? ACEP is the elephant in the room. I don’t see how you can explain where we are going as a specialty without including the largest of the specialty organizations. That is obvious.

I always preface that discussion in my presentations by addressing the acrimonies of the past. I explain that I do not want to rekindle them. It’s too bad Dr. Kivela doesn’t give me credit. Conversely, however, when you talk about ACEP’s apparent lack of leadership on those core issues, it’s going to look bad. Because it is bad. It isn’t meant to be an attack. And I see a lot of heads nodding. Because it makes sense.

Audiences understand. ACEP continues to fill top leadership positions with never-been-board-certified doctors. How is that championing the importance of certification in our specialty? A disproportionate number of ACEP leaders are executives with, officers of, and/or equity holders in, contract holding corporations whose operation requires the exploitation and control of our peers. How can we expect them to formally and definitively push back against those abuses? We can’t. People get it.

Then the big finish. I tell audiences that ACEP really isn’t interested in me. I am too close to the end of my career. But ACEP is very interested in my audience — young physicians just starting off. In the audience sit people who will be members for 30-35 years. Future committee members, board members, and officers at state and national levels. Those are the folks both AAEM and ACEP want, or need. Of course.

Because of that, young physicians have power. I encourage audience members to exercise that power by asking direct questions of ACEP leaders. Why isn’t exploitation of our colleagues formally considered unethical? Why does ACEP make a statement of an emergency physician’s “rights” but then have no mechanism to defend those rights? Leaders of tomorrow should start demanding change today. It’s their future.

So the slide. I got rid of it even before Dr. Kivela called me and complained about a broad array of issues and people. I am not surprised by the vehemence of his letter. Ultimately the slide just did not fit into the flow of the talk or its ultimate theme. I still think the slide captured the spirit of the issue, although it has some factual errors. And I regret that. As I should.

Some folks respond poorly when I say “I think our core issues are the most important issues in our specialty. They are about professional and practice integrity and we are their champion.” It may well sting but that’s the way I see it, as do many others. I understand that we face many other issues. But how can we maintain our integrity as a specialty when violation of those core issues seems to be condoned through silence? We can’t.

One last thing. Someone please tell ACEP to stop sending me those “We miss you” recruiting letters. It would save them considerable postage. Obviously. ●

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# Upcoming Conferences: AAEM Directly, Jointly Provided & Recommended

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

## AAEM Conferences

### March 7-8, 2019

AAEM Written Board Review Boot Camp  
Caesars Palace, Las Vegas, NV  
[www.aaem.org/education/events/wbr-bootcamp](http://www.aaem.org/education/events/wbr-bootcamp)

### March 9, 2019

AAEM19 Pre-Conference Courses

- Resuscitation for Emergency Physicians (Two Day Course)
- Medication Assisted Treatment Waiver Training - *Jointly provided by the American Academy of Addiction Psychiatry*
- Ultrasound — Beginner
- Bleeding to Death? What's New in Military Hemorrhage Control - *Jointly provided by USAAEM*

[www.aaem.org/AAEM19/program/precons](http://www.aaem.org/AAEM19/program/precons)

### March 10, 2019

AAEM19 Pre-Conference Courses

- Resuscitation for Emergency Physicians Cont'd (Two Day Course)
- ECG in the Emergency Department: Acute Coronary Syndrome and Dysrhythmia
- 2019 Medical Student Track
- 2018 LLSA Review Course
- Ultrasound — Advanced

[www.aaem.org/AAEM19/program/precons](http://www.aaem.org/AAEM19/program/precons)

### March 9-13, 2019

25th Annual Scientific Assembly – AAEM19  
Caesars Palace, Las Vegas, NV  
[www.aaem.org/AAEM19/](http://www.aaem.org/AAEM19/)

### April 6-7, 2019

Spring Oral Board Review Course  
Chicago and Philadelphia  
[www.aaem.org/oral-board-review](http://www.aaem.org/oral-board-review)

### April 13-14, 2019

Spring Oral Board Review Course  
Dallas and Orlando  
[www.aaem.org/oral-board-review](http://www.aaem.org/oral-board-review)

### April 17-18, 2019

Spring Oral Board Review Course  
Las Vegas  
[www.aaem.org/oral-board-review](http://www.aaem.org/oral-board-review)

### August 13-16, 2019

Written Board Review Course  
Orlando, FL  
[www.aaem.org/written-board-review](http://www.aaem.org/written-board-review)

### September 4-6, 2019

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

### September 22-25, 2019

Mediterranean Emergency Medicine Congress - MEMC19  
Dubrovnik, Croatia  
[www.aaem.org/MEMC19](http://www.aaem.org/MEMC19)

## AAEM Jointly Provided Conferences

### February 2, 2019

Southern California EM Symposium -  
Sponsored by CAL/AAEM and AAEM/RSA -  
*Jointly provided by CAL/AAEM*  
Harbor-UCLA Medical Center, Torrance, CA  
[www.aaem.org/CALAAEM](http://www.aaem.org/CALAAEM)

### February 7, 2019

2019 CAL/AAEM Bay Area Speaker Series  
San Francisco, CA  
[www.aaem.org/CALAAEM](http://www.aaem.org/CALAAEM)

### March 9, 2019

TeachingEM – *Jointly provided with The Teaching CoOp*  
Caesars Palace, Las Vegas, NV  
[www.aaem.org/education/events/teaching-em](http://www.aaem.org/education/events/teaching-em)

### April 18, 2019

DVAEM Residents' Day and Meeting  
Philadelphia, PA  
[www.aaem.org/DVAEM](http://www.aaem.org/DVAEM)

### May 10-11, 2019

8th Annual Florida Chapter Division Scientific Assembly - FLAAEM19  
Miami Beach, FL  
[www.aaem.org/FLAAEM](http://www.aaem.org/FLAAEM)

### September 11, 2019

2019 AAEMLa Residents' Day and Meeting  
New Orleans, LA  
[www.aaem.org/AAEMLa](http://www.aaem.org/AAEMLa)

## AAEM Recommended Conferences

### March 29-31, 2019

The Difficult Airway Course: Emergency™  
San Diego, CA  
<https://theairwaysite.com/>

### April 26-28, 2019

The Difficult Airway Course: Emergency™  
Boston, MA  
<https://theairwaysite.com/>

### May 17-19, 2019

The Difficult Airway Course: Emergency™  
Orlando, FL  
<https://theairwaysite.com/>

### September 13-15, 2019

The Difficult Airway Course: Emergency™  
Seattle, WA  
<https://theairwaysite.com/>

### October 4-6, 2019

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

## EIGHTH ANNUAL FLAAEM SCIENTIFIC ASSEMBLY



[WWW.AAEM.ORG/FLAAEM](http://WWW.AAEM.ORG/FLAAEM)

**REGISTER TODAY!**

**May 10-12, 2019**

Fontainebleau Hotel • Miami Beach, Florida

# Highlights for Scientific Assembly 2019

Joelle Borhart, MD FAAEM  
 Evie Marcolini, MD FAAEM  
 Jack Perkins, MD FAAEM  
 AAEM19 Scientific Assembly Subcommittee



## Don't Miss the Keynote Speaker

We could not be more excited for Scientific Assembly 2019 in Las Vegas. Don't gamble on missing any of the opportunities to meet with your colleagues from across the country and hear some of the latest scientific material from your favorite speakers and some exciting new talent. Our keynote speaker this year, Matthew Wetschler, MD will share his perspective on life and career. Matthew is an emergency physician, artist, and former professional athlete who drowned and suffered ten minutes of cardiac arrest. Even though he has sustained right-sided weakness, he has developed his artistic talents, and works to explore our relationship with limits, edges, and the space beyond. We are looking forward to his message.

## Come Early: Pre-Conference Opportunities

Our pre-conference sessions will include the ever-popular ultrasound, resuscitation, ECG, and LLSA reviews, as well as Medication Assisted Treatment (MAT) waiver training and a session on military hemorrhage control. New this year will be a Written Board Review Boot Camp, for those of you taking the ABEM exam in April, and AAEM will jointly provide a teaching program with the Teaching CoOp, for those of you looking to brush up your teaching and presentation skills.

## Back by Popular Demand

This year — back by popular demand — we will double the number of highly popular hands-on small group sessions. Our plenary speakers will cover the latest knowledge on cardiology, sepsis, trauma, resuscitation, critical care, and neurology. Also by popular demand, we will have the Airway Storytelling session, hosted by the unstoppable Billy Mallon.

There will be many other events to participate in, such as Open Mic, Resident and Student Research Competition, WestJEM Competition and the RSA sessions. The Wellness Committee has some fun plans, including a new attendee welcome and a coffee crawl for you early risers.

## New Panel: Patient as Educator

On Tuesday, the AAEM Scientific Assembly Subcommittee is delighted to announce a pilot format featuring patients as the educators in a session entitled: "Oncology Patient Perspective Panel." In some diseases, there is no better way to learn about "best practice" than to hear from the patients themselves and see the emergency department (ED) encounter through their eyes. In this session, Dr. Jack Perkins (FAAEM) will serve as the moderator, and the panel will consist of oncologist Dr. Jennifer Vaughn, her patient Mr. Ben Bane, and the wife of her late patient Mr. Jason Price. Both Mr. Bane and Mr. Price spent dozens of hours in the ED with neutropenic fever, various chemotherapy complications, and other oncology related issues. Mr. Bane and Mrs. Susan Price will discuss details of their ED encounters in terms of what went smoothly, as well as opportunities for improvement. Dr. Vaughn will provide insight and expertise in a discussion of optimal collaboration between the emergency medicine provider and the patient's oncologist.

This session will introduce a new "patient as the educator" format for educational sessions that may be utilized for future scientific assemblies. We will cover best practice in evaluation of neutropenic fever, optimal ways to initiate goals of care or end of life discussions, and the critical importance of collaboration with the patient's oncologist regardless of the perceived severity of the presenting complaint. Please come to hear this engaging panel where the patients will give us their perspective. We guarantee it will be insightful and valuable.

## Join Us!

Because we will be in Las Vegas, you will also have easy access to flights, and the opportunity to take in a show or maybe even practice your card shark skills. Don't play the odds — join us for some of the best emergency medicine education and a great time! ●

**FREE**  
 REGISTRATION  
 FOR MEMBERS  
 WITH REFUNDABLE  
 DEPOSIT!

# REGISTER TODAY!

AAEM was founded in 1993 and held the first Scientific Assembly in Philadelphia, PA in 1994. Join us this year in Las Vegas as we celebrate 25 years of providing outstanding EM education.

# AAEM19 Exhibitors – Thank You!

Plan your visit to the exhibit hall in Las Vegas to network with these exhibitors.

EXHIBITOR	BOOTH	EXHIBITOR	BOOTH
DuvaSawko	100	Weatherby Healthcare	209
Locum Leaders	101	MedaPhor	210
B-Line Medical LLC	104	Vituity	211
Locums United, Inc.	123	PEPID	214&216
Daily Care Solutions	200	PennState Health	215
LogixHealth	201	Tower Health	217
OSF HealthCare	202	Bandgrip, Inc.	220
Med-Care Pharmaceuticals	203	ProScribe	221
MedData	204	Smart ER	222
Ceribell, Inc.	205	VISTA Staffing Solutions	223
Shift Administrators, LLC	208		

More to come! Visit [www.aaem.org/aaem19/exhibitors-and-sponsors/](http://www.aaem.org/aaem19/exhibitors-and-sponsors/) for the most up-to-date list.

## Check Out these MOC Related Sessions at AAEM19

View the full program and all topics covered at AAEM19 on the website: [www.aaem.org/aaem19/program/preliminary-program](http://www.aaem.org/aaem19/program/preliminary-program)

### Cardiovascular

#### SUNDAY, MARCH 10, 2019

- (Plenary) Emergency Cardiology 2019: The Articles You've Got to Know! | *Amal Mattu, MD FAAEM*
- (115) Electrocardiography Literature Update | *Amal Mattu, MD FAAEM*
- (116) The Patient in Extremis: Dysrhythmias Recognition and Management | *William J. Brady, MD FAAEM*
- (116) Critical Care of the Post Cardiac Arrest Patient | *Michael E. Winters, MD MBA FAAEM*

#### MONDAY, MARCH 11, 2019

- (216) AV Blocks: What Your Residency Probably Never Taught You! | *Jerry W. Jones, MD FAAEM*
- (218) Afib Cardioversion in the ED: A Shocking New Approach | *Laura J. Bontempo, MD MEd FAAEM*
- (268) That's a Looong QT | *Katrina Kissman, MD FAAEM*
- (268) Patient in Cardiac Arrest Has a Dilated Right Ventricle. It's a Massive PE, Right? | *Matthew L. Wong, MD MPH FAAEM*

#### TUESDAY, MARCH 12, 2019

- (317) LVADs: Be Not Afraid | *Andrew W. Phillips, MD MEd FAAEM*  
\*Small Group Clinic - Advanced registration full. Limited onsite spots available.
- (318) Syncope Made Easy as 1-2-3 | *Andrew Grock, MD FAAEM*
- (331) Right Ventricular Failure | *Susan R. Wilcox, MD FAAEM*
- (332) LVADs: Be Not Afraid | *Andrew W. Phillips, MD MEd FAAEM*  
\*Small Group Clinic - Advanced registration full. Limited onsite spots available.
- (333) The Pressure is On!: Hypertensive Emergencies - Their Presentations, Involved Organs, and Targeted Treatment | *Jason Hine, MD FAAEM*

#### WEDNESDAY, MARCH 13, 2019

- (415) Do No Harm (and Convince your Colleagues): Asymptomatic Hypertension in the ED | *Jonathan S. Jones, MD FAAEM*

### Endocrine/Metabolic/Nutrition

#### SUNDAY, MARCH 10, 2019

- (118) Deadly Pitfalls to Avoid in the Management of DKA | *George C. Willis, MD FAAEM*

### Infectious Disease

#### SUNDAY, MARCH 10, 2019

- (117) ED Antimicrobial Essentials | *Bryan D. Hayes, PharmD DABAT FAACCT FASHP*

#### MONDAY, MARCH 11, 2019

- (215) Resistant Organisms | *Nilesh N. Patel, DO FAAEM FACOEP*

#### TUESDAY, MARCH 12, 2019

- (331) Biomarkers in the ED | *Nilesh N. Patel, DO FAAEM FACOEP*

#### WEDNESDAY, MARCH 13, 2019

- (411) Nontraumatic Back Pain: Reasons Why It Should Tighten Your Sphincter | *Rahul Bhat, MD FAAEM*

### Nervous System (Neuro)

#### TUESDAY, MARCH 12, 2019

- (327) Shades of Gray Matter: Neuroimaging in the ED | *Wan-Tsu W. Chang, MD FAAEM*
- (333) Stroke Update 2019 | *Karen Greenberg, DO FAAEM*

#### WEDNESDAY, MARCH 13, 2019

- (Plenary) Neurology Updates | *Evie G. Marcolini, MD FAAEM FACEP FCCM*
- (411) Nontraumatic Back Pain: Reasons Why It Should Tighten Your Sphincter | *Rahul Bhat, MD FAAEM*
- (412) EMS: Stroke? More Than Six Hours? BYPASS, BYPASS! | *Kerry Ahrens, MD FAAEM and Robert P. Zemple IV, MD FAAEM*

## Pain Management & Opioids

SUNDAY, MARCH 10, 2019

(118) Buprenorphine in the ED | *Eric M. Ketcham, MD FAAEM FASAM*

MONDAY, MARCH 11, 2019

(218) Narcotic Abuse in America: Past, Present and Future | *James R. Gill, MD MBA FAAEM*

TUESDAY, MARCH 12, 2019

(318) The Dark Side of the NSAID's - When Dose Makes a Difference | *Sergey M. Motov, MD FAAEM*

(325) Can We Get Better With That Painful Sickling? - Advances in ED Management of Vaso - Occlusive Crisis | *Sergey M. Motov, MD FAAEM*

WEDNESDAY, MARCH 13, 2019

(415) Opioid Masterclass | *Richard M. Pescatore II, DO FAAEM*

## Palliative Care and End-of-Life Care

MONDAY, MARCH 11, 2019

(218) Compassionate Extubation: Not Just Pulling the Plug | *David H. Wang, MD*

TUESDAY, MARCH 12, 2019

(316) The Grey Zone: End of Life in the ED & Beyond | *Genese Lamare, MD FAAEM*

(326) The Next Wave: What Every Emergency Physician Needs to Know about Palliative Care | *Mari Siegel, MD FAAEM FACEP*

## Pediatrics

SUNDAY, MARCH 10, 2019

(115) Challenging Cases in the Peds ED | *Mimi Lu, MD FAAEM*

MONDAY, MARCH 11, 2019

(Plenary) Efficient EM Care of the Child with Special Needs | *Ilene Claudius, MD FAAEM FAAP FACEP*

(215) More Cowbell! Updates in Infants with Fever | *Mimi Lu, MD FAAEM*

(217) Tubes for Tots | *Jennifer Fisher-Repanshek, MD FAAEM*

(218) Checking Urine in Infants: Who, How, and Why | *Ilene Claudius, MD FAAEM FAAP FACEP*

WEDNESDAY, MARCH 13, 2019

(414) Are You Safe to Go Home? Screening for Suicidality in Pediatric ED Patients | *Emily C. MacNeill, MD*

## Psychobehavioral

SUNDAY, MARCH 10, 2019

(118) Buprenorphine in the ED | *Eric M. Ketcham, MD FAAEM FASAM*

MONDAY, MARCH 11, 2019

(218) Narcotic Abuse in America: Past, Present and Future | *James R. Gill, MD MBA FAAEM*

TUESDAY, MARCH 12, 2019

(326) Sedation for the Agitated Patient | *Kevin C. Reed, MD FAAEM*

WEDNESDAY, MARCH 13, 2019

(414) Are You Safe to Go Home? Screening for Suicidality in Pediatric ED Patients | *Emily C. MacNeill, MD*

## Trauma

MONDAY, MARCH 11, 2019

(Plenary) New Horizons in Trauma Resuscitation | *Thomas M. Scalea, MD*

(218) Traumatic Ocular Emergencies | *Gregory Patek, MD OD FAAEM*

# Candidate Statements Now Available Online

# 2019 AAEM Election Cast Your Vote Online



- **Review the candidate statements:** Now available online and printed in this issue of *Common Sense*.
- **Join the Candidates' Forum** at the 25th Annual Scientific Assembly in Las Vegas, NV. Monday, March 11, 2019 from 2:30pm-3:30pm.
- **Cast your vote:** Vote online at [www.aaem.org/elections](http://www.aaem.org/elections) or electronically onsite at Scientific Assembly or from home. To learn more visit the AAEM elections website.

### Open Positions

- At-Large Directors (5 positions)  
- Must be a full-voting or emeritus member
- Young Physicians Section (YPS) Director - Must be a YPS member

[www.aaem.org/elections](http://www.aaem.org/elections)

**Voting closes: March 11, 2019 at 11:59pm PT**

## Plenary Speakers

Sunday, March 10, 2019 | 1:30pm-2:15pm  
**Emergency Cardiology 2019: The Articles You've Got to Know!**  
 Amal Mattu, MD FAAEM



Sunday, March 10, 2019 | 2:45pm-3:30pm  
**Sepsis – New Recommendations**  
 Peter M.C. DeBlieux, MD FAAEM



Monday, March 11, 2019 | 8:00am-8:45am  
**New Horizons in Trauma Resuscitation**  
 Thomas M. Scalea, MD FACS MCCC



Monday, March 11, 2019 | 9:00am-9:45am  
**Efficient EM Care of the Child with Special Needs**  
 Ilene Claudius, MD FAAEM FAAP FACEP



Monday, March 11, 2019 | 1:00pm-2:15pm  
**Essential Resuscitation Articles 2018-2019**  
 Corey M. Slovis, MD FAAEM FACP FACEP



Wednesday, March 13, 2019 | 8:00am-8:45am  
**Neurology Updates**  
 Evie Marcolini, MD FAAEM FACEP FCCM



Wednesday, March 13, 2019 | 9:00am-9:45am  
**Critical Care in Review**  
 Haney Mallema, MD FAAEM



## Keynote Speaker

Tuesday, March 12, 2019 | 8:00am-8:45am  
**Water and Stars**  
 Matthew Wetschler, MD



In November of 2017, Dr. Matthew Wetschler, a Stanford-trained emergency physician, former professional athlete, and visual artist had a catastrophic surfing accident, which nearly killed him and initially rendered him a quadriplegic. In less than a year, he has made a near-complete recovery. Inspired by his experience, and lessons gained on the journey to recovery, Dr. Wetschler has developed a new lecture about navigating our most difficult challenges with strength and grace. Prior to his injury, drawing from his

experiences during clinical training, Dr. Wetschler toured nationally to renowned institutions such as Harvard, Duke, UCSF and Stanford as a guest lecturer speaking to the phenomenon of physician burnout, well-being, and personal optimization.

## AAEM19 Speakers

Kerry Ahrens, MD FAAEM  
 Abena O. Akomeah, MD  
 Ashely Alker, MD MSc  
 Patricia Ruth A. Atchinson, DO  
 Zeki Atesli, MD  
 Heatherlee Bailey, MD FAAEM FCCM  
 Jeffery A. Baker, MD FAAEM  
 Benjamin Bane  
 Rahul Bhat, MD FAAEM  
 Michael Billet, MD  
 Howard Blumstein, MD FAAEM  
 Michael C. Bond, MD FAAEM FACEP  
 Laura J. Bontempo, MD Med FAAEM  
 Joelle Borhart, MD FAAEM FACEP  
 Matthew P. Borloz, MD FAAEM  
 William J. Brady, MD FAAEM  
 Nicholas Burjek, MD  
 Katharine Burns, MD FAAEM  
 David J. Carlberg, MD FAAEM  
 Wan-Tsu W. Chang, MD FAAEM  
 Eric Chin, MD MBA FAAEM  
 Ilene Claudius, MD FAAEM FAAP FACEP  
 Ryan Clouser, DO  
 James AP Connolly, MBBS FRCS(Ed) FCEM  
 Peter M.C. DeBlieux, MD FAAEM  
 Matthew C. DeLaney, MD FAAEM  
 Christopher I. Doty, MD FAAEM  
 Sarah B. Dubbs, MD FAAEM  
 Erick Eiting, MD MPH MMM FAAEM  
 Molly K. Estes, MD FAAEM  
 David A. Farcy, MD FAAEM FCCM  
 Jennifer Fisher-Repanshek, MD FAAEM  
 Jessica Fleischer-Black, MD  
 Kevin L. Foss, MD  
 Jessica K. Fujimoto, MD  
 Rajat Gangahar, MBBS FRCS(Ed) FCEM  
 Manish Garg, MD FAAEM  
 Gus M. Garmel, MD FAAEM FACEP  
 James R. Gill, MD MBA FAAEM  
 Jacob Goertz, MD  
 Michael Gottlieb, MD RDMS FAAEM  
 Karen Greenberg, DO FAAEM  
 Andrew Grock, MD FAAEM  
 Jordana Haber, MD MACM FACEP  
 Elise H. Hart, MD  
 Bryan D. Hayes, PharmD FAACT FASHP  
 Megan Healy, MD FAAEM  
 Andrew A. Herring, MD FAAEM  
 Jason Hine, MD FAAEM  
 Amy F. Ho, MD  
 Beatrice Hoffmann, MD PhD FAAEM  
 Dallas Holladay, DO  
 Korin B. Hudson, MD FAAEM  
 Maite A. Huis in 't Veld, MD FAAEM  
 Ashika Jain, MD FAAEM FACEP  
 Robert Jarman, MBBS MSc FRCSE FRCM  
 Jerry W. Jones, MD FAAEM  
 Jonathan S. Jones, MD FAAEM  
 Michael P. Jones, MD FAAEM FACEP  
 Carolyn Kanter, MD  
 James K. Keaney, MD MAAEM FAAEM  
 Ross Kessler, MD  
 Eric M. Ketcham, MD FAAEM FASAM  
 Danya Khoujah, MBBS FAAEM  
 Katrina Kissman, MD FAAEM  
 John G. Knight Jr., MD  
 Robert P. Lam, MD FAAEM  
 Genese Lamare, MD FAAEM  
 Michael J. Lambert, MD RDMS FAAEM  
 Hein H. Lamprecht, MD PhD  
 Skyler A. Lentz, MD  
 Ashley Liebig, RN CCRN  
 Rebecca Liggins, MD FAAP FAAEM FACEP  
 Mimi Lu, MD FAAEM

Emily C. MacNeill, MD FAAEM  
 Mark Magee, MD  
 Haney Mallema, MD FAAEM  
 William K. Mallon, MD DTMH FAAEM FACEP  
 Julian G. Mapp, MD MBA MPH FAAEM  
 Evie G. Marcolini, MD FAAEM FACEP FCCM  
 Amal Mattu, MD FAAEM  
 Colin G. McCloskey, MD FAAEM  
 Siamak Moayedi, MD FAAEM  
 Lisa A. Moreno-Walton, MD MS MSCR  
 FAAEM  
 Sergey M. Motov, MD FAAEM  
 Christofor Muhr, MD  
 Molly Mulflur, MD FAAEM  
 Jose V. Nable, MD MS NRP FAAEM  
 Ana Maria Navio Serrano Sr., MD PhD  
 Mark A. Newberry, DO FAAEM  
 Ryan K. Newberry, DO MPH  
 Michael A. Nitzberg, MD FAAEM  
 Brian Parker, MD  
 Gregory Patek, MD OD FAAEM  
 Ketan Patel, MD FAAEM  
 Nilesh N. Patel, DO FAAEM FACOEP  
 Jessica Patterson, MD  
 Jack C. Perkins Jr., MD FAAEM  
 Richard M. Pescatore II, DO FAAEM  
 Andrew W. Phillips, MD Med FAAEM  
 Elizabeth Pontius, MD RDMS FAAEM  
 Susan Price  
 Michael Pulia, MD MS FAAEM  
 Moiz Qureshi, MD  
 Ryan P. Radecki, MD MS FAAEM  
 Karen A. Randall, DO FAAEM  
 Kevin C. Reed, MD FAAEM  
 Mark Reiter, MD MBA FAAEM  
 Zachary Repanshek, MD FAAEM  
 Salim R. Rezaie, MD FAAEM  
 Jeffrey Riddell, MD  
 Matthew A. Roginski, MD MPH FAAEM  
 Sherri L. Rudinsky, MD FAAEM  
 Christopher S. Russi, DO FAAEM FACEP  
 Thomas M. Scalea, MD  
 Kramfin E. Schreyer, MD CMQ FAAEM  
 Richard D. Shih, MD FAAEM  
 Mari Siegel, MD FAAEM FACEP  
 Michael E. Silverman, MD FAAEM FACP  
 Zachary M. Sletten, MD  
 Corey M. Slovis, MD FAAEM FACP FACEP  
 Ryan Spangler, MD FAAEM  
 Eric M. Steinberg, DO FAAEM  
 Jon Strong, MD MPH  
 Matthew J. Stull, MD  
 Michael E. Takacs, MD MS FAAEM  
 Semhar Z. Tewelde, MD FAAEM  
 Joseph E. Tonna, MD FAAEM  
 Joseph R. Twanmoh, MD MBA FAAEM  
 Jennifer Vaughn  
 Julie Vieth, MBChB FAAEM  
 David H. Wang, MD  
 Matthew Wetschler, MD  
 Susan R. Wilcox, MD FAAEM  
 R. Gentry Wilkerson, MD FAAEM  
 George C. Willis, MD FAAEM  
 C. J. Winckler, MD FAAEM  
 Michael E. Winters, MD MBA FAAEM  
 Matthew L. Wong, MD MPH FAAEM  
 Joseph P. Wood, MD JD RDMS MAAEM  
 FAAEM  
 Allison Zanaboni, MD FAAEM  
 Robert P. Zemple IV, MD FAAEM  
 Matthew D. Zuckerman, MD FAAEM

*Topics and speakers are subject to change.*

Dr. Wetschler's lecture discusses the experience of death, paralysis, and, eventually, a remarkable recovery. Weaving in his expertise of burnout and the psychology of elite-athletic performance, he distills valuable mental frameworks for self-optimization, resilience, durational effort, and, ultimately success inside intensely demanding and uncertain endeavors. These lessons are anchored within a riveting, against-all-odds story of recovery, one that involves narrowly escaping death, the cutting-edge science of modern spinal injury management, and a vibrant testament to our innate human capacity.

Visit the AAEM19 website for full educational details including session titles, speakers, and more!

[www.aem.org/AAEM19](http://www.aem.org/AAEM19)

## Pre-Conference Courses

### Hands-On Courses

#### Ultrasound — Beginner

Saturday, March 9, 2019 | 8:00am-3:45pm

This is the ultimate ultrasound course for EPs. This year includes additional focus on echocardiography and central line placement. Didactic lectures will provide state of the art audiovisual presentation by veteran faculty, followed by small groups of a maximum four participants / one instructor allowing you ample hands-on time for ultrasound scanning.

6.25  
Credits

#### Bleeding to Death? What's New in Military Hemorrhage Control

Saturday, March 9, 2019 | 12:30pm-5:45pm  
Jointly Provided by USAAEM

Would you like to learn about translating military damage control resuscitation strategies into your civilian practice? A unique military-civilian partnership has allowed for the widespread deployment of low titer O+ whole blood (LTO+WB) in the San Antonio metropolitan area. The Uniformed Services Chapter Division of AAEM (USAAEM) will offer our experience with deploying LTO+WB in hospitals and on ground ambulances. We will also provide education on a variety of techniques (REBOA, modified thoracotomy, and AAJT) you can deploy in the setting of traumatic arrest and peri-arrest. Approximately twenty five percent of the time will be dedicated to hand-on instruction and demonstrations.

4.75  
Credits

#### Ultrasound — Advanced

Sunday, March 10, 2019 | 8:00am-12:30pm

A fully hands-on experience! Didactic lecture videos will be available at your convenience one month prior and one month following the advanced US course. At the onsite course there will be a maximum four participants to one instructor allowing you ample hands-on time for ultrasound scanning.

3.75  
Credits

### Expert Instruction

#### Resuscitation for Emergency Physicians

Two-Day Course

Saturday, March 9, 2019 | 7:30am-5:00pm  
Sunday, March 10, 2019 | 7:30am-11:00am

Resuscitation for Emergency Physicians (REP) is an outstanding course for the emergency physician that encompasses a broad spectrum of topics including cardiac arrest, noninvasive ventilation, ED mechanical ventilation, post-intubation hypotension, septic shock, pediatric resuscitation, CNS catastrophes, toxicologic disasters, trauma, and complex cardiac conditions. Quite simply, this course will help you save lives!

9.25  
Credits

#### Medication Assisted Treatment Waiver Training

Saturday, March 9, 2019 | 7:30am-5:00pm

Jointly provided by the American Academy of Addiction Psychiatry, a DATA 2000 sponsoring organization and Providers Clinical Support System

Physicians are required to complete eight hours of medication assisted treatment (MAT) training to apply to the Drug Enforcement Agency for a waiver ("X-license") to prescribe buprenorphine, one of three medications (buprenorphine, naltrexone and methadone) approved by the FDA for the treatment of opioid use disorder.

9  
Credits

Emergency physicians have an opportunity to profoundly impact the deadly opioid epidemic by bridging patients to addiction treatment from the ED with buprenorphine. Along with the X-license, the information in the course will facilitate this life-saving, and potentially life-transforming, intervention.

Funding for this initiative was made possible (in part) by grant nos. 5U79TI026556-02 and 3U79TI026556-02S1 from SAMHSA. The views expressed in written conference materials or publications and by speakers and moderators do not necessarily reflect the official policies of the Department of Health and Human Services; nor does mention of trade names, commercial practices, or organizations imply endorsement by the U.S. Government.

Please visit the website for more information on course eligibility.

Act Now for Early Bird Rates!

Prices increase February 7, 2019

#### ECG in the Emergency Department: Acute Coronary Syndrome and Dysrhythmia

Sunday, March 10, 2019 | 7:30am-12:00pm

The ability to interpret the electrocardiogram (ECG) is a life-saving skill, but ECG training in most specialties only teaches the basics. Through a series of mini-lectures and multiple case-presentations, you will learn an assortment of ECG pearls to elevate your ability to interpret ECGs to a significantly higher level. The course will also discuss many of the common pitfalls that can lead to disastrous outcomes. Whether you are a new residency graduate or a seasoned physician, you will learn new and useful information that will truly make a difference in patient care and will save lives!

4  
Credits

#### 2018 LLSA Review Course

Sunday, March 10, 2019 | 8:00am-12:00pm

The experienced emergency physician will value this evidence-based review course for all of the required readings for the 2018 LLSA Review. Course content will be discussed both via lecture and through small group discussion on key topics for each mandated journal article.

3.75  
Credits

#### 2019 Medical Student Track

Sunday, March 10, 2019 | 7:30am-12:05pm

The medical student track will provide you with invaluable advice on how to successfully apply to an emergency medicine residency. There will also be a residency program director panel. Pre-registration is required and open to medical students only, so take advantage of the opportunity to learn more about the specialty and meet other students and physicians practicing emergency medicine. We hope to see you there!

Free  
for student  
members!\*

## Breve Dulce Talks (Formerly PK)

In 2014, the AAEM Scientific Assembly introduced the Pecha Kucha (PK) sessions: an innovative, fast-paced series of lectures that was the first of its kind at a major emergency medicine conference, and is now an annual attendee favorite.



#### Same exciting talks – new updated name!

For 2019, we are excited to announce that these sessions are getting a makeover, with a new name that fully captures the spirit of these sessions: *Breve Dulce*, which is derived from *breve et dulce* – Latin for "short and sweet."

#### What is Breve Dulce?

These rapid-fire talks will cover a variety of important topics. The Breve format is a succinct, high-level overview in less than seven minutes (*short*) of EM pearls that you can immediately put to use in your everyday practice (*sweet*).

Learn more and register at  
[www.aaem.org/AAEM19](http://www.aaem.org/AAEM19)



Dear AAEM Member,

Enclosed are the candidate statements for the 2019 AAEM board of directors election.

As you are aware, the call for nominations was sent to all voting members. Those AAEM members who appear on the enclosed ballot have indicated their willingness to serve on the AAEM board.



Statements from each of the candidates full listing of previous board service and awards, and AAEM activities dating back five years (2014 and greater) are on the following pages. Please review the enclosed information, then exercise your democratic right to vote for the representatives you would like to see serve as AAEM's leaders. Remember, we have a one member, one vote system, so your voice counts. Please follow these instructions for casting your ballot in the 2019 election.

#### **If You Will Attend the Scientific Assembly:**

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- ***We recommend that you do not complete your official ballot at this time.*** There will be a Candidates' Forum held during the Scientific Assembly on March 11, 2019, 2:30pm-3:30pm, where you can hear the candidates respond to direct questions from the voting membership. You will be asked to submit your ballot online at the conclusion of that Forum.
- ***If certain of your choices or unsure if you will attend the Forum,*** you may vote online at [www.aaem.org/elections](http://www.aaem.org/elections). Voting will remain open until March 11, 2019 at 11:59pm PT.

#### **If You Are Unable to Attend the Scientific Assembly:**

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- You may complete your official ballot online at [www.aaem.org/elections](http://www.aaem.org/elections). Online voting will remain open until March 11, 2019 at 11:59pm PT.

#### **Balloting Procedure for 2019:**

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- ***Voting ballots will only be available online.***  
Please visit [www.aaem.org/elections](http://www.aaem.org/elections) to cast your vote electronically.

**Thank you for your continued support of AAEM.** Please call 800-884-2236 with any questions you may have regarding the election procedure.

Sincerely,

A handwritten signature in black ink that reads "Kay Whalen". The signature is written in a cursive style.

Kay Whalen  
Executive Director



## Patrick D. Cichon, MD JD MSE FAAEM

### **CANDIDATE FOR AT-LARGE DIRECTOR**

Nominated by: Self Nomination

Membership: 2011-2019

Disclosure: Nothing to disclose at this time.

There are many challenges confronting us in Emergency Medicine today: the erosion of Physician autonomy, increasing metrics, hospital & medical group politics, increasing physician burnout with decreasing wellness culminating in higher physician suicide rates. Average physician debt obligations have soared to about \$200K though it's not uncommon to have a lot more while MD compensation averages about \$280K/yr, up 31% over 10 yrs (about 9% healthcare costs) but piling in comparison to the 93% increase in hospital CEO compensation from \$1.6M to 3.1M from 2005 to 2015 (about 25% of healthcare costs). While our administrative and nursing colleagues self impose patient care limits, have lunch and rest breaks, ER physicians work sometimes without having any time to eat or go to the bathroom and stay longer and often take work home with them facing significant medicolegal liability. Well intentioned standards developed to help us improve patient care have sometimes been turned into weapons by attorneys to attack us and our colleagues.

There is a need to rethink our future approach to Emergency medicine if we wish to preserve the appeal, autonomy and value of our profession for future generations of ER docs. Medical degrees need to be affordable and have a reasonable lifestyle associated with them. In the emerging world of telemedicine, A.I. and the emergence of alternative Health Practitioners we need to be certain that our profession remains economically rational and relevant with reasonable lifestyles.

We need to be not only altruistic but realistic in the costs we incur for ourselves, our families and on account of future generations of physicians. We need to have the same rights, due process and protections as other medical staff members and union employees. We need, perhaps, to discuss and consider some of the same approaches that our nursing colleagues have used such as setting physician-patient ratios to ensure patient safety and make ER work and lifestyle manageable and decrease liability and overextension. ER physicians deserve the same protections as other staff, employees and practitioners in the various fields of medicine. We need to understand and contribute to sculpting liability and reimbursement regulations in telemedicine and AI so that we are appropriately paid and protected from unreasonable liability in these merging fields. For these reasons, I am seeking this position: to try to protect ourselves, our families and the future practitioners within the field of Emergency Medicine.



## Robert A. Frolichstein, MD FAAEM

### CANDIDATE FOR AT-LARGE DIRECTOR

Nominated by: David A. Farcy, MD FAAEM FCCM; Robert McNamara, MD MAAEM FAAEM; and Mark Reiter, MD MBA FAAEM

Membership: 1998-2018

Disclosure: Nothing to disclose at this time.

AAEM Board of Directors 2017-2019

AAEM Foundation Board of Directors 2017-2019

James Keane Award 2017

EMS Committee Board Liaison 2017-2018

Geriatrics Interest Group Board Liaison 2018

Independent Practice Support Committee 2016-2019

Palliative Care Interest Group 2016-2019

Wilderness Medicine Interest Group Board Liaison 2018

*Common Sense* Author 2018

Thank you all for electing me to the AAEM Board of Directors in 2017. I enthusiastically desire a second term. It has been a gratifying experience and I believe I have been an asset to the Academy. Drs. David Farcy, Mark Reiter and Bob McNamara evidently agree as they have nominated me for a second term. I have been involved in several projects as part of the AAEM Board including:

- A team exploring the feasibility of physician unions as a mechanism of protecting the individual emergency physician
- Explored and authored a letter of support to a group of emergency physicians in Texas
- Numerous discussions with individuals advocating for the AAEM Physician Group
- Represented the EMS committee, Wilderness Medicine and Geriatric Interest Groups as the board liaison
- Served on the team to create and define the AAEM Institute for Leadership, Education & Advancement in the Development of Emergency Medicine (LEAD-EM), a tribute to Dr. Kevin Rodgers
- Part of an AAEM task force investigating the role of the Advanced Practice Providers (APP) in emergency medicine
- The AAEM representative to an ACEP led, multi-organizational task force exploring emergency medicine workforce issues most prominently the role of the APP

The specialty of emergency medicine has a unique and meaningful history. We defined our specialty and have evolved using research and experience to become the experts in acute unscheduled care to anyone at any time.

For most, the care we deliver at the bedside is our calling and we do it because we feel it is what we are supposed to do in this life. However, we cannot escape the fact that is also our job and means of supporting our family. Just as we decide the best care for the patient at the bedside, I believe we should also decide how our jobs are structured. Physicians are the producers in the economy of the delivery of healthcare. We should be the ones to determine how the fruits of our labor are used to run the business and be distributed to the producers. More than the fair market value for services provided should not be taken from us. Yet we see this every day.

I sense a change coming. I talked to dozens of emergency physicians over the last year that are just starting their careers and they have a genuine interest in being part of a democratic group and involving themselves in group decisions. They do not want to create profit for organizations that define their workplace environment and group structure. I want to be part of an organization that advocates for the emergency physician first and foremost. AAEM will, and does advocate for emergency medicine as a whole, but their *raison d'être* is the individual emergency physician.

I believe the next 5-10 years may be tumultuous times in the house of medicine. I want to continue to be a part of the AAEM Board of Directors as the Academy works diligently to "have the back" of each and every emergency physician.



## Luis E. Gomez, Sr., MD MBA FAAEM

### **CANDIDATE FOR AT-LARGE DIRECTOR**

Nominated by: David A. Farcy, MD FAAEM FCCM and Evie G. Marcolini, MD FAAEM FACEP

Membership: 2006-2019

Disclosure: Nothing to disclose at this time.

Florida Chapter Division Board of Directors 2010-2013

Florida Chapter Division Board of Directors Vice President 2013

AAEM/RSA Congressional Elective Fellow 2014

Government and National Affairs Committee 2014-2019

Scientific Assembly Speaker 2017

Diversity and Inclusion Committee Chair 2018-2019

*Common Sense* Author 2018

It is an honor to be nominated to the Board of Directors of our courageous medical specialty society. Without AAEM to protect the rights of our specialty, and advocate for the integrity of our practice, the priority would never be the best interests of patients. With advocacy for our profession that rivals none, and a mission that puts the quality of the care we provide above profits, we promote a culture of professionalism that encourages equity and welcomes diversity beyond self-serving ends.

In an era of waning attention to ethics, professional organizations like AAEM and National Medical Association (NMA) steadily promote integrity, taking proactive positions to protect us on our most vulnerable fronts. My efforts at AAEM will go on being directed in this way. We acknowledge the education of residency-trained and boarded emergency medicine specialists. We consistently maintain oversight over corporate management groups (CMG) that includes questioning corporate sponsored training programs. We continue to defend due process. We call out discriminatory and suspect business practices such as lack of transparency, fee-splitting, and financial kick-backs. We remain watchful for evolving threats to the unencumbered practice of emergency medicine, even as the reimbursement landscape contracts profits, putting pressure on all of us. We will keep supporting these positions through advocacy and research. A physician's right to stable employment should not be compromised for calling out lax standards of quality in the interest of increased profit margins. For decades, I have watched AAEM make this work an unquestioned priority and despite threats to my own right to practice, I plan to keep defending these values.

Finally, I believe the increased presence of underrepresented physicians in leadership in all aspects of our profession is critical to realizing health equity and best outcomes for all patients. This goal has been a major part of my focus as Chair of the Diversity and Inclusion Committee. I feel fortunate that, after education in places like Cornell, B.U and U. Chicago, I help train underrepresented physicians at an inner city safety net hospital at Howard University College of Medicine. None of it would have been possible without the support of organizations like AAEM and NMA, who welcome all voices. I am loyal to AAEM's commitment to professional integrity despite the challenges of economic expediency from flawed benchmarks such as patient satisfaction scores. We know these are the real sources of stress leading to physician burnout. Most of us recognize that the allostatic load that leads to exhaustion more often comes from pushing back against lack of integrity, creating conflicts of interest. We will persist in focusing on setting ourselves apart using a moral compass to guide the invisible hand and keep up the fight for what is right in our profession.



## Bobby Kapur, MD MPH FAAEM

### CANDIDATE FOR AT-LARGE DIRECTOR

Nominated by: William T. Durkin, Jr., MD MBA MAAEM FAAEM and David A. Farcy, MD FAAEM FCCM

Membership: 2012-2018

Disclosure: Nothing to disclose at this time.

AAEM Board of Directors 2017-2019

AAEM Foundation Board of Directors 2017-2019

Academic Affairs Committee Board Liaison 2017

Academic Affairs Committee 2014-2019

ACCME Sub-Committee Board Liaison 2018-2019

India Chapter Division (AAEMi) Board Liaison 2018-2019

Inter-American Emergency Medicine Congress Speaker 2014, 2016, 2017

Mediterranean Emergency Medicine Congress Pre-Congress Chair 2019

Residency Visit Liaison 2017-2019

Scientific Assembly Student Ambassador Liaison 2018, 2019

At the 2017 Scientific Assembly, I had the opportunity to share my thoughts about the key issues facing Emergency Medicine and Emergency Physicians:

- Policy of Emergency Medicine
- Practice of Emergency Medicine
- Practitioners of Emergency Medicine

After being elected to the AAEM Board, I have had the privilege to work with friends and colleagues throughout the country the past two years to address these critical topics.

With Emergency Medicine serving as the nation's healthcare safety net, health policy inextricably becomes linked to EM. As Chief of Emergency Medicine at Jackson Memorial Hospital in Miami, FL, I have helped tackle health policy and public health issues such as the Opioid Crisis, the Zika Epidemic, Hurricane Irma preparedness and response, HIV/HCV screening and treatment, and the impact of the Affordable Care Act. Through AAEM, many of us across the US have been able to share resources and best practices to address these and many more policy issues. Our specialty has bonded together to speak about and act upon Injury Prevention and Intimate Partner Violence. Working within AAEM and with partner organizations, we are advancing the dialogue through social media advocacy and substantive policy changes.

We strive shift each shift to provide the highest quality medical care to our patients. How we practice emergency medicine has become more and more complex: documentation, billing & coding, CMS regulations, metric driven practice, insurance reimbursements. And now we face the threats of Due Process constraints and Restrictive Covenants. Listening to the stories and sharing these concerns with members of Congress, the Board members and I have helped draft legislation and introduce new bills to protect our Practice of Emergency Medicine.

Our Emergency Medicine students and residents are the future Practitioners of Emergency Medicine and the future of AAEM. I serve as the AAEM Board lead for our Residency Visits Program where AAEM speakers travel to residency programs and discuss with EM residents the key issues confronting Emergency Physicians. These engagements are important to establish a foundation of well-informed Emergency Physicians who will make a vital impact in the years to come. In addition, I serve as the AAEM Board lead for the Scientific Assembly Medical Student Ambassador Program. As a previous residency program director at Baylor College of Medicine and International EM fellowship director at George Washington University, I understand the importance of providing guidance and resources for EM physicians in training and for AAEM's Resident and Student Association (RSA).

I am proud to be a member of AAEM, and, more importantly, I am proud to be part of an Academy where we work together to improve the lives of our patients and colleagues as we serve our communities each and every day. It has been an honor to serve you on the AAEM Board, and I ask for your continued support.



## Evie G. Marcolini, MD FAAEM FACEP

### CANDIDATE FOR AT-LARGE DIRECTOR

Nominated by: Howard Blumstein, MD FAAEM; David A. Farcy, MD FAAEM FCCM; and Lisa Moreno-Walton, MD MS MSCR FAAEM

Membership: 2005-2018

Disclosure: Nothing to disclose at this time.

AAEM Board of Directors 2017-2019

AAEM Foundation Board of Directors 2017-2019

ACCME Sub-Committee 2014-2017

Critical Care Medicine Section Board Liaison 2017-2019

Education Committee Board Liaison 2017-2019

Education Committee 2014-2019

International Conference Committee 2017-2019

Mentorship Sub-Committee 2016-2019

Palliative Care Interest Group Board Liaison 2018-2019

Women in Emergency Medicine Committee 2017-2019

Scientific Assembly Speaker 2014-2019

Scientific Assembly Planning Sub-Committee Co-Chair 2015-2019

Scientific Assembly Abstract Competition Reviewer 2015, 2018

Mediterranean Emergency Medicine Congress Speaker 2015, 2017

Mediterranean Emergency Medicine Congress Abstract Reviewer 2017

Inter-American Emergency Medicine Congress Speaker 2014, 2017

Inter-American Emergency Medicine Congress Abstract Reviewer 2017

Speaker Development Group Mentor 2017-2019

Medical Student Ambassador Mentor 2018

*Common Sense* Author 2017, 2018

Thank you for considering my nomination for reappointment to the AAEM Board of Directors, At-Large position. This will be my first reappointment, and I consider myself even more eligible for appointment after having been on the board for two years, learning much about the process and the opportunities to make a difference for members.

You may remember that my first candidacy was based on my desire to contribute to the education mission of AAEM. I am committed to promoting education in order to fulfill AAEM's mission of providing affordable high quality continuing medical education in emergency medicine for its members. In that vein I have accomplished the following:

- Co-Chaired AAEM Scientific Assembly for 4 years, bringing a new budgeting format to the SA, bringing small group sessions and introducing up and coming new speakers to the program
- Helped develop AAEM's Speaker Development Program to mentor new speakers
- Member of Scientific Assembly subcommittee for 6 years
- Member of Education Committee, ACCME Subcommittee, International Conference Committee, Women in Emergency Medicine Committee and Critical Care Section
- Represented AAEM through didactic sessions at Scientific Assembly, Mediterranean Emergency Medicine Conferences, as well as the Argentinian Emergency Medicine Congress and the IAEMC Congress in Costa Rica
- Promoted AAEM by giving talks to residency programs around the country
- Represented AAEM on a position letter to the ACGME regarding a Neurocritical Care Specialty Designation.
- Represented AAEM on a letter to ACGME/RRC with regard to changes in protected time for Emergency Medicine Core Faculty
- Chaired AAEM task force group to create a tool to help physicians working in low acuity, low volume or locums tenens positions to fulfill their MOC requirement for Practice Improvement (PI) activity.
- Chaired AAEM task force to address current issues facing Emergency Medicine around Advance Practice Providers (APPs) with regard to independent practice
- Represented AAEM on a multidisciplinary writing group to produce a review paper on Meniere's Disease
- Facilitated AAEM Board of Directors to approve becoming a partner organization to American Foundation for Firearm Injury Reduction in Medicine, which will enable us to support unbiased research on a topic that affects us all

In my view, my most significant accomplishments are in the area of promoting new and young speakers to present at Scientific Assembly by promoting them through the subcommittee and helping them to develop presentation skills through the Speaker Development Group. AAEM gives a lot to Emergency Medicine, and will have the most impact on new physicians entering practice with challenges such as due process and advocacy. Helping young physicians to develop their talents and get involved in the organization that best represents their interests will continue to make AAEM the leader in Emergency Medicine.

I appreciate your vote in helping me to continue to represent you on the Board of Directors.

Sincerely,

Evie Marcolini, MD



## Carol Pak-Teng, MD FAAEM

Nominated by: Self Nomination

Membership: 2017-2019

Disclosure: Nothing to disclose at this time.

Women in Emergency Medicine Committee 2018

I am an Emergency Physician passionate and driven in the areas of women's advocacy, community based policy change, and physician wellness strategy events. To date, I have built multiple communities of women leaders in and out of EM, organized cultural awareness conferences, and been acknowledged nationally for my work by the Academy for Women in Academic Emergency Medicine as the 2015 Outstanding Resident while at Mt. Sinai St. Luke's Roosevelt Hospital. I have also received accolades for my work in Political Psychology and Asian American Studies at NYU.

I grew up in a working class immigrant Korean family in a predominantly Black neighborhood with a Caucasian Uncle father figure from a military family. This upbringing gives me deep insight into the human experience.

I propose that AAEM can stand out as a leader by putting aside of the old term of "diversity" and instead promoting intersectionality, the multiplicity of race, ethnicity, gender, class, and socialization and how they converge in our identities and how others view us. With this understanding, we can develop better programs that help all EPs understand themselves and their patient populations, hopefully to bring more humanism back into our profession.

Many good physicians are leaving EM or deeply unhappy with the way we are forced to practice.

I myself was crippled by the pressures I placed on myself and from the constantly increasing volumes, innumerable charting, focus on metrics and billing, and expectation to be perfect with an impossible work load. This all while pushing myself to the brink with additional outside advocacy for women physicians and Residency Union contract negotiations. In fact, it sent me into 3 months of a Major Depressive Episode.

This is why I am so passionate about physician wellness. It has taken me a long time to admit this openly but I now see it was symptomatic of the broken system we all have come to accept. I am done accepting this as the only way. I envision that AAEM can play a pivotal role in changing the growing sentiment that EM does not care about our colleagues. We cannot stand idle while large corporations erode our specialty and our hearts.

Emergency Medicine is at a crossroads now in terms of EMR challenges, political advocacy, large corporate interests, and the jeopardization of the art of medicine. I would like a seat at the table to help steer these issues at this critical time in our evolution as a speciality.

Ultimately, I love to connect with people. Once I meet you, I will advocate for you; listen to your concerns, whether I agree or not; generate solutions; and help us meet our goals.

Thank you for your willingness to take a chance on a young but inspired candidate.



## Leslie S. Zun, MD MBA FAAEM

### CANDIDATE FOR AT-LARGE DIRECTOR

Nominated by: William T. Durkin, Jr., MD MBA MAAEM FAAEM and Mark Reiter, MD MBA FAAEM

Membership: 1993-2019

Disclosure: Nothing to disclose at this time.

AAEM Board of Directors 1998-2002, 2011-2016

AAEM Foundation Board of Directors 2011-2016

David K. Wagner Award 2011

Academic Affairs Committee Board Liaison 2014-2017

Academic Affairs Committee 2014-2017

Finance Committee 2014-2016

Independent Practice Support Committee 2014-2018

International Conference Committee 2018

Operations Management Committee 2014-2018

Palliative Care Interest Group Board Liaison 2016

Quality Standards Committee Board Liaison 2015-2016

Quality Standards Committee Chair 2014-2016

Inter-American Emergency Medicine Congress Speaker 2014, 2016

Mediterranean Emergency Medicine Congress Speaker 2017

Mediterranean Emergency Medicine Congress Abstract Judge 2015

Scientific Assembly Speaker 2014-2017

AAEM & AAEM/RSA Residency Visit Speaker 2014-2015

*Common Sense* Author 2014-2018

AAEM/RSA Podcast Contributor 2017

I am running for Board of AAEM to bring my fervor about contract management companies taking over emergency departments across the country. I want to bring my experience and expertise to ensure that you are represented in the house of medicine. I want to bring my energy to wage a constant battle against unfair labor practices, non-compete clauses and waiving of due process rights. I want to continue our excellent education programs both in the US and internationally. I want to ensure that no residency program is ever again put in jeopardy because the department was taken over by a contract management company.

I contributed to the formation new specialty organization focused on empowering emergency physicians, the American Academy of Emergency Medicine. I served on the board a few times in the past, participated on multiple AAEM committees and received the Wagner Award for service to emergency medicine. I am residency trained in emergency medicine at the University of Illinois and acquired a MBA from Northwestern University. I am professor and chair of Emergency Medicine at Chicago Medical School and teach residents in Emergency Medicine. I had the experience to see the emergency department from the other side as the president and CEO of a 250 bed hospital in Chicago.

I want to continue to serve the members, new and experienced in the field, not only to improve our practice environment but also to continue AAEM's quest to raise concern about contract management companies. Thank you for your consideration.

Les



## Phillip Dixon, MD MPH FAAEM CHCQM

### CANDIDATE FOR YPS DIRECTOR

Nominated by: Self Nomination

Membership: 2013-2019

Disclosure: Nothing to disclose at this time.

Young Physicians Section Board of Directors 2016-2018

Resident and Student Association Board of Directors 2015-2017

Resident and Student Association Vice President's Council 2014-2015

Government and National Affairs Committee 2015-2018

Resident and Student Association Advocacy Committee Chair 2015-2016

Scientific Assembly Student Ambassador Mentor 2017, 2018

I am applying for the Young Physician Section Director of the American Academy of Emergency Medicine. I very much appreciate the opportunity and consideration to continue my involvement in this tremendous organization. In the past, I have served on both the RSA board as a resident, as well as the YPS board after residency. My interests in emergency medicine include patient and physician advocacy, health policy, as well as administration. I am currently completing my MBA and my goal is to use that knowledge to improve operations and efficiency in the emergency department, as well as understanding budgets and financial accounts, which I was not taught previously in formal education.

Among the many initiatives that AAEM participates in, the most important to me has been the advocacy efforts. I have participated in AAEM's advocacy day and feel AAEM provides an important voice for emergency physicians. AAEM's strong support for the emergency medicine physician is ultimately why I want to continue to participate in this organization. AAEM's position and advocacy efforts help fight against unsafe work environments that some physicians are faced with too often. AAEM's support for democratic groups are second to none in emergency medicine, as well as fighting for and sustaining due process. Due process is integral to practicing emergency medicine and something I believe in strongly. I am applying for this position in order to continue my involvement with AAEM and participate in its important advocacy efforts.

I believe emergency medicine plays a unique role in the community as it functions as not only guaranteed care in case of emergency, but it also functions as a safety net for the most underserved and vulnerable patients. Unlike most other specialties, we as emergency medicine physicians do not choose our patients or their financial circumstances and the medical services we provide and the patient's insurance status or ability to pay are not connected at all whatsoever. We need to protect our specialty and the physicians that practice this amazing specialty. AAEM champions those who serve our most vulnerable patients and I would be proud to continue my service in AAEM.

Dollars &amp; Sense

# Fidelity's Free Mutual Funds and the Resulting Fidelity Mania

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



If you read financial blogs or follow the financial news, you probably read multiple articles about Fidelity's latest offensive in the investment company price war — free index mutual funds. Yes ... completely free with a 0% expense ratio.

What does this mean for the average investor? Let's take a look...

## What Happened?

About a year ago I wrote about how all of the major investment companies — Fidelity, Schwab, and Vanguard — were competing for your business by lowering their investment fees. Vanguard has been the low-cost leader and used that focus and their unique non-profit structure to become the largest investment company, managing over \$5 trillion. For comparison, Fidelity oversees \$2.5 trillion. Yes, TRILLION.

Vanguard's mantra emphasizes the following central tenets of investing:

1. The lower your investment fees, the more of the investment return you get to keep.
2. Costs last forever.
3. You should invest with low cost, broadly diversified index funds.

As you might have guessed, this is what I do. I do this at Vanguard and with my military retirement plan accounts.

In July, Fidelity announced that they were offering two new mutual funds at no cost — free — to investors with no investment minimums. The funds are the:

- Fidelity ZERO Total Market Index Fund (FZROX) — a diversified US stock index fund
- Fidelity ZERO International Index Fund (FZILX) — a diversified international stock index fund

Everyone was waiting for one of these investment giants to offer free mutual funds. Fidelity became the first.

Eventually someone will offer a fund that PAYS people to invest in it, but we're not there yet.

## Fidelity Mania

Ever since this announcement, there have been countless news articles and blog posts about the free funds. I guess I'm now contributing to that. People have been clamoring to switch to Fidelity funds, but a closer look will show you that switching to Fidelity is not guaranteed to be a good move or even what most people trying to minimize their fees should do.

## They're Free! Why Not Switch?

First, Fidelity is not a stupid company. There is no such thing as a free lunch, and they are going to make money from their customers somehow. One way would be by luring you to Fidelity for these free funds, but charging you more on other investments. As the author of this article on



Morningstar stated:

"But, ultimately, no companies toil for free. What they give away in one place, they recoup in another."<sup>1</sup>

They'll make up the difference with other funds or brokerage services.

In addition, "The White Coat Investor" wrote one heck of an article that deep dives on expense ratios and the new Fidelity funds. In it he points out that when you look at equivalent Vanguard, Schwab, and Fidelity funds you'll see that Vanguard seems to win even with slightly higher expenses and they have a tax efficiency advantage that Schwab and Fidelity don't have. As he notes:

"It just turns out that Vanguard is better at indexing than Fidelity and Schwab. Is that really a surprise to anyone?"<sup>2</sup>

I hate to reinvent the wheel, so those interested in the details should really read his article: [www.whitecoatinvestor.com/expense-ratios/](http://www.whitecoatinvestor.com/expense-ratios/).

## What Does This Mean for Investors?

If you are already a Fidelity investor, their drive to compete with Vanguard is going to give you some really useful low-cost investment opportunities.

If you are not already a Fidelity investor, realize that if you sell any investments in a regular taxable account (outside of a tax advantaged retirement account like a 401k or IRA), you will have to pay taxes on any capital gains you have. Unless selling won't generate any taxes (you don't have any gains) or what you are invested in is an extremely poor choice, I wouldn't give Uncle Sam some of your money just to save a few hundredths of a percentage point on your expense ratio.

Here's a good quote from another Morningstar article about the new Fidelity funds that demonstrates how little of a difference these small percentages can have on your bottom line:

Continued on next page

“To illustrate the modest stakes for your portfolio, let’s look at the growth of a \$10,000 investment in Fidelity Total Market Index (FSTVX), Schwab Total Stock Market Index (SWTSX), and Vanguard Total Stock Market Index (VTSAX). Over the years, the three have changed leadership on fees, and investment minimums have changed, too. For the past 10 years, \$10,000 in Vanguard Total Stock Market Index would have grown to \$28,520, while the Schwab fund would have grown to \$28,460 and the Fidelity fund to \$28,350. And the differences at times were greater than they are today. So, keep costs low and save as best you can, but don’t worry too much about a couple of basis points.”<sup>3</sup>

In addition, you can’t underestimate the benefit of simplicity when it comes to your investment portfolio. I had the military retirement accounts and Vanguard. That was it. Then my wife changed employers and now we have an expensive 401k with John Hancock that drives me nuts.

While I keep track of everything with Personal Capital and that makes it pretty easy, having yet another website (John Hancock) I have to login to when I want to make changes is kind of a pain. Don’t underestimate the peace of mind that comes with simplicity, and adding Fidelity to the mix for a few basis points might not be worth the hassle.

If you are just starting out as an investor, just realize that you really can’t go wrong with Fidelity, Schwab, or Vanguard as long as you focus on their low cost funds. At Vanguard, all the funds are low cost, so that simplifies your investing life, but Schwab and Fidelity are fine as well.

#### What’s the Bottom Line?

1. If you’re already invested with Fidelity, enjoy the new free funds and

use them for your US and international stock investments.

2. If you haven’t picked an investment company yet, Fidelity is certainly one to consider but I’d still go with Vanguard if it was up to me.
3. You probably should not switch from another company just for free funds, and certainly should not sell anything that would trigger a capital gain just to switch.

The White Coat Investor summarized the strategy you’d employ no matter what company you pick in his article about the Fidelity funds:

“There is no new investing strategy going on here. It’s the same old, same old investing strategy – buy all the stocks, hold them, keep your costs and taxes down, and in the long run, your money grows at the same rate as the market and if you save enough, you become financially independent.”<sup>4</sup>

If you’d like to contact me, please email me at [jschofer@gmail.com](mailto:jschofer@gmail.com) or check out my Navy blog for physicians, [MCCareer.org](http://MCCareer.org).

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

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# Achieving Great Outcomes in Your Discharged ED Patients

Tom Scaletta, MD MAAEM FAAEM  
AAEM Past President



Emergency physicians (EPs) have two seconds to establish patient trust, two hours to determine the diagnosis, and two days of responsibility for patients they send home. The latter is a point of contention for some EPs who believe patients are fully responsible for following their discharge instructions and returning to the emergency department (ED) if their symptoms worsen or change.

Delivering great emergency care depends on training and experience, applying skills to the particular situation, establishing patient trust, making the right diagnosis, explaining the aftercare plan, and motivating the patient to adhere to it. Checking on patients the day after their ED visit sheds light on what is otherwise a blind spot as to whether all of these components of great care fell into place.

## Establish Trust

Patients trust physicians that they perceive to be competent, compassionate, and great communicators. Most patients start out willing to trust their EP even though they never met. Patient confidence in a physician is either fortified or threatened within the first few minutes of the encounter. Encouraging patient trust optimizes adherence with medications and follow-up, which improves outcomes. Similarly, creating positive patient experience is subjective, research shows that it improves patient outcomes.<sup>1,2</sup>

Physicians perceived as competent have a professional appearance, actively listen, and seem confident and not arrogant. They are attentive to patient needs and personally share updates during the ED course.

Compassion stems from being mindful of the patient's situation and respecting their autonomy. An effective strategy is to match the care you would deliver to a good friend's family member. Compassionate physicians are kind, relate well to their patients, and show empathy.

Great communicators are honest, transparent, and use plain language delivered at a deliberate pace to explain medical issues. They understand that communication has more to do with tone and body language rather than the words themselves. Effective communication means the patient understands the diagnosis and what needs to be done after discharge. An acronym for the components of highly effective communication is GREAT, which stands for Greet, Relate, Explain, Ask, and Thank.<sup>3</sup>

With trust and effective communication, the ED visit is more likely to proceed smoothly as there will be less resistance with the planned work-up and more tolerance for waiting or other issues that may arise. When patients trusted the doctor that took care of them and understood the diagnosis and treatment plan, malpractice claims are much less likely.



## Check Wellbeing

While residency-trained, board-certified EPs are experts in making disposition decisions, there is never certainty that the expected medical trajectory over the ensuing 24 hours will be realized. In fact, the majority of post-discharge liability claims relate to misdiagnoses associated with new or worsening symptoms that become apparent the next day.

The only way to uncover next-day wellbeing and service issues is to contact the patient. Twenty years ago, I used a relational database application to facilitate a structured, patient callback system. By standardizing the questions and responses, a clerk was able to make the phone calls instead of a nurse. When patients perceived they were worse or had difficulties with an aspect of aftercare, the case was relayed to the charge nurse to be reconciled. Robert Wood Johnson Foundation published this system as a best practice, yet very few EDs adopted it due to the cost of staffing and managing a callback team.<sup>4</sup>

The ubiquity of smartphones now allows the overwhelming majority of patients, regardless of age or socioeconomic status, to be reached electronically. Text messaging is a form of asynchronous communication and preferred by most patients since they are no longer interrupted by a ringing phone. My hospital was the beta development site for a system that automatically sends one-minute surveys by text message and relays wellbeing or service concerns to the appropriate staff members.<sup>5</sup> Using this strategy in our three emergency departments and seven immediate care centers helps us maintain a very low risk profile, reduce unnecessary ED returns, and achieve top-decile satisfaction.

Continued on next page

Physicians are more apt to send patients home when they know they will be checked the next day. About one in 20 discharged patients will relay they are “worse” though most instances are benign (e.g., more neck pain after a whiplash mechanism). However, 5% are worrisome and warrant a return to the ED. Of these, 5% will have a serious issue that could become a lawsuit if not addressed.

Unlike comments in CAHPS surveys, complaints that are realized the next day can result in prompt service recovery. This will help patients maintain faith in the institution.

### Assure Adherence Verifying Adherence

Aftercare encompasses keeping follow-up appointments, obtaining prescriptions, and initiating home care (e.g., rest, wound treatment, hydration, etc.). Adherence is maximized when patients appreciate that recommendations are beneficial, within their financial means (e.g., can afford a prescription), and easy to arrange (e.g., transportation to appointments).

Physicians are more apt to send patients home when their patients are routinely checked on the next day. When aftercare gaps are uncovered, they can be relayed to the case managers for reconciliation. For instance, if a child on Medicaid with a Type II supracondylar fracture is refused follow-up by the on-call orthopedic surgeon then the case manager can remind the office manager about the medical staff policy and EMTALA obligations.

Written instructions are a passive means of education. Patients usually want to exit quickly and often indicate that they understand the aftercare plan when they do not. Upon discharge let your patients know that you can never be 100% sure the correct diagnosis was made or the ideal recovery will occur. Ask them to report any questions or concerns that arise.

### Summary

Establishing trust during the ED visit increases the likelihood of adherence. Checking on discharged patients reveals those with interval worsening and those falling off track with the aftercare plan. Next day contact, regardless of the means, improves outcomes, prevents malpractice claims, and satisfies patients. ●

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## G.R.E.A.T.

G.R.E.A.T.™ stands for Greet, Relate, Explain, Ask, and Thank. It is a communication standard that can help EPs improve patient trust. The open source program includes teaching videos and other education materials. [Ref: GREATservicestandard.com]

### Greet — Create a positive first impression

- Knock at the door and ask to enter the room
- Relay your name, title, and role
- Acknowledge all in room - smile, eye contact, shake hands
- Maintain a professional appearance

### Relate — Connect with the patient and friends/family

- Discuss common interests (e.g., local sports teams)
- Sit down next to the patient while history taking
- Don't interrupt for at least 60 seconds
- Stay mindful and focused
- Speak highly of your team members
- Offer comfort measures (e.g., analgesics, blanket, water)

### Explain — Carefully explain the clinical details

- Use lay terms and speak at a deliberate pace
- Breakdown every step in work-up process and estimate timelines
- Perform hourly updates whenever possible

### Ask — Question the patient to assure comprehension

- Since patients often misunderstand discharge instructions, ask specific questions to test comprehension
- Examples of clarifying questions
  - “How will you change this dressing at home?”
  - “When will you start the antibiotic?”
  - “How will you decide your breathing is worse enough to return?”
  - “What is your greatest concern?” is a great catch-all question

### Thank — Leave a lasting impression

- Shake hands or briefly touch their shoulder
- Examples of closing comments
  - “I appreciate you putting your trust in our team.”
  - “Please let us know if there is any change in your condition.”

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## Call for Members: Join the EM Observation Medicine Interest Group

We would like to create an AAEM EM Observation Medicine Interest Group that would benefit from the collective wisdom and experience of interested emergency physicians nationwide.

In the era of value-based care and the ever-growing need to control healthcare costs, Observation Medicine has emerged as not only a solution to some of these issues, but serves as a prototype for the sort of evidence-based, protocol driven, high-quality care that not only controls costs reduces the unneeded variability seen in much of hospital care.

Emergency Medicine and Emergency Medicine Physicians are well suited to the task of delivering such care due to our understanding of process improvement, flow, and the delivery of high-quality, time sensitive care.

As a leader in the development of quality, patient-centered, Emergency Medicine initiatives, AAEM and its members have much to offer the field of Observation Medicine. Through research and collaborative problem solving, as well as educational and policy initiatives, AAEM can help to shape this ever-growing field. Thus, we feel it is essential for AAEM to take steps toward developing an interest group that can foster ongoing collaboration among EM Physicians involved in Observation Medicine and educated those who are interested in knowing more about this field.

If you would like to be a part of this interest group, please contact Anthony Rosania, MD, FAAEM at [rosanian@njms.rutgers.edu](mailto:rosanian@njms.rutgers.edu). **We would like to hold an initial meeting at the AAEM Scientific Assembly in Las Vegas, NV in March 2019.** Watch the AAEM website for additional updates! ●

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Operations Management Committee

## Flow Improvement Strategies: Provider-In-Triage (PIT)

Gerry Maloney, DO FAAEM



Do you have problems with patient flow? Does your waiting room fill and your department vapor-lock by mid-afternoon every day? Do you have to deal with long waits and patient complaints?

If you don't have these issues, consider yourself in the minority nationwide. Most of us are running into flow problems during our peak volume hours, and the higher your volume and acuity, the worse the

issues become. In general, they result from issues both intrinsic to the emergency department (triage, rooming and discharge processes, bed capacity, efficiencies in seeing patient, and ordering tests) and extrinsic (difficulty in obtaining inpatient beds, radiology and laboratory results). While the primary issues may differ by site, it is likely that everyone experiences at least some of these issues to some degree.

The concept of ED flow has been the subject of a growing body of scientific research. The earliest research dates back to the 1980's, when overcrowding in the ED (defined as patients in hallway beds) was identified with delays in care, longer time spent in the waiting room, and higher left without being seen (LWBS) rates. Their early papers identified a lack of inpatient beds as a driving factor behind these flow issues. Throughout the 1990's and into the 2000's, studies continued to identify increasing problems with crowding, ED length of stay (EDLOS), and boarding of admitted patients. As ED volumes have continued to trend up nationally, the population has aged and become more medically complex. Concurrently, inpatient bed capacity has decreased both due to hospital closures and staffing issues. For these reasons, flow problems have become a daily reality in ED's across the country, whether community, academic, or government hospitals.

There has been an equally robust growth in research looking at ways to improve flow and optimize ED operations to compensate as much as possible in ways that can be controlled by the ED. The evolution of fast tracks for lower acuity patients, split flow triage to room the sickest patients and move the lower acuity patients through an area where they can be seen quickly, use of order sets to have labs and certain imaging studies ordered at triage to speed the diagnostic process, and use of holding areas to move patients awaiting results to free up bed space are all examples of flow improvement schemes that have been successful. Another major flow improvement strategy that will be discussed now is the use of a provider (generally a physician) in triage to help speed the disposition of patients.

The physician in triage (PIT) process has been studied in multiple configurations, with the published research largely in academic centers, though in practice most of the PIT programs happen in community ED's. The basic premise is similar-use of a provider seeing the patient during or very shortly after triage with a goal of determining disposition (immediate discharge, immediate rooming in back, or movement to a holding area for reassessment). Ordering of diagnostic testing and initiation of

treatment commonly begins much earlier than in a traditional queuing process, and as the patients are seen in triage or some other specially designated area the door-to-provider times are lowered. Successful PIT programs have seen lower door-to-provider, door-to-disposition, and EDLOS times. The team configuration differs somewhat among models, generally including a medic, registration person, or nurse with the provider. The majority of research has focused on using a physician instead of an APP in triage as this allows for independent evaluation of the highest acuity patients waiting to be seen without needing to involve another provider. The timing of provider assessment differs as well; recent research has looked at "team triage" where the assessment of the patient by provider and triage nurse happens simultaneously. The extent to which the PIT program is implemented differs as well, with reported times ranging from as low as 4 hours during peak volumes up to 12 hours of PIT coverage. While this heterogeneity makes determining the ideal format for use of a PIT program difficult to precisely nail down, what has been consistent across the literature is that implementation of successful PIT program based on the characteristics of the institution has resulted in flow improvement.

PIT does not work in isolation; places that have utilized PIT have paired it with other flow initiatives, and the better the metrics initially (i.e., the shorter your wait times and crowding issues), the less additional impact of adding more flow initiatives. That said, the literature has reported varying degrees of flow improvement, based on where the department started and what other process improvements they have put in place. As flow issues are multifactorial, flow solutions are also best approached in a multifactorial fashion.

So, should you be in the unlucky majority with crowding and flow issues in your department, and are looking at flow improvement initiatives, consider creating a PIT program as an additional step.

*Dr. Maloney is a member of the Operations Management Committee and associate chief of the emergency department at the Cleveland VA Medical Center. ●*

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Women in Emergency Medicine Committee

# Woman of Substance: Yvette Calderon, Emergency Physician

Interviewed by Laleh Simani, MS4, edited by Marianne Haughey, MD FAAEM



## Yvette Calderon, MD

Chair, Department of Emergency Medicine, Mount Sinai Beth Israel; Professor of Emergency Medicine; Past Associate Dean of Diversity Enhancement at The Albert Einstein Medical School Training; Medical School, Albert Einstein College of Medicine; Residency, Emergency Medicine at Jacobi Medical Center; MS in Clinical Research Training, Albert Einstein Medical School

### Research interests and awards:

Project BRIEF: An HIV counseling, testing, and prevention intervention in the Bronx, NY

Awards: K23 from the National Institute of Child Health and Human Development to conduct HIV prevention studies engaging adolescent and young adults. Dr. Linda Laubenstein Annual HIV Clinical Excellence Award: for physicians who provide the highest quality of clinical care and compassion for people with HIV/AIDS. 2009 Nova Award from the American Hospital Association for effective collaborations that improve the public health. 2010 Safety Net Award from the National Association of Public Hospitals.

### Question & Answer

#### 1. What was your path to medicine? And emergency medicine?

I was raised in the Chelsea projects and then Hells Kitchen. I was very fortunate to have an amazing mentor, Alice Miller, who was a philanthropist. She told me “within medicine, there should be a real diversity of physicians’. Alice put together a weekend program for students to keep them off the streets. She used Columbia’s and Mount Sinai’s medical schools as two sites where the medical students would come and teach the high school students about medicine. I was always strong in science and math in school. Through Alice Miller’s mentorship in High School, I ended up going to Brown University for my undergraduate education and then Albert Einstein for medical school. That trajectory was good for me.

Where and when I grew up, was the height of the heroin, crack, and cocaine epidemic. My exposure to Alice Miller’s program really influenced me to give back to the community. I chose emergency medicine because after my first year of medical school, I met Dr. Gary Lombardi. I remember he was at the foot of the bed and there was a resuscitation being done. He was like an orchestra leader. He had the amazing ability to stay calm and make everyone feel calm around him. I thought to myself, if I can have an ounce of his knowledge and his ability to take care of patients in such a chaotic setting, I would be very fortunate. It was the sense of every patient having a different story and every patient having a different need; it was there I felt I was doing something useful.

#### 2. What are the key challenges in emergency medicine and what are your own challenges?

The tract of woman holding academic leadership roles going from assistant to associate professor and then to professor, is difficult and you don’t see as many women going into the field as we should. I think that it is due to the lack of mentorship and the thought that everything must be done in a time sequence manner, when it really doesn’t.

Within emergency medicine, I think the biggest challenge is life-work balance. There will come a day that you will need to work the holiday that is important to you. On the contrary, emergency medicine is the best field because it opens up so many doors and so many different directions you can go into.

#### 3. What excites you the most about the position you hold currently as chief of the emergency medicine department at Mount Sinai Beth Israel?

Faculty development is one of my biggest endeavors. I identify that they can achieve and send them to programs for advancement and really push them along because I see their talents.

The second most exciting part of my position currently is being able to implement public health programs within the emergency department. This requires persistence, but the payoff is worth it for the community and my sense of myself as an emergency physician.

#### 4. To date, what professional achievement are you most proud of?

I have two. I am most proud of my work in HIV because that is when I realized seeing a patient individually is very important and has a critical significance for changing patterns of care and policy. Putting together programs that impact community health and patient populations is an amazing feeling. As a physician you realize that you have touched all of these people that you don’t even know.

My second biggest achievement was my position of Dean of Diversity at Albert Einstein — specifically mentoring the college students and medical students. That position allowed me to provide support to those who felt like they didn’t have a voice. The students would not hear “no” from me. My answer to them was “you try and you don’t give up.”

#### 5. Tell me about your research in HIV prevention and Project BRIEF?

In the 80’s, the stigma around being diagnosed with HIV had many implications. To get tested, people needed an in-person counseling session. In the ED we were seeing patients coming in very late in the disease process, without having been diagnosed. I went back to Albert Einstein to receive my Master’s Degree in the Clinical Research Training Program. I



Continued on next page

worked collaboratively with my colleague, Dr. Jason M. Leider, MD, who was the Infectious Disease Specialist and the Director of the HIV clinic. We worked together to implement a testing program for the ED for HIV as we were seeing many patients who came to the ED without having other avenues for accessing health care.

We implemented a video consent program which was completely novel at the time. The advantages of a standardized approach to counselling, allowed patients to have an opportunity to give consent without the barriers (such as individual value judgments, language limitations, or hours of work) that are involved with requiring an employee to impart the information can't be overstated. It was that moment in my life that triggered everything else. This is how Project BRIEF started.

#### 6. What is the importance of mentorship to you? Both being mentored and mentoring others.

Mentoring others is the best thing in the world. There are students who tell me they have a great idea and need someone to help them realize it. Sharing how I view medicine and especially the need to care for the vulnerable with students, residents, and young faculty — that means the world to me. It is renewing to see how they own that as well.

With respect to being mentored — it is critical. I've had different mentors for different aspects of my career. You need a mentor who can help you with wellness and life balance and incorporating family life priorities. You need a mentor for research, a mentor to guide you through promotions, a mentor to guide you through your clinical years. You will have about five to six mentors — maybe even more. Your mentor is not only your mentor, but also can be your friend and colleague.

#### 7. What still keeps you in the game? What is your every day drive and motivation?

I am still in the game because I still have a lot to do. Whether it has to do with identifying and transitioning to treatment those with Hepatitis C, or approaching the opioid crisis in the ED with fruitful pathways I want to benefit my community of humanity. Every five to 10 years, I redirect myself to something different and challenging — something where I can grow.

I have to be the voice of the community — because if I am not at the table then who is going to have that voice. I think when you are an emergency medicine physician, it gives you that ability because you see humanity walk through the door every day — you see it at its worst and at its best. ●

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Diversity and Inclusion Committee

# Applied Without Insight, Lean Six Sigma Adversely Affects ED Flow and Health Care Quality

L.E. Gomez, MD MBA FAAEM  
Chair, Diversity and Inclusion Committee



Hospitals, insurers, and corporate group practices have used Lean Six Sigma methodology for years to improve patient safety and financial performance, with an increasing emphasis in recent years on simply maximizing revenue. However, applied without the required attention to ways in which health care differs from other service industries, the approach can undermine the value it proposes to capitalize

on: the health of the patient. Application of Lean Six Sigma concepts to the delivery of medical care requires deeper insight and customization of these concepts or the goal of improved health outcomes will not be realized.

The term Lean Six Sigma combines two, well-known, business improvement principals aimed at performance: lean manufacturing (taken from the Toyota Production System), to remove waste

and inefficiency, and Six Sigma (taken from Motorola and GE), to reduce variation and error. Some aspects of Six Sigma, a way to measure and reduce defects in the manufacturing, were directly transferable to reduction of errors and improving consistency in medical operations such as the ordering and administration of medications. The well-known landmark Institute of Medicine report of 1999, "To Err is Human: Building a Safer Health System," described the dire need for approaches to improve accuracy when performing straightforward tasks such as physician orders and delivery of medications. Reducing errors using checks and balances pioneered in Six Sigma, including confirming correct surgical sites, urgently needed addressing and saved lives almost overnight. Not surprisingly, these changes improved satisfaction as outcomes improved immediately.

However, Lean Six Sigma business strategies aimed at increasing revenue by improving production require more consideration to apply safely in health care. Any series of activities can be analyzed in the interest of increasing measurable steps to improve production and flow. This concept can be applied in a clear-cut manner when the goal is the sale of physical products or other uncomplicated services. But there are fundamental differences not shared by other industries in health care. For instance, higher sales and consumer expenditures do not correlate favorably health outcomes or patient satisfaction when measured in context. Health care business leaders, often focus disproportionately on metrics such as speed and quantity to gauge the success of operations which may lead to critical errors when applied to health care delivery.

Emergency physicians seeing patients, rather than managing operations, typically prioritize focus on health outcomes and prudent utilization

of scarce resources. Although, they may be financially incentivized to increase production to a lesser extent than managers, they recognize markers of performance other than patient turnover. They understand the relationship between patients and health is unlike any other customer product relationship. However, these clinicians also introduce variation into process improvement measures. I suspect the internal conflict this dynamic causes is a significant contributor to what has erroneously been termed "physician burnout," and a source of waste antithetical to Lean Six principals.

Lean Six Sigma can be applied more usefully to improve health given a more considered approach.

Currently, the focus on short-term returns, like immediate customer satisfaction based on attention to environment and entertainment (TV in every patient room), food and liberal use of narcotic pain medication as primary measures of performance, is a risky proposition

applied indiscriminately. Care quality, when weighted too heavily towards a patient's comfort, rather than more focused on clinical effect, is not only wasteful, but irresponsible. Quality medical care requires that clinical interpretation and professional judgment supersede the immediate subjective preferences of patients as consumers. Moreover, the role of clinicians is not equivalent to salesman in other industries: as educators their opinion needs to be valued more highly in the context of the goal. If hearsay suggests clear coat does not protect your vehicle and you should forego the option, this does not equate to recommendations regarding vaccination. The issue of vaccines being flawed due to an unproven association with behavioral illness requires educated physicians, nurses and researchers to keep the world's population safe by valuing the time required to clarify the issue. This difference must be recognized and factored into applications of Lean Six to health care.

Caution must be taken to balance the business goal of improving the quarterly bottom line against long-term health outcomes. There is a risk in paying incentives to physicians and others in leadership interpreting Lean Six Sigma in unsophisticated ways. For example, equating patient satisfaction with speed of care and then prioritize it over clinical judgment, is a deeply flawed approach. Research increasingly supports that, current high satisfaction ratings from patients most often require they receive health care in excess of that provided the rest of the population. This leads to overmedication and avoidable hospitalizations which not only result in higher cost but poorer outcomes.<sup>1</sup> It represents a massive conflict of interest and should be reason enough to re-evaluate our current



Continued on next page

unexamined approach. Alarming, more satisfied patients suffer death at a higher rate than their less satisfied counterparts. By tying compensation to the wrong patient satisfaction indicators, our health care system is not only failing to realize the stated goal of improving patient safety and health, it is violating a primary tenet of medical care: “first do no harm.”

The need for Lean Six Sigma methodology to be clinically informed by trained ethical leaders could not be more urgent. Process and quality improvement by identification using root cause analysis (RCA) helps reduce medical errors quickly and efficiently. However, losing levels of sophistication in medical assessment in order to simplify a process and increase turnover may both increase revenue and harm patients. We should be sensitive to the fact that continuous quality improvement (CQI) can easily stray from the primary goal of realizing improved health outcomes. For example, what happens when CQI analysis of a case is tainted by the desire to support an initiative that is financially favorable to the operation?<sup>2</sup>

Unexpected deaths typically trigger departmental chart review as part of CQI with the goal to uncover RCA. But what if the cause of death is unclear and leadership is interested in finding justification for increase in use of trauma consult services? Consider the following fictional example. Hospital trauma services are struggling to justify maintenance of Level 1 services and have pushed emergency services leadership to reduce under-triage to less than 1% and recommend 100% consultation on all trauma cases along with pan-scanning with CT. Higher utilization of services, would, after all, improve revenue and appear to increase safety. We can all imagine a case such as this: A patient presents to the emergency department alert and oriented but with mild lethargy immediately following a head injury and denies other injuries. No other injuries are found or documented on physical exam. Initial CT of the head and C-spine show no evidence of acute trauma, however Neurology is consulted immediately and explain mild alteration in mental status as due to concussive injury. The patient is transferred to the floor but becomes increasingly confused, lapses into coma, aspirates and has a cardiac arrest. After a prolonged resuscitation attempt, including extensive chest compressions, there is no spontaneous return of pulses. A middle manager in charge of CQI reviewing the case a couple of weeks later concludes based on the autopsy report including evidence of chest injury that the critical error occurred at presentation: failure to recognize traumatic chest injury and call for surgical trauma team evaluation of the chest. This, in turn, results in justification for pushing an agenda aimed at higher rates of trauma surgery consultation for chest trauma. The critical error in the RCA: the chest trauma is temporally out of sequence as it was actually caused by the resuscitation attempt rather than injury prior to arrival. Clearly, objectivity was compromised by confounding factor of external agenda.

Several factors, in fact, contributed to the incorrect assessment in this sample case. They include a hierarchical structure of leadership that put management agenda ahead of careful analysis of timeline, insufficient knowledge of medical care and perhaps the relative inexperience of the safety officer. The erroneous conclusion that the trauma team would have caught the chest injury and saved the patient’s life is both wrong and misses the opportunity to educate the neurology team on the need for more aggressive evaluation of traumatic brain injury (TBI).<sup>3</sup> Correctly identifying the presentation of TBI might have resulted in recognizing

required emergent MRI, intubation and ICU admission earlier in the patient’s course. The case also illustrates a real observation made by other medical professionals about migrating practices from other safety critical industries to health care: the underlying principle must be customized to the level of sophistication required to explain the outcome. Application of RCA to CQI requires consideration of the danger of allowing external agendas to cloud the judgment of managers.

As for applications of business processes more focused on Lean concepts from manufacturing and production, the devil is in the details. Improving throughput and eliminating wasted time required for processing patient care, such as at patient registration, can decrease time to patient bed placement and reduce time to physician encounter with patients. However, what happens when the staff becomes more beholden to patient tracking boards and focus on identifying and addressing time stamps rather than patient needs? In fact, we all know staff learns to game electronic tracking systems to appear to be performing at the required level. Some clinicians, click on a patient icons significantly before seeing a patient, or charge nurses place patients in a room virtually that are still in triage. The tracker can become a fictional representation of reality and not represent actual ED flow, while hiding inefficiencies and waste they were created to eliminate.

Early patient testing and evaluation can expedite flow when the method is applied selectively and wisely. However, operations cannot be streamlined when upfront testing is applied blindly. Instead of decreased throughput times, flow is decreased due to over-utilization. Selective point of care testing, on the other hand, is useful to this end. Testing all patients liberally without a clear indication backs up scarce resources and slows the overall time required for safe efficient care. Responsible leadership balances such initiatives with what provides advantage for all stakeholders, rather than thoughtlessly push indiscriminate testing of all patients. Middle managers incentivized to follow protocols, unquestioningly focused on meeting bonus metrics, rather motivated by protecting all stakeholders, threaten to destroy the industry if not the profession. No priority should pre-empt the patient’s best interests in a drive for remuneration for performance if for no other reason than it increases risk and adds, rather than removes, inefficiency and waste to the system.

Patient flow is often targeted for Lean method application without full consideration of the goal. Increased throughput efficiency brings patients to the point of requiring hospital admission, but where do patients go when inpatient beds are not available? This is a long recognized problem throughout U.S. hospitals, but is underappreciated cause of health inequity. Frequently, limited ability to hire staff takes precedence over actual hospital bed availability. In the case of safety net hospitals, economic constraints limit the ability to address bottlenecks, leading to increased patient hold times. Often reduction in wait times on the front end in the waiting room triage is all that is addressed in the ED, while the so called blocked back door is allowed to persist. Some hospitals attempt to create a work-around such as creating a holding area in an ED Annex, but run up against the same limitations in bed availability on the in-patient floors: nurse staffing. These constraints negatively impact safety net hospitals disproportionately as they have tighter budgetary constraints. Beyond that, often the same hospitals are overburdened by hospitals closings,

Continued on next page

as will be the case in the DC Metro area this year with the closing of Providence Hospital. A universal application of Lean concepts would consider the critical need to make patient admission to the hospital a pre-eminent concern rather than push the burden towards holding areas that would meet criteria for emergency services performance but not be the best interests of patients.

Next, Lean Six Sigma methodology is frequently applied by leadership to doing more with less. Management often makes the case that the quickest and best way to reduce cost is by requiring increased productivity while simultaneously decreasing salaries. As administrators are rewarded with bonuses for achieving these benchmarks, employees, in this case physicians and nurses, are essentially incentivized to price themselves out of a job, also increasing the stress burden referred to as burnout. In fact, when work force supply and demand equation is favorable to management, it does lead to lower cost. However, less experienced, less qualified clinicians deteriorate the quality of the product. This is, of course, not in the best interest of patients as consumers. Moreover, inexperienced clinicians would be less likely to challenge leadership, reducing internal oversight. An extension of this case might be made for increasing non-physician and non-nurse clinicians penetration and entice them to practice beyond their scope or experience. While these providers can expedite routine care of low level complexity, it would be inconsistent with reaching for ideal Lean Six Sigma performance levels to introduce more potential error into the system. Insisting lower-salaried caretakers evaluate increasingly medically complex cases is counter to the ultimate goal when Lean Six is applied wisely and should at minimum require transparency regarding level of quality.

Lean Six Sigma applied to health care in an informed manner requires practically experienced clinicians with undivided attention to the goal of achieving health in the best interest of patients. If a trained medical professional sees no indication for testing or consultation, using an untoward outcome to justify the increased utilization of those services, will bankrupt the system and still not help patients. A similar case can be made for any intervention with no proof to support their efficacy over time. The oversimplified objective to increase revenue by defaulting to defensive practice adds cost without benefit and will eventually deteriorate the value of service. We can easily imagine the conflict of interest caused by creating fear of reprisals to require clinicians to use needless services as a condition for continued employment. Physicians and nurses know that one incomplete chart in a patient with a poor outcome can be used against them, particularly if that professional tends to advocate for patients and invest time in unrecognized added value activities. Who better to recognize value than experience clinicians working in the trenches?

Health care corporations that continue not to adequately value patient contact time are missing an important opportunity. At one time the physician-patient and nurse-patient relationship was an unquestioned value, and the engendered trust generated satisfied patient customers more often. Prudent health care leaders should require that clinicians be valued for the quality of contact with patients. As noted above, that quality of care should be based on more than patient satisfaction. The Lean Six Sigma Tool known as DMAIC (Define, Measure, Analyze, Improve and Control) is commonly used for data-driven improvement and could be applied to value the quality of patient contact time and outcomes, over reproducibility

and revenue cycles. This certainly merits discussion if only to highlight the competing interests of various stakeholders in the equation and what should be the ultimate objective of a health care system: improving health.

Limitation of physician or nurse activities for health care delivery may reduce variance, but it may simultaneously reduce autonomy and incentive to advocate for what is in the best interest of patients. We may fail to identify new causes of poor outcomes and accurate root causes of poor health states. Such steps would not be expected to have an immediate impact on improving the bottom line, but as actual health states improve, patient consumers can be expected to correlate the result of care with a higher value provider. Protocols used to enhance reproducibility may be out-competed by an allowance for professional judgment to protect the best interests of the individual. They may well begin to appreciate an organization that is willing to deviate from protocol and offer patients a higher value at a lower cost. As physicians have less flexibility to advocate on behalf of their patients, there is less attention given to the efficacy of expensive procedures or alternative interventions. The needs of economically disadvantaged patients, especially those struggling with mental disease or drug addiction, are often not factored into the equation, under the assumption that “no margin, no mission.” There is no excuse for taking a more considered approach to tailoring care to needs of the entire spectrum of the population.

A final consideration to broadly applying Lean Six Sigma across the health care industry without a global considered approach: negative impact on health inequities. There is an ever-increasing chasm growing between billing and collections limited by payer mix of a particular catchment area for a hospital largely determines ability to drive revenue as the system is conceived now. As technology, services, interventions, usage and billing increase along with revenues for private services, the ability of underinsured populations and public insurers to cover costs is increasingly impossible. The economic competitive advantage the methodology offers to large, affluent for-profit hospitals and health care systems, deteriorates competition as fewer hospitals whose mission it is to serve the underinsured can stay afloat. Prudent application of these methodologies would allow all the entire health care system to remain competitive, as quality would be based on outcomes and value lower cost care.

All of these considerations are why it is a much more complex proposition to apply Six Sigma principles when the “product” is the health state of a human being. An unbending, formulaic approach to becoming Lean and unconsidered implementation of Six Sigma method is not in the best interest of patients. We must recognize the universe of difference between manufacture of even the most complicated of machines versus the delivery of health care. A great deal can be remedied by valuing the resource that are trained medical professionals that have direct contact with patients and reward their ability to connect what should be the goal of the operation: patients’ best interests. If the trend towards rigid oversimplification of the methods is not modified, we can expect to continue to reap short term financial reward along with professional burnout and poorer health outcomes until the system ultimately fails. We will see quarterly earnings rise only until then, while in the long term goal, human health and the beauty of what was once a noble enterprise will continue to deteriorate. ●

Continued on next page

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# It's Election Time: Cast Your Votes or Run for a Position!



## AAEM Elections

Voting is now open. Voting will close March 11, 2019.

- Open positions: At-Large Board Member (five positions) and Young Physicians Section Director

[www.aaem.org/elections](http://www.aaem.org/elections)



## Florida Chapter Division

Nominations will open March 2, 2019 and close March 25, 2019.

- Open positions: President, Vice President, Secretary-Treasurer, Resident Representative, and Student Representative

[www.aaem.org/FLAAEM](http://www.aaem.org/FLAAEM)



## AAEM/RSA Elections

Voting will open January 15, 2019 and close February 15, 2019.

- Resident elections open positions: President, Vice President, Secretary-Treasurer, and At-Large Board Member (six positions)
- Student election open positions: President, Vice President, Regional Representatives (West, Midwest, South, Northeast), and International Member

[www.aaemrsa.org/about/leadership/elections](http://www.aaemrsa.org/about/leadership/elections)



## Great Lakes Chapter Division

Nominations are now open and will close February 7, 2019.

- Open positions: President, Vice President, Secretary-Treasurer, State Representative – Michigan, Resident Representative (two positions)

[www.aaem.org/GLAAEM](http://www.aaem.org/GLAAEM)



## Critical Care Medicine Section

Voting will open February 4, 2019 and close February 18, 2019.

- Open positions: President, Vice President, Secretary-Treasurer, At-Large Directors (four positions)

[www.aaem.org/CCMS](http://www.aaem.org/CCMS)



## New York Chapter Division

Voting will open January 30, 2019 and close February 14, 2019.

- Open positions: President, Vice President, Secretary-Treasurer, At-Large Members (five positions), Resident Representative, and Student Representative

[www.aaem.org/NYAAEM](http://www.aaem.org/NYAAEM)



## Emergency Ultrasound Section

Voting will open February 1, 2019 and close February 2, 2019.

- Open Positions: President-Elect, Secretary-Treasurer, At-Large Board Members (four positions), and Resident Representative

[www.aaem.org/EUS](http://www.aaem.org/EUS)



## Young Physicians Section

Voting will open January 21, 2019 and close February 11, 2019.

- **Open positions:** President, Vice President, Secretary-Treasurer, At-Large Board Member (four positions)

[www.aaem.org/YPS](http://www.aaem.org/YPS)



Critical Care Medicine Section

# Deep Dish is the BEST Pizza — Most of the Time

Andrew W Phillips, MD MEd FAAEM



We all have preferences and tendencies in various aspects of our lives and work. After living (and eating) in Chicago for five years, I can attest that it is a fact that Chicago deep dish pizza is the best kind of pizza. New York style is unfilling, unsatisfying, and always an unnecessary menu item. Or is it? If I'm in New York, I don't order deep dish because the deep dish is not as good there as in Chicago: not enough

cheese, soggy crust — you get the idea. My preference is deep dish, but that doesn't mean it's the best choice in every setting. Sometimes the geography dictates the best choice despite your typical preference.

So, too, ventilator management in the ED, I will argue, demands AC/VC, not AC/PC, or PS or a host of other settings (See Box 1 to buy a vowel for those letters). Not that I don't use the others in my ICU practice — and have a great personal preference generally for PRVC — but when I'm in New York, I eat New York style pizza...

## Box 1. Common Ventilator Abbreviations

AC	Assist Control
VC	Volume Control
PC	Pressure Control
SIMV	Synchronized Intermittent Mechanical Ventilation
PS	Pressure Support
PRVC	Pressure Regulated Volume Control (same as "autoflow")

### 1. Rate: Initial vent settings in the ED must include a set minimum rate. Recommendation: Assist Control. Avoid: SIMV and PS

The patient was just intubated and was paralyzed. Depending on emergency backup rates programmed into pressure support is a dangerous practice. Do not depend on fancy ventilator computers.

Some places use SIMV, which has a rate but then supports breaths above the set minimum rate, and I would argue that it is superfluous settings that muddy the interpretation of how the patient is handling the vent. The supported breaths above the minimum set rate (when the patient is no longer paralyzed) do not constrain tidal volumes or pressures. If you recently intubated a patient in the ED, by definition he or she is ill, and if it is a primary cardiopulmonary illness, he or she is going to get worse, not better. SIMV was initially conceived as a weaning setting, not a resuscitation setting.

### 2. Delivery: Controlling tidal volume is more important than controlling pressure. Recommendation: Volume Control. Avoid: Pressure Control

Trials have repeatedly shown lung protective ventilation to be just that: lung protective. There is also some evidence to suggest that all medically ill patients, even if they do not have ARDS, should be on lung protective ventilation starting in the ED.<sup>{Fan:2017ca, Fuller:2017jd, Fuller:2013ic}</sup>

Although pressure control does indeed solve the pressure problem (trying to prevent barotrauma), pressure control also prevents you from regulating ventilation. First, extraordinarily hypoxemic or hypoxic patients will require a certain tidal volume to receive sufficient oxygen. Although tidal volume is part of ventilation, patients can be so sick that the volume impacts them. Second, the inability to control ventilation can lead to increased CO<sub>2</sub>. Permissive hypercapnia is encouraged for ARDS unless there are extenuating circumstances such as intracranial hemorrhage, pressure control does not allow a reliably measurable way of resolving a pH that is too low (usually 7.2).<sup>{Laffey:2004jb}</sup>

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Some advanced vent aficionados are likely to counter that tidal volume is less important than driving pressure, a stance for which there is growing evidence. Even if that is true, pressure control prevents physicians from knowing the plateau pressure so they cannot even calculate a driving pressure, much less aim for a particular target. Once again, volume control affords more controlled ventilation and protection.

### 3. Diagnostics: Fancy algorithms interfere with the emergency physician's ability to use the ventilator settings and alarms to diagnose problems. Recommendation: old fashioned Volume Control. Avoid: PRVC, autoflow, any fancy manufacturer additions

A big part of the ventilator market is proprietary algorithms that make ventilation more comfortable for patients so they require less sedation and can be weaned faster. But this is completely irrelevant in the ED. The

Continued on next page

negative to settings like PRVC (pressure regulated volume control) and autoflow is that they change the pressure and flow, which prevents a real volume guarantee and hides the patient's changing physiology.

For example, if a patient has a developing pneumothorax, you would expect the peak (and plateau) pressure to rise. But if the patient is on PRVC, the ventilator takes steps to minimize the pressure by changing flow, among other things. Thus, rather than see an increase in pressure leading to alarms and early warnings for the physician, there are only silent adjustments under the hood. The pneumothorax won't be diagnosed until clinically visible changes occur.

The ability to constantly measure true airway pressures in AC/VC mode can be live saving since trends can be seen and problems can be noted before they become clinically significant.

Use peak pressure alarms to prompt you to check the plateau pressure (Pplat) and intrinsic PEEP (PEEPi or auto-PEEP) if your vent has the capability. Even if you cannot check Pplat and PEEPi, peak pressure alarms should prompt circuit evaluation and use alternative methods to evaluate the differential for high peak pressures. Important diagnoses to

consider with this early warning are pneumothorax, severe alveolar disease such as ARDS, and the patient biting the endotracheal tube, among many others listed in Box 2.

**Box 2. High Yield Differential Diagnosis for High Peak Pressure Alarms on Ventilator. Upper limit of peak pressure is 35 mmH2O. Upper limit of plateau pressure is 30 mmH2O.**

High Peak Pressure, Normal Plateau Pressure	High Peak Pressure, High Plateau Pressure
Circuit blockage	Mainstem intubation
ETT kink	Tension pneumothorax
Mucus plug	Breath stacking
Bronchospasm	Abdominal compartment syndrome

*Dr. Phillips is an emergency physician and intensivist at the University of North Carolina at Chapel Hill. ●*

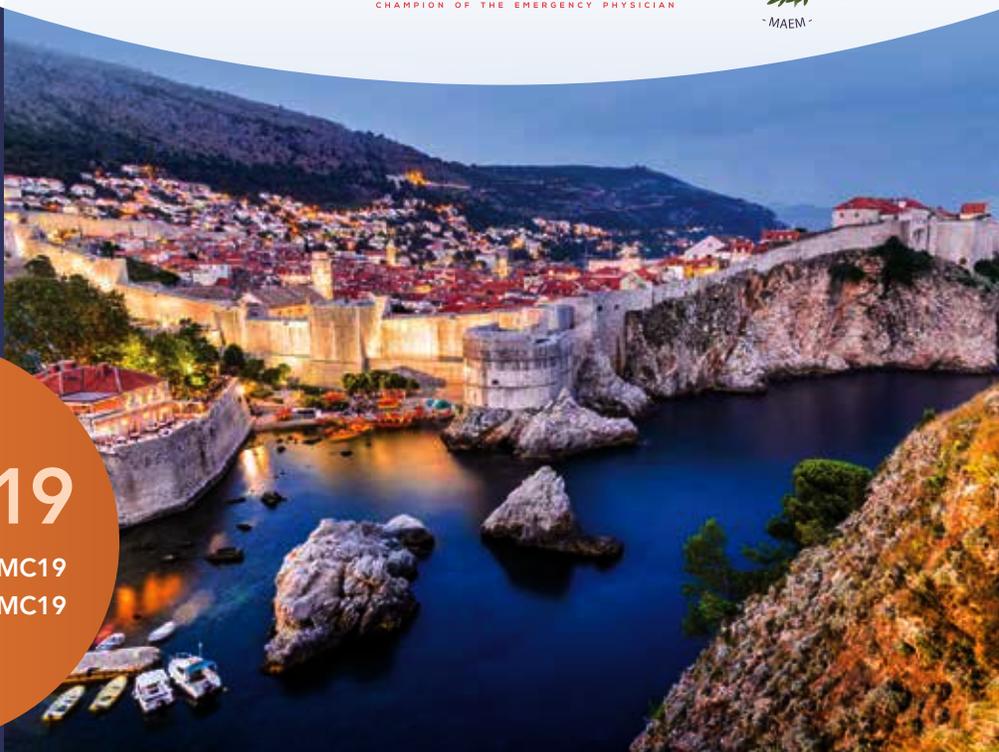
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# What is ABEM and What Do They Do for Me?

*Note: This is the first in a series of articles about ABEM and board certification. Next: The Steps to Certification.*

## What is ABEM?

The American Board of Emergency Medicine (ABEM) was approved by the American Board of Medical Specialties (ABMS) in 1979 as the 23rd recognized medical specialty (there currently are 24 recognized Boards). ABEM's mission is to ensure the highest standards in the specialty of emergency medicine (EM). It certifies emergency physicians who meet its educational, professional standing, and examination standards; that is, have graduated from an ACGME-accredited, EM residency program; have all medical licenses in good standing; and successfully completed an evaluation process that assesses the knowledge and skills required to provide quality patient care.

To date, there are 36,166 ABEM-certified physicians, 91 percent of whom are residency trained. Approximately six percent are ABEM-subspecialty certified in fields such as EMS or Medical Toxicology. At 76 percent of the total, community practice physicians represent the largest cohort of ABEM-certified physicians; 57 percent of all ABEM physicians participate in some form of teaching (i.e., residents, medical students). ABEM's board of directors is comprised of 19 clinically active emergency physicians, both academic and community-based.

## Value of Certification

ABEM certification is voluntary and unlike organizations such as AAEM, ABEM is not a membership association. While ABEM works to support physicians, its focus is the public as well as the physician. The intent of ABEM certification is to help provide assurance to the public that a

physician specialist will provide the safest and highest-quality emergency care. Certification is a concrete way to demonstrate to patients, hospital administrators, peers, and the public that physicians have a strong knowledge base and have achieved a high level of skill in clinical practice. In this way, certification provides recognition as a specialist and can be a source of professional pride.

The value of certification is reflected in the higher compensation of ABEM-certified physicians. The 2015 Stern-ACEP survey shows that the total average compensation for an ABEM-certified emergency physician is nearly \$7,000 more than that of a non-certified emergency physician.

ABEM-certified physicians have the opportunity to choose from 14 subspecialties in which to specialize. The most recently approved is Neurocritical Care, which is the fourth critical care subspecialty in which ABEM-certified physicians can become subspecialty certified. The option of subspecialty certification expands practice opportunities for emergency physicians. Also recently approved is a focused practice designation in Advanced EM Ultrasonography.

ABEM also works on behalf of certified physicians to tell stakeholders about the value of being ABEM certified and what certification means for hospitals and their patients. ABEM is collaborating with AAEM, AAEM's Resident AND Student Association, and each of the national Emergency Medicine organizations to oppose unnecessary merit badges (e.g., ACLS, procedural sedation) that is superseded by your residency training and board certification. ●



## ABEM-Certified Physicians

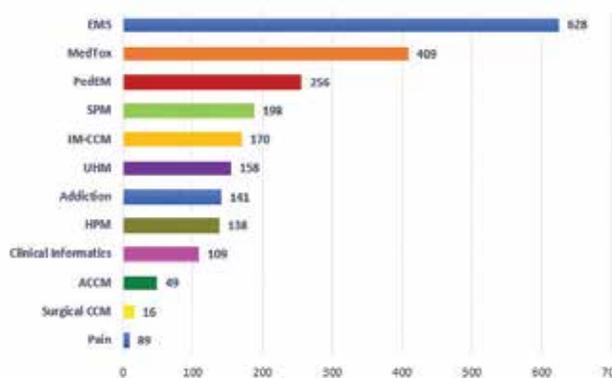
**36,116 Diplomates**

91% Residency Trained



9% Practice Pathway

**ABEM Subspecialists\***



\* Includes ABEM physicians certified by other ABMS Member Boards. Data as of September 2018.

# How to Teach in the Midst of the Crazy

Molly Estes, MD FAAEM  
YPS Board of Directors



We've all seen our waiting rooms on an "average day." And we've all read the studies about annual census numbers. And we all dread every approaching flu season with increasing levels of anxiety as we try to imagine seeing even more patients with no beds or room to speak of. And in the middle of the administration meetings about flow, setting up tents and triage units in parking lots and hallways,

and trying to prevent patients from dying in the waiting room, those of us who work at academic institutions are also expected to impart our hard-fought knowledge onto the next generation. Now how in the world is that possible?

For those who work in academics, we tend to have some kind of special soft spot for the learner, whether that be a medical student, PA or nursing student, EM or off-service resident. Part of us likes the challenge of trying to get our learner to understand a concept and takes joy when the lightbulb moment of realization occurs. And yet, we are under ever-increasing pressure to move our departments, to see higher and higher patient volumes and meet door-to-disposition times. One would think that these two desires, to do well at our jobs and to fill the role of teacher, to be in opposition to each other. After all, explaining something to another person takes longer than just doing it yourself. There is some truth to this, it does take extra time to engage in the teaching process. But I would like to make the argument that it doesn't have to completely disrupt your day. Here are some tips and tricks to continue your instructor legacy while making hospital admins happy.

## Think bigger, teach smaller.

When presented with a broad topic, most of our inclinations is to settle in to a thorough explanation. "What is on your differential for chest pain? Well, let me tell you about the six can't-miss differential diagnoses for chest pain, compare and contrast PERC and Wells, explain how the HEART score relates to cardiac events, and discuss patient disposition depending on access to stress testing." In the busy department, this is waaayyy too much information and takes too much time. Instead, try breaking your go-to lectures into mini, bite-sized pieces. Piece #1: what are the absolutely top, 100% can't miss diagnoses for chest pain? Piece #2: what is the HEART score? Piece #3: how is the HEART score calculated? By doing this, you can stretch one single massive discussion into tiny pieces that take no longer than 60 seconds each to discuss.

## Teach one person and then have them teach the next.

See one, do one, teach one, is still a mantra of emergency medicine. Why shouldn't we also apply it to teaching? Especially in a department with a mix of residents and students, this can be a valuable technique for getting more distance out of a single teaching moment. Take one to two minutes to explain to one learner your teaching point. Then, when

another learner needs the same information, call out your first learner to teach it to them. It will reinforce your teaching as well as save you a few minutes until you can cross-check their explanation.

## Rally the troops.

If a great case rolls through the door, capitalize on a few minutes to do a general teaching session. Quickly call for all your learners in the vicinity, spend two to three minutes talking about what makes this presentation, lab result, image, etc. so special, then send everyone on their way. You will save time in trying to share the awesomeness on an individual level.



## Have a handout or picture.

The saying, "a picture is worth a thousand words," absolutely applies to many standard teaching topics. Find a blog or podcast about one of your favorite teaching topics. For example, *Life In The Fast Lane's* blog post on how to read a chest X-ray. Then, when presented with the chance to discuss the topic, refer your learner to the post, handout, picture, etc. You can briefly discuss the topic afterwards, but it won't take as much time as teaching de novo.

## Have the learner look it up.

The tried and true method of high school teachers everywhere. There is nothing wrong with encouraging your learner to find the answer to their question themselves. Check their results but have them teach themselves.



Continued on next page

**Assign "homework."**

Inevitably one of your learners will find a broad topic or complex management question that is simply impossible to address in the middle of a busy shift. In that case, it is completely fine to admit you don't have time to discuss the answer. Give them the short pearl of knowledge, then ask them to look up or read more about it after the shift. You can even refer them to a journal article, blog post, or book chapter that you yourself have used to learn the topic. Then you can continue the

discussion either on your next shift, next conference day, or via email. This way you encourage their learning while giving the time needed for the complexity of the topic.

Hopefully these ideas will help you fulfill your teaching role at the same time as helping you keep your sanity in the midst of the ever-crazier months to come. ●

## Vote for the YPS Director on the AAEM Board

The YPS director represents the section on the national AAEM board of directors.

- YPS Full Voting Members: Vote for the AAEM board and the YPS Director, who represents YPS on the AAEM board.
- YPS Associate and Fellow-in-Training Members: Vote for the YPS Director, who represents YPS on the AAEM board.

**Voting closes: March 11, 2019 at 11:59pm PT**

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# CAST YOUR VOTE!



## Vote for the YPS Board of Directors

These individuals are directly involved with the leadership and development of YPS section in AAEM.

**Voting closes: February 11, 2019 at 11:59pm CT**

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FOR ADDITIONAL INFORMATION PLEASE CONTACT:



**PennState Health**

Susan B. Promes, Professor and Chair, Department of Emergency Medicine c/o Heather Peffley,  
Physician Recruiter, Penn State Health Milton S. Hershey Medical Center  
500 University Drive, MC A595, P O Box 855, Hershey PA 17033  
Email: [hpeffley@pennstatehealth.psu.edu](mailto:hpeffley@pennstatehealth.psu.edu)  
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## AAEM/RSA President's Message

# Three vs. Four and Everything in Between

Mohammed Moiz Qureshi, MD  
AAEM/RSA President



As interview and rank season comes to an end and the ever-anticipated Match is just a few short months away, I thought it would be a good time to reach out to our medical students who have questions and concerns regarding the variations in residency training programs. Emergency medicine programs are abundant nationwide and vary in length between three and four years. Students are often confused

whether the extra year makes a difference in overall training or ability to pass board certification and it remains one of the most commonly asked questions on the interview trail.

## “The 300K Dollar Mistake”

Emergency medicine physicians are not known for withholding their opinions and most are vocal for or against the four-year programs. Many have deemed it the “300 thousand dollar mistake,” implying that fourth year residents give up a year of attending salary for no tangible benefit. Others however are adamant that a career in academics is hindered without that fourth year. From a logistical perspective, generally the average medical student has had anywhere from 8-10 years of education and in the grand scheme, a single year of attending salary will not make or break retirement plans. So from a monetary perspective, if the program faculty, location and curriculum are appealing, the loss of income is marginal for four years of contentment.

## “More Conducive to Academics”

After anecdotal experience from working with and interacting with residents and attendings from both three and four year programs, the collective consensus remains that residents graduating from three year programs are just as capable as residents graduating from four year programs. In fact there has been no correlation of higher board passing rates between the two training lengths. Furthermore, most will agree that if three year graduates truly want a career in academics, pursuing a one year fellowship or accepting a junior faculty position at the desired institution for a year will suffice for a more senior/tenured position very shortly thereafter.

## “Variety/Career Building”

Most of us went into emergency medicine because we knew what we were getting into. We wanted sporadic rushes of adrenaline, variety in our clinical practice, and wanted definitive start and end times. Often, however, there are those of us that desire a more specific niche. Exposure to fellowship opportunities, different ward experiences, and international electives, these are all opportunities that are more afforded to residents in four year programs; simply because of the increased time available. This is not to say three year graduates don't get them, more so the frequency

is less. The argument also remains that if a resident in a three year program is truly invested in these same opportunities, then building a custom fellowship after graduation will allow similar experiences.



In the end most people agree given all this variety that the ideal EM training program would be three and a half years. And while this is obviously not possible, deciding ranking/applying between the two should not be the end all be all for students. The end of fourth year is a celebration of the culmination of four years of intense hard work and is an important transition for an even harder few years to come, so look to celebrate, plan an exciting trip if possible, and reflect on your remarkable journey.

## “Words of Caution”

As some parting advice, while completing a three vs. four year residency program will only marginally alter your career path, considering lay entity run residencies is much more concerning. A lay entity means that a non-physician owns and operates the emergency department and the subsequent emergency medicine residency. No one wants to go unmatched, and I would be remiss to advise not ranking all programs, but for the more competitive applicants it is imperative to ensure the programs you rank support the mission of the specialty. For an excellent history lesson I encourage every medical student and resident to read *The Rape of Emergency Medicine*: [www.aaemrsa.org/get-involved/the-rape-of-em](http://www.aaemrsa.org/get-involved/the-rape-of-em).

In it readers are exposed to the ongoing threat of lay corporations fighting to take control of emergency departments nationwide. A growing number of emergency medicine residency programs and fellowships are operated by said incorporated lay entities. Some of these lay corporations have been found to encourage family medicine practitioners to complete one-year EM fellowships. This continues to prove to be dangerous, as research has shown that patient outcomes in the ED are optimal when there is a board certified emergency physician managing their care. Applicants and residents should be well aware of their future and current employers and the motives that drive the program.

Lay entities that manage emergency departments and residency programs can be found nationwide with at least 14 residency programs and significantly more projected to come.

Corporate-owned programs exist in Florida, Georgia, Pennsylvania, Ohio, Michigan, West Virginia, Illinois, Nevada, Texas, and Oklahoma.

For a list of questions to ask on the interview trail or follow up email communication to ensure please visit:

[www.aaemrsa.org/get-involved/committees/advocacy#lay-corporations](http://www.aaemrsa.org/get-involved/committees/advocacy#lay-corporations) ●

AAEM/RSA Editor's Message

# A Life Almost Saved

Nick Pettit, DO PhD  
AAEM/RSA Board Member



Very few jobs, let alone, medical specialties have the potential to encounter death on a daily basis. With this comes responsibility, honor, reward, pride, but also despair, death, and failure. Politics and biases aside, as clinicians, it is engrained early in our training that we are present to aid, cure, educate, and comfort the patient. The patient is the focus of everything, patient satisfaction, outcomes, money, litigation, politics, and

this is so true when we as a health care team almost save a life.

Imagine Billy, a 12 year old boy riding his bicycle on a sidewalk and is struck by a drunk driver. EMS arrives and finds a child as a GCS 3. Intubated and sent to local ED, where thorough radiographic imaging demonstrates diffuse axonal injury, possible cervical spine injury, bilateral hemopneumothoraces, etc., and clinically has experienced a nonsurvivable event. After being admitted to the pediatric intensive care unit, and after numerous consultations with subspecialists, the parents do the most heroic thing of all and consent to organ donation.

## A life almost saved.

In this process of trying to save a life, the family's life is devastated. As part of the health care team, we need to appreciate that the family are not the only ones impacted by this tragic event. There are:

- Witnesses to the event
- EMT personnel
- All the nursing staff
- The residents and medical students involved in the care
- The recipients of the donated organs
- And most relevant for this article, the doctors taking care of the patient

Burnout and resilience are heavily discussed in residency training and like the prototypical emergency medicine physician we all try to do it all. We cover the extra shifts, we pick up the new patient in bed 10 near the end of our shift, we say yes to that extra endeavor that may be a great boost to the CV, and most importantly we do it with pride. But what happens when we fail? What happens when we almost save a life? Failing and experiencing loss and devastation is something that will occur during our practice and it hurts. No curriculum teaches us how to fail.

## How silly would it be to have a lecture named "how to fail."

As a soon to be graduating resident, I would love that lecture. I have had lectures in every other critical topic in emergency medicine, but nothing has prepared me how to handle an almost saved life, a "honey your

schedule is too busy," or "can you take on this new academic role." In a little more than two years of training I have experienced the gamut of human experience from best to worst, and like everyone else we move on and see the new patient in bed 10, or push ourselves to pick up that extra shift. For the sake of all physicians, we need to readjust our lens of focus to the patient, to now encompass the patient and the physician. Where does this start? No one knows, but I would advocate for refocusing the lens early in medical training as to make it a priority as we advance the academic totem pole.

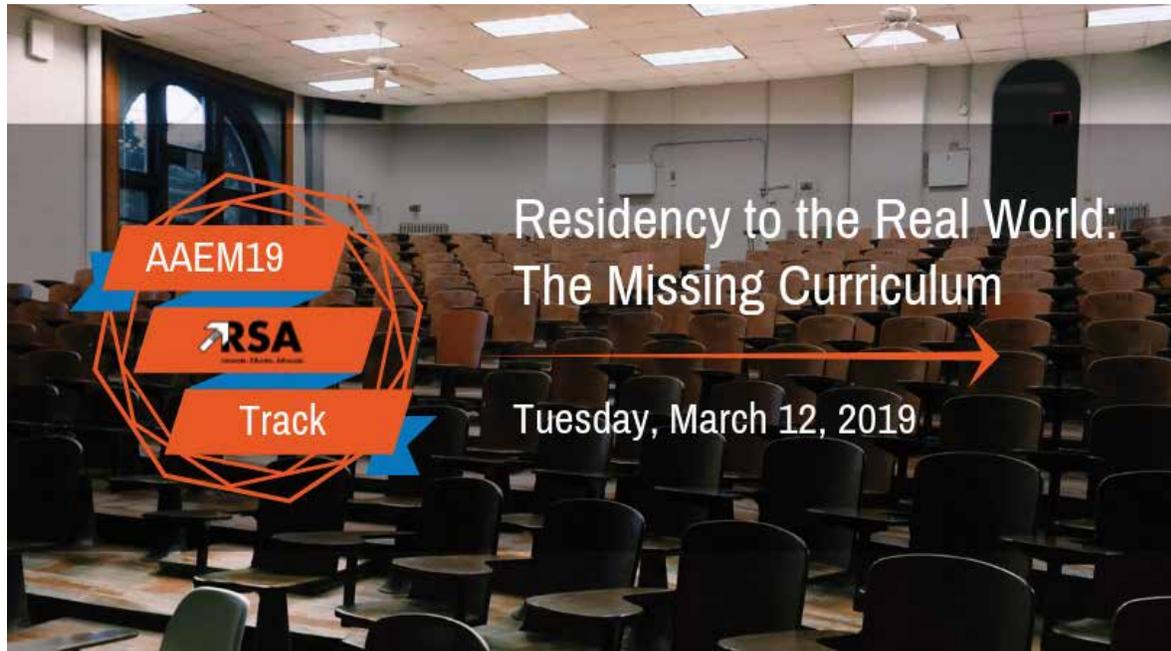


In a medicolegal climate where we are as interested in taking care of patients as we are practicing to avoid lawsuits, in an era where corporations and governmental agencies are imposing reimbursements based on satisfaction score, emergency medicine can become the life almost saved. With major corporations running residency programs and being our major employers we need to make sure that we ensure our livelihood and careers are protected. How do we do this? We recognize the need to take care of each other and our specialty. We need mentors to lead the future generation emergency physicians. We need advocacy to continue to pursue legislation that helps protect us as physicians. We need continued wellness initiatives that promote student, resident, and physician self-improvement.

This is asking to create a wave in a well-established paradigm of medical training. Physicians need to be given permission to fail and say no. We are asking to put the physician and the physician's interest and experiences at the level of the patients'.

Emergency medicine is hard, and is a life we can save with collaboration, teamwork, and communication. Take care of thyself and don't be afraid to fail. Say no. Debrief with team members and watch out for your peers. Most importantly get help if you need it and recognize we all fail, we just don't talk about it. ●

# AAEM19 RSA Track: Residency to the Real World: The Missing Curriculum



RSA would like to thank Carey D. Chisholm, MD FAAEM and the late Kevin Rodgers, MD MAAEM FAAEM, for creating the concept of the track. Dr. Rodgers' support and collaboration in the development of the track with RSA leadership was invaluable. The goal of the track is to prepare residents for their careers in emergency medicine by concentrating on topics such as interviewing, contract negotiation, health policy, ways to prevent burnout, and more.

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RSA has partnered with the AAEM Emergency Ultrasound Section (EUS-AAEM) to bring you a hands-on component to this exciting track. Join us for an afternoon of ultrasound simulation and didactics by some of the best ultrasound educators in EM. \*Pre-registration required – limited spots available.

## **Tentative Schedule**

10:15am-10:45am	Nuts and Bolts: Formulating your Resume, CV & Promotion Portfolio
10:55am-11:25am	Job Interviewing Like a Pro
11:35am-12:05pm	Evaluating Job Opportunities
12:05pm-1:30pm	Lunch - on your own
1:30pm-2:00pm	Easing the Transition to Attending
2:10pm-2:40pm	Arriving At Your New Job
2:50pm-3:20pm	Understanding Your Compensation: Metrics, RVUs, and the Evolving Economics of EM
3:20pm-3:50pm	Networking Break
3:50pm-5:40pm	Ultrasound Session* – Jointly provided by EUS-AAEM

\*Pre-registration required – limited spots available. Sign-up when you register for AAEM19.

Focus on topics not typically  
covered in residency

[www.aem.org/aaem19/attendees/residents](http://www.aem.org/aaem19/attendees/residents)

# Update on Attitudes Towards Patients with Sickle Cell Disease and Effects on the Provision of High-Quality Care in the Emergency Department

Authors: Hannah Goldberg, MD; Sharleen Yuan, MD PhD; Samantha Yarmis, MD  
 Editors: Kami M. Hu, MD FAAEM and Kelly Maurelus, MD FAAEM

## Question

Do emergency physicians have biases towards patients with sickle cell disease and do biases affect the delivery of appropriate care?

## Introduction

Many patients with sickle cell disease (SCD) have disease that is well managed in the outpatient setting. However, among patients with severe symptoms of SCD, there is a high recidivism rate in the emergency department (ED).<sup>1</sup> Care of patients with sickle cell disease with vasoocclusive crises (VOC) can often elicit frustration on the part of both the patient and the emergency physician due to many factors. These patients tend to have pain that is difficult to assess, as well as a high opiate tolerance requiring large doses to control pain. Additionally, physicians can have negative feelings about patients with sickle cell disease, with hesitancy regarding redosing of parental opioids due to concerns about opiate addiction and drug-seeking behavior.<sup>2</sup> These exist despite evidence that patients with sickle cell generally present with less outward distress or vital sign abnormality despite sincere pain and that lab-work does not correlate to presence of VOC or severity of associated discomfort.<sup>3</sup> We attempt to discern how pervasive these negative biases may be and whether or not they affect patient care.

**Glassberg J, Tanabe P, Chow A et al. Emergency provider analgesic practices and attitudes toward patients with sickle cell disease. *Ann Emerg Med.* 2013;62(4):293-302.**

The American Pain Society and National Heart, Lung, and Blood Institute (NHLBI) have issued national guidelines making recommendations for emergency department management of acute pain crises.<sup>4</sup> There is, however, a perception among patients and specialists that emergency physicians often deviate from these guidelines while treating patients with SCD in the emergency department. It had been unclear whether this nonadherence was due to emergency providers being unaware of the existence of these guidelines, or whether providers were aware but their compliance was hindered by conscious or subconscious negative feelings towards patients with SCD.

In this 2013 cross-sectional convenience sample survey study, Glassberg, et al., surveyed 795 emergency medicine providers and examined the association of negative attitudes toward patients with sickle cell disease and adherence to the NHLBI guidelines. Surveys were made available to attendees of the 2011 American College of Emergency Physicians (ACEP) Scientific Assembly in San Francisco, California. A 33-question survey assessed physicians' demographics, provider practice patterns, and provider attitudes towards patients with SCD. Specifically, practice patterns assessed included pharmacologic approach including choice of agent, route, dose, and frequency of selection. Of the 795 surveyed,

671 answered completely and were included in analysis. In analysis of provider attitudes, six survey items were grouped together to form a "negative attitudes scale" (mean score 39.5±21.9; potential range 0-100). Higher scores indicated more negative feelings about sickle cell disease patients. Four items grouped together to form a "positive attitudes scale" (mean score 37.1±23.1; potential range 0-100), where higher scores indicated more positive views about patients with SCD. Five items grouped



together to form a "red-flag behavior scale" (mean score 58.7±22.4; potential range 0-100), where higher scores indicated a greater belief that certain sickle cell disease patient behaviors indicate that the patient is inappropriately drug-seeking.

Glassberg, et al., found that negative views of patients with SCD were associated with lower guideline adherence. Of survey responders, pediatric providers had more positive attitudes, and physicians working in environments that see a higher frequency of patients with SCD had worse attitudes. Providers who identified themselves as black had more positive attitudes and lower scores on the red-flag behavior scale. Interestingly, when controlled for outside factors, working at institutions that had comprehensive sickle cell disease clinics did not significantly influence provider attitudes towards patients with SCD.

The most common medications prescribed to treat pain were morphine (95% of physicians) and hydromorphone (91% of physicians). Eighty-five percent of those surveyed indicated they were comfortable reassessing and redosing opioids if the patient's analgesia was inadequate. Pediatric emergency providers were six times more likely than adult providers to

Continued on next page

use patient-controlled analgesic devices for pain management. High-volume ED providers were less likely to reassess and redose pain medication after 30 minutes.

Results of the survey administered in this study indicate that emergency department treatment (and particularly administration of opioid pain medication) of SCD patients with VOC is significantly affected by provider attitudes towards this patient population. Of the eight recommendations made by NHLBI, those less accepted by emergency physicians included use of subcutaneous over intramuscular opioids, hypotonic fluid administration, frequent acetaminophen use, and sparing use of non-steroidal anti-inflammatory drugs. Of particular importance in our patient population, the study found that providers who frequently treat patients with SCD were more likely to have negative attitudes and were also less likely to adhere to the main recommendation from the NHLBI: to reassess pain every 30 minutes and redose opioid medications as needed.

Limitations in this study are mostly related to sample population. As this study was given at a large academic assembly, a disproportionate number of those surveyed (67.9%) were affiliated with academic medical centers and were more likely to be aware of national guidelines than emergency providers in the community. Additionally, a frequent limitation to surveys is a bias towards selecting the “correct” response when presented with a number of options where one option is obviously accepted as the correct action, even if this is not representative of the provider’s actual practice. A major criticism of ED providers is non-compliance in reassessing and redosing pain medication every thirty minutes. It is important to consider potential confounding variables; emergency physicians may be tending to multiple or critically-ill patients and simply do not have the time available to reassess stable patients every thirty minutes. Given this limitation, it is more difficult to arrive at the conclusion that ED physicians are unwilling to reassess SCD patients frequently as recommended by the guidelines.

Overall, this study suggests that emergency physicians are well-trained in selecting the appropriate pain medication but are not generally in compliance with the NHLBI guidelines, and often do not reassess pain or re-administer pain medication frequently enough in patients with SCD. Data from this study further suggests that adequate pain management is likely hindered by physician negative attitudes towards patients with SCD and that physicians may benefit from self-awareness of their own potential biases, education regarding the presentation of pain in patients with SCD, and greater empathy in the treatment of their patients.

**Glassberg J, Tanabe P, Richardson L, & DeBaun M. Among emergency physicians, use of the term “sickler” is associated with negative attitudes toward people with sickle cell disease. *Am J Hematol.* 2013;88(6):532-533.**

The use of labels to describe patients with chronic diseases is not uncommon, but in SCD the label of “sickler” correlates with negative attitudes in emergency medicine. Another survey conducted by Glassberg and colleagues at the 2011 ACEP annual meeting hypothesized that physicians utilizing the “sickler” nomenclature both entertained negative attitudes and were less likely to follow practice guidelines/protocols regarding SCD management.

A total of 655 emergency physicians from 49 states (2% of the 32,000 ACEP members) were surveyed. Individual physicians were approached

at ACEP 2011 to provide information regarding demographics, provider practice patterns, and provider attitudes. The question “How often do you refer to a patient with SCD as a ‘sickler?’” was the primary predictor variable using the 4-point Likert scale. Survey data indicated that the term “sickler” was commonly used, with 8.7% of responders answering “always,” 43.3% “frequently,” 34.7% “rarely,” and 13.1% “never”. Using the “rarely” reference group as the control group, negative attitudes were 17.1 points higher on the negative attitudes scale in the “always” reference group and 7.8 points lower on the negative attitudes scale in the “never” group. While there was a significant difference of attitudes regarding SCD and the “sickler” terminology, there was no significant correlation to lower adherence to existing NHLBI guidelines. There was, however, a difference in the redosing of opioids within 30 minutes: over 70% of physicians that use the term “sickler” would redose, but those who used the term “frequently” were 12% less likely to do so.

There are limitations of this survey, including a small percentage (2%) of ACEP members, who may not be representative of general practice. A majority of respondents were also from academic emergency departments. Additionally, self-reporting may not accurately describe adherence to guidelines or practice.

**Singh A, Haywood Jr C, Beach MC, et al. Improving emergency providers’ attitudes toward sickle cell patients in pain. *J Pain Symptom Manag.* 2016;51(3):628-632.**

The surveys above indicate that some emergency medicine providers have negative attitudes regarding patients with SCD. Previous research has shown that attitudes improved in internists and nurses regarding SCD patients after viewing a short video about interventions.<sup>5</sup> This study focuses on emergency physicians and their attitudes after viewing a video about SCD and commonly used interventions.

The study used a single group pretest/multiple posttest design, surveying a total of 96 participants including attendings, residents, nurse practitioners (NPs), physician assistants (PAs), and nurses in a large, urban, academic emergency department. The primary outcome was an assessment of the attitudes of providers using the Sickle Cell Patients Scale (which examines positive and negative attitudes, red flag behaviors). Participants completed a baseline survey on SCD attitudes prior to watching an 8-minute video featuring SCD patients and ED providers discussing challenges, misinformation, stereotypes, biases, and perspectives of sickle cell disease. A posttest survey was given at one week and then again at three months after the video viewing.

The authors discovered that after watching the video, there was a statistically significant decrease in negative attitude scores (-11.5 difference, 95% CI -14.3 to -8.7) and in red flag behavior scores (-12.8 difference, 95% CI -16.3 to -9.3), with a significant increase in positive attitude scores (+10 difference, 95% CI 6.6 to 13.45). The scores at three months displayed a small amount of attenuation from the initial intervention effect (4.5 difference, 95% CI -7.9 to -1.0).

Limitations of this study include the urban environment, which may limit generalizability. There is also potential selection bias in that academic providers knowledge and behaviors might be different from the general

Continued on next page

healthcare provider population, and surveys are always subject to possible social desirability bias – bias introduced when respondents answer questions in a manner that would be most accepted to others though they may not be consistent with their actual views or practices. Additionally, the control group design was within groups as a before-and-after study, as opposed to between groups.

Overall, this study demonstrated that brief video-based interventions can improve providers' attitudes regarding patients with SCD in the emergency department. Perception and attitude adjustments can change barriers to management and treatment, which could improve patients' quality of care and experience.

**Binding A, Ward R, Phua C, et al. An innovative short-stay health care model for treatment of uncomplicated vaso-occlusive crisis in adult sickle cell disease patients in Canada to reduce emergency department utilization. *CJEM* 2017:1-8.**

Approximately 90% of acute health care visits for patients with SCD occur for vaso-occlusive crisis (VOC). Management of VOC involves early analgesia, preferably within 30 minutes, but this goal is frequently not met in the ED. Short-stay units have been developed in several countries specifically to treat VOC outside of the ED, with a goal of treating symptoms more promptly, reducing costs, and decreasing hospital admission rates. This study was the first evaluation of a short-stay unit in Canada and its effect on patient satisfaction and clinical outcomes.

The study included patients aged 18 or older with a known diagnosis of SCD who were followed at University Health Network in Toronto. The study was designed as a historical case-controlled study, with a comparison of patients during the existence of the short-stay unit (October 2014 – July 2016) to those at a prior time period (August 2009 – September 2012). Patients who were followed in the SCD clinic could call a clinic nurse who directed them either to the short-stay unit or to the ED. Patients were excluded if they had symptoms concerning for a “complicated VOC,” defined as pain with neurologic symptoms, chest pain, severe abdominal pain, shortness of breath, priapism, or fever  $>38.3^{\circ}\text{C}$ . Historical controls were excluded if they received a transfusion in the ED or did not have a diagnosis of SCD based on clinic notes. The short-stay unit was open 24 hours per day Monday to Friday, and consisted of an internist, nurses, and a pharmacist. Patients received a protocolized treatment with supplemental oxygen, intravenous (IV) fluids, and opioids. Patients were transferred to the ED if they developed signs or symptoms of complications, if their IV pain control requirement exceeded 72 hours, or if they continued to require care after the unit closed for the weekend. The primary outcome was time from patient arrival to receiving first dose of opioid pain medication. Secondary outcomes included the total opioid dose per hour, pain scores on arrival and at certain intervals, unit length of stay, and disposition.

During the study period, there were 21 visits to the short-stay unit by 12 patients. The mean age was 28.2 years old. The mean time from arrival to first opioid dose was 23.5 minutes and the average length of stay was 28.7 hours. Three patients (16%) were admitted, of which two had persistent pain and one had signs of acute chest syndrome. Overall patient satisfaction scores based on surveys administered prior to discharge were high ( $>4/5$  on a Likert scale), with the exception of satisfaction

with unit location. In comparison to 80 historical cases, the mean time to first opioid dose was significantly lower (23.5 vs 100.3 min,  $p<0.001$ ) and mean total opioid dose per hour was higher (46.7 vs. 11.9 morphine equivalent mg/hr,  $p<0.001$ ). Discharge rate was also higher from the short stay unit (84.2% vs. 69.7%, no p value provided).

This study demonstrated that a short-stay unit is a feasible model to decrease time to analgesia and decrease admission rates for patients with sickle cell disease presenting with uncomplicated VOC. Patient surveys revealed that major barriers to short-stay unit utilization were lack of information regarding its availability and travel distance to the unit. A major limitation of the study was low recruitment, with only 12 unique patients presenting to the unit during the nearly two-year study period. Patients were not sent directly from ED triage, but rather had to call a nurse coordinator from the clinic, which likely resulted in low utilization. In addition, the historical case-control design may contribute to confounding. The authors conclude that a short-stay unit with a protocolized approach is a feasible model for management of uncomplicated VOC. Other medical centers have also displayed promising outcomes utilizing the short stay model for care of SCD patients. Amdemariam, et al., found that after enacting a similar short stay algorithmic model in the ED, there was a significant decrease in admission rate with shorter hospital length of stays.<sup>6</sup>

## Conclusion

There remains a negative attitude towards patients with sickle cell disease amongst some emergency physicians. The recognition of these attitudes is important because studies suggest that physicians with more negative feelings towards patients with SCD provide less adequate care of patients, with the resultant effect of souring physician-patient relationships and further perpetuating negative attitudes. It is important to reassess and redose analgesic medication for VOC every 30 minutes to ensure adequate pain management. Many emergency physicians may not be aware of the NHLBI guidelines for treating patients with SCD. Both physicians and patients would benefit from utilization of these guidelines to help standardize care of patients with SCD and remove the factor of physician attitude and thus the influence that negative attitudes have on patient care. Additionally, at institutions with a high SCD population, it is worth further investigating the implementation of a short-stay model which could standardize care of SCD patients with VOC, thereby decreasing ED utilization and hopefully removing potential contributors to negative attitudes resulting in sub-standard care.

## Answer

Negative biases regarding patients with sickle cell disease persist amongst the emergency physician population, with evidence that providers with negative attitudes regarding this population provide suboptimal care, which can result in incomplete pain management, poor physician-patient relationships, prolonged emergency department length of stays, and increased hospital admission rates.<sup>1,6</sup> It is important that we seek to assess our personal attitudes, improve them through education, and adhere to existing guidelines for care. ●

Continued on next page

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Medical Student Council President's Message

## Questions from MS3s

Shae Boles  
Medical Student Council President



I have been getting questions from many MS3s regarding scheduling their rotations for next year. Going into fourth year, I too felt overwhelmed and unsure about the perfect combination. What I have learned this year is that while there is no "one size fits all" schedule there are some ways to arrange away rotations and STEP 2 to make things a little bit easier down the road.

### 1. How many SLOE's do you need?

The first thing to know going into fourth year is that you will need at least two SLOE's for your application to be considered complete for many programs. A SLOE is like a specialized letter of recommendation specific to emergency medicine. One of these can potentially come from your home institution, so my recommendation would be to have at least two EM rotations completed by the end of September, and the earlier the better! That gives the institution you rotated at some time to get a SLOE uploaded within the first week of October (the ERAS application is due September 15th, but many programs will tell you that they do not look until October). If you rotate in October you can still definitely ask for a SLOE but many programs may have already looked at your application. If you have no other choice it is fine to upload it and update programs if you are in that boat — overall it is just easier if you already have two in the system.



### 2. When to take STEP 2?

If your school gives you dedicated time to study for STEP 2, I would highly recommend taking it. Sure STEP 2 does not require quite as much rigor as STEP 1 for some, but for others the study process is very similar. Most programs are content with only seeing your STEP 1 score in by the September 15<sup>th</sup> ERAS deadline. I can say for myself it was nice to have taken STEP 2 in July and not have to worry about it later, but that meant my three EM rotations were August-October. This ended up being fine, but as I mentioned before, getting a SLOE in October is on the later-end.

Ultimately how you create your schedule must be individualized to your needs, and most of the time it works out any way you slice it. Your advisors will be key in helping you make decisions. I just hope this sheds a little bit of light on what worked for me and what I've heard from other MS4s.

### 3. When should you schedule away rotations?

The last questions I get asked quite a bit is about setting up away rotations. My experience was a little bit different as I did mine through the Air Force, however the best

advice I could give based on my classmates' experiences is to schedule early! Programs fill up very quickly through VSAS — some the day they open. So keep an open mind, you could end up loving a place you never thought you would! I encourage you to work hard on your rotations, bring a positive attitude every day, explore if you are in a new place, and have fun while you are there! Please reach out with any questions! sboles@luc.edu ●

## 2019 Annual DVAAEM Residents' Day and Meeting

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Join the Delaware Valley Chapter Division for a day of networking with area residents & attendings and enjoy stand-out speakers.

Registration opens in early February 2019 – watch for more information coming soon!



# AAEM Medical Student Ambassador: The Door to a Brighter Future

Nahal Nikroo  
AAEM18 Medical Student Ambassador  
AAEM/RSA Wellness Committee Member



In a tiny hotel room a few blocks away from the AAEM Scientific Assembly, I spent the end of every evening in stunned incoherence and happiness. Immersed in the day-to-day activities of an AAEM Medical Student Ambassador, I compulsively tried to reconstruct the events of the day, from meeting with my new mentor to learning about Airway, an open storytelling experience of emergency physicians, at AAEM. Despite my best efforts to envision what

attending the conference for the first time would hold for me, my expectations had been surpassed.

On a Wednesday evening in March and one month prior to the Scientific Assembly, I received the first email correspondence from my assigned AAEM physician mentor, signaling my acceptance as a Medical Student Ambassador. I had been matched with Dr. Loice Swisher! The truth was that I had already stopped believing I would ever find an emergency medicine advisor. As a student going to a relatively new medical school with no established home emergency medicine (EM) program, it had become quite a challenge finding an accessible EM mentor. Long recognized as an important pillar in academic medicine, quality mentorship has been cited as important for success, advancement, and productivity.<sup>1,2</sup> Yet, finding a sustainable mentor-mentee relationship in the field of EM continued to elude me. I had long held a passion for emergency medicine, but that was not enough to help me pave my path. Unwittingly, I had stumbled across the AAEM Ambassador application and applied as a last desperate effort. Several months later, I received my first email correspondence, days prior to the start of the conference.

It seems almost impossible to delineate the precise impact that having a mentor like Dr. Swisher has done for me. Yet from this AAEM Ambassador connection, I was catapulted into the vastly connected world of emergency medicine. As an energetic, smart, and unbelievably kind woman, my new mentor ended her first email to me with, “Let me know what you’re interested in. If my Google is correct you are a medical student with an interest in ultrasound and presented at a cardiology conference in Europe last September and are Iranian. Sounds like you’ve been really busy.” Inspired by Dr. Swisher’s candor, I found myself opening up about my own struggles as a student as we made plans to meet at the conference. Dr. Swisher became a direct guide to my first EM conference experience, and shared a slew of valuable professional advice, such as the importance of having a Twitter account to stay connected to the professional world of EM.

Resourceful as usual, Dr. Swisher further ‘e-connected’ me with yet another mentor, Dr. Danya Khoujah, who epitomized my ideal future aspirations and opened me to the world of Women in Emergency Medicine and FemInEM. Throughout the conference, I had multiple opportunities to interact with my newly acquired mentors, attend committee meetings, and

go to networking events. It was not long before I discovered that my new mentors not only exemplify the grit, intelligence, and optimism of generations of successful emergency physicians, but they also stay involved and give back to the growing generations after them. As mentors, not only do these women provide direction and opportunity so that I may carve my own career pathway, they also serve as role models in personal areas of growth such as balancing family with work. Meeting them through the AAEM Ambassador program allowed me the opportunity to acquire crucial guidance and key professional opportunities, which I would not have been privy to otherwise.

Over the past year, my relationship with both mentors resulted in significant professional growth. This level of proximity to emergency medicine paid off tremendously. To this day, both of my mentors continue to provide astonishingly detailed and insightful commentary and guidance — emblematic of the extraordinary generosity that I received from several EM physicians and medical students I encountered almost a year ago at the AAEM conference.

As a current medical student, I had only caught a glimpse of what it means to be an emergency physician. However, through the AAEM Ambassador program, and more specifically through guidance from my mentors, I have learned so much about the profession and the countless leadership opportunities for medical students that had once been inscrutable and unattainable to me.

I was once told that national EM conferences are not made for medical students, but I now have my own experience to the contrary. I discovered to my surprise the number of emergency physicians willing to wholeheartedly mentor and support me and other students at AAEM. As I drove that fateful April morning to San Diego for my first day of conference, I barely realized I was embarking on an entirely new world of pivotal opportunities.

Through the AAEM Medical Student Ambassador Program I didn’t just find mentors — I found a sense of community. I often think of what Dr. Khoujah told me as I was ruminating to her about how she willingly reaches out and mentors so many. “I got to where I am by standing on the shoulders of giants; I am just paying it forward.”

AAEM19 is now recruiting its new batch of medical students for the ambassadors program. There is so much in store for these medical students, such a wealth of experience, and wonderful possibilities. My life has changed due to these connections, and now yours can as well! ●

## Resources

1. Sambunjak D, Straus SE, Marusic A. Mentoring in academic medicine: A systematic review. *JAMA*. 2006;296:1103–1115.
2. Gray J, Armstrong P. Academic health leadership: Looking to the future. *Clin Invest Med*. 2003;26:315–326.

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