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SENSE

THE NEWSLETTER OF THE AMERICAN ACADEMY OF EMERGENCY MEDICINE



PRESIDENT'S MESSAGE Academic Advocacy

Larry D. Weiss, MD JD FAAEM

Throughout its relatively brief history, emergency medicine faced continual challenges to its academic legitimacy. Unfortunately, these challenges continue today. From the time of our founding, AAEM primarily focused its advocacy efforts in three areas: (1) in support of the personal practice rights of emergency physicians, (2) against illegal practice models in emergency medicine and (3) in support of the academic integrity of emergency medicine.

In our early years, older physicians from other specialties questioned the need for emergency medicine training programs and often contended that any physician could work in an emergency department. This problem persists to a limited extent, but the most serious challenges to the academic integrity of emergency medicine now come from within our specialty.

The American Board of Emergency Medicine (ABEM) had a liberal "grandfather clause" declaring physicians board eligible if they completed 8,000 hours of clinical practice in emergency departments by 1988. However, a determined group of emergency physicians filed a class action lawsuit in 1990, *Daniel et al v. ABEM et al*, arguing the "grandfather clause" should remain open permanently.¹ In their lawsuit, they couched their claims in antitrust language, claiming ABEM and multiple other defendants engaged in antitrust violations. According to their argument, closure of the "grandfather clause" resulted from a conspiracy in restraint of trade, designed to artificially inflate the salaries of ABEM diplomates.

Like most other new specialty boards, ABEM granted practice eligibility to the founders of our specialty who never had the opportunity to complete residency training.² Like any other legitimate medical specialty board, ABEM requires primary residency training and successful completion of board examinations. The *Daniel* case languished in federal court for 15 years before final dismissal in 2005. Unfortunately, this did not end the controversy over board certification in emergency medicine.

We must now contend with challenges to board certification created by an alternative board examination offered by the American Association of Physician Specialists (AAPS). This organization offers a certification entitled "Board Certification in Emergency Medicine" (BCEM).

Eligibility for the BCEM examination does not require residency training in emergency medicine. In 2002, BCEM representatives successfully petitioned the Florida Board of Medicine, winning recognition as board certified emergency physicians. Since that time, they made a similar attempt before the North Carolina Medical Board (NCMB) and recently filed suit in New York to win formal recognition of their certification board. AAEM supplied documentation to the NCMB and testimony from our Vice President, Howard Blumstein, MD FAAEM. NCMB did not grant recognition to BCEM. The New York action is still pending.

By insisting that board eligibility in emergency medicine should not require residency training, the *Daniel* plaintiffs and the current BCEM representatives essentially argue that emergency medicine is not a legitimate specialty with its own unique body of knowledge requiring residency training. AAEM will always oppose such arguments. At recent hearings before the Florida legislature, BCEM representatives claimed representatives of FLAAEM, AAEM's Florida state chapter, were involved in a conspiracy to prevent them from working in emergency departments. To the contrary, AAEM never proposed that only ABEM diplomates should work in emergency departments. We recognize the reality of a shortage of ABEM certified emergency physicians. We also recognize the independent authority of organized medical staffs to grant clinical privileges. On the other hand, we strongly oppose efforts by self-interested individuals without ABEM certification who insist on the right to call themselves "board certified" in emergency medicine. Such claims have the effect of denigrating the academic integrity of emergency medicine and misleading the public. Well-informed members of the public can reasonably conclude that a board certified specialist has formal training in a designated specialty.

While taking a strong stand in support of proper residency training in emergency medicine, AAEM highly honors practice-eligible ABEM diplomates. We have several policies in our books opposing any form of discrimination against these founders of our specialty. In fact, we do not accept advertisements of positions only open to residency trained emergency physicians, while excluding practice-

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Editor's Letter

David D. Vega, MD FAAEM

As you may already know, David Kramer, MD FAAEM, recently resigned as editor of *Common Sense*. AAEM owes Dr. Kramer a debt of gratitude for his service as editor for the past three years. He has certainly continued the legacy of excellence established by preceding editors of the newsletter. We wish him the best of luck as he begins his tenure on the ABEM board of directors. This new position is quite an achievement and a fitting role for someone who has committed much of his career to the education of emergency medicine residents. It is also exciting to see an active member of AAEM, previous board member and Peter Rosen Award winner selected for such a prominent position.

I consider it a privilege to serve as Dr. Kramer's successor as editor of *Common Sense*. I am dedicated to ensuring that this newsletter remains informative and useful to all members of AAEM. As I move into this new role, I challenge you to read through every issue and provide us with feedback on what works and what does not. *Common Sense* is the newsletter of the Academy and we will continue to keep you up-to-date with the latest happenings in the organization, but we also want to know what can be done to make this publication the most useful it can be for you.

In this issue, you will find an article by outgoing board member James Li, MD FAAEM, who notes that we cannot take the continued success of AAEM for granted. Only through the continued dedication and hard work of its members will AAEM be able to continue to fight for excellence in the care of patients in emergency departments across the country. I join Dr. Li in wholeheartedly encouraging you to actively participate within the organization.

Emergency medicine was not founded by passive individuals. It took the sweat, tears and personal sacrifice of many individuals who wanted the best for patients and providers to get us where we are today. We owe it to these founders of our specialty, our current and future colleagues and most importantly, our patients, to ensure the continued

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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: \$365 (Must be ABEM or AOBEM certified in EM or Pediatric EM)

*Associate Member: \$250

Emeritus Member: \$250 (Must be 65 years old and a full voting member in good standing for 3 years)

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

International Member: \$125 (Non-voting status)

AAEM/RSA Member: \$50 (voting in AAEM/RSA elections only)

Student Member: \$50 (voting in AAEM/RSA elections only)

*Associate membership is limited to graduates of an ACGME or AOA approved Emergency Medicine Program.

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Hospital Fined for Failure to Provide Emergency Care

Kathleen Ream, Director of Government Affairs

A California hospital was ordered by the US Department of Health and Human Services Office of Inspector General (OIG) to pay a penalty of \$50,000 for failing to provide required emergency care for a patient who died in the emergency department (St. Joseph's Medical Center v. OIG, Departmental Appeals Bd., Civil Remedies Div., Dec. No. CR1895, 1/30/09).

In a January 30, decision, Administrative Law Judge (ALJ) Steven T. Kessel – Departmental Appeals Board, Civil Remedies Division – sustained the OIG's determination that St. Joseph's Medical Center in Stockton, California, violated EMTALA by failing to provide a medical screening examination and stabilizing treatment for the patient. The OIG issued a press release to highlight the fact that St. Joseph's pursued litigation before an ALJ, which is a relatively unusual situation.

In the decision, the ALJ stated that the failure to provide the patient with a screening examination was "shocking" in light of the facts that were known to St. Joseph's staff the night the patient died. He also noted that the events that took place on December 29, 2001, show that St. Joseph's staff "botched horribly" the care they gave to the patient. "This case demonstrates that OIG will impose the maximum civil monetary penalty for egregious violations of the requirements of EMTALA," HHS OIG Daniel R. Levinson said.

The patient was brought to the hospital's emergency department (ED) by members of his family. After waiting about an hour and a half, the triage nurse checked the patient, but was unable to take his temperature because his tongue was swollen. However, the triage nurse classified the patient as "routine" and sent the patient back to the waiting room. The patient's condition appeared to deteriorate, and an hour later, a family member notified the nurse that he might be having a heart attack.

The emergency department charge nurse instructed a technician to put the patient on a cardiac monitor and to administer oxygen, but the instructions were not followed. After another half hour, the patient demonstrated serious breathing problems, but when a medical team arrived, the patient was in full cardiopulmonary arrest, and the team was unable to resuscitate the patient, who died an hour later.

The ALJ was not persuaded by St. Joseph's argument that EMTALA is not a federal malpractice statute that makes hospitals liable for all negligence committed in emergency rooms. The ALJ determined that the evidence supported a conclusion that the hospital's staff grossly neglected the patient's needs and failed to provide him with a screening examination even after being told that the patient was having difficulty breathing.

Judge Kessel wrote, "EMTALA does not excuse a hospital for failing to perform a screening examination where that failure is the consequence of the hospital's staff's gross negligence. EMTALA is unequivocal. A hospital must provide a screening examination to every individual who comes to its emergency department requesting treatment. There is no 'negligence' exception to the law."

He determined that the evidence proved that St. Joseph's manifested a high level of culpability for its neglect of the patient and also found additional evidence that underscored both the hospital's culpability and the seriousness of its EMTALA violation. The ALJ also found that the person performing triage on the patient was not qualified – under St. Joseph's own criteria – to perform triage.

"This may have been the first instance of an EMTALA violation by [St. Joseph's]," the ALJ concluded. "But, if so, it is so egregious as to merit a maximum civil money penalty in and of itself."

HHS Announces Stimulus Funds for Hospitals Serving the Poor

On March 20, 2009, the US Department of Health and Human Services (HHS) announced the availability of \$268 million in funds under the economic stimulus law to hospitals that treat large numbers of low-income or uninsured patients.

The funds are available to so-called DSH hospitals, which treat a disproportionate share of the poor. The stimulus law increases funding for DSH facilities from \$11.06 billion to \$11.33 billion in 2009. States will have to show that they have exhausted their existing DSH allotments before they can gain access to the added funds.

"Thousands of hospitals around the country are the first place many families take their sick children for care or the only place where some of the more than 45 million uninsured Americans can receive some form of health care," said Acting HHS Secretary, Charles E. Johnson. The funding "will help ensure hospitals can keep their doors open to the people who need care most."

Larry S. Gage, president of the National Association of Public Hospitals, issued a statement thanking the administration and Congress for the funds. "Public and other safety net hospitals in communities across the country are reporting increases in uninsured care of between 10 and 20 percent depending on where they are located," Gage said.

US Healthcare System Fails Youth

According to a recent report from the National Research Council and the Institute of Medicine, the US healthcare system often fails adolescents age 10 to 19. The report found that adolescents, more than any other age group, rely on hospital EDs for routine treatment. In addition, many youths lack access to specialty services for mental health, substance abuse and sexual and reproductive health – this despite the fact that while most US adolescents are healthy, many engage in risky behavior, from binge drinking to carrying weapons, and have physical and mental conditions that can ultimately be harmful. "Even when services are accessible, many adolescents may not find them acceptable because of concerns that confidentiality is not fully ensured, especially in such sensitive domains as substance use or sexual and reproductive health," the authors said. To address their findings, the authors recommend that government, private foundations and insurers promote a coordinated healthcare system that seeks to improve care for adolescents and that lawmakers develop plans to ensure comprehensive health coverage.

These recommendations may be pursued next month when Democrats in Congress plan to renew their efforts to add four million youngsters to the State Children's Health Insurance Program (SCHIP). The legislation was vetoed twice by President Bush last year, but President Obama supports an overhaul of the healthcare system that would expand subsidies for health insurance and make coverage of all children mandatory.

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Study Portrays ED Crowding as a Patient Safety Issue

A new study surveying 3,562 ED clinicians in 65 hospitals across the nation raises concerns about the safety of critically ill patients. The study, funded by the US Agency for Healthcare Research and Quality, states that, no matter the size or locale, EDs across the country need major improvements in design, management, staffing and support to ensure high-quality patient care in a safe environment.

According to the study's lead author, David Magid, an emergency physician and a senior scientist at the Kaiser Permanente Colorado Institute for Health Research, ED clinicians are reporting widespread problems in four systems that are critical to safety: physician environment, staffing, inpatient coordination and information coordination and consultation. "We found the same problems everywhere," Magid said. He emphasized that hospitals across the country – large, small, academic-based, community-based – can all experience these problems.

While ED overcrowding has been shown in prior studies, Magid said that this study "...was the first to closely examine safety from the perspective of the clinicians who actually work in the emergency department, including physicians and nurses." In their responses, 25% of the clinicians said their ED is too small, 32% said the number of patients exceeds their ED's capacity to provide safe care most of the time, and 50% said their patient capacity is exceeded some of the time. Half of the clinicians reported that ED patients requiring ICU admission are rarely transferred from the ED to the ICU within one hour. Fewer than half said that most specialty consultations for critically ill patients occur within 30 minutes of being contacted.

Part of the problem is that while demand for emergency care has increased by 26% over the past decade, the number of EDs has declined by 9%. EDs "weren't designed to handle the amount of patients that are coming in now," Magid said. He added that when sick patients are put in waiting rooms or hallways, the ED staff may not be able to adequately monitor them. In addition, when patient demand exceeds staff capacity, clinicians may give rushed evaluations or improper treatment in an attempt to provide care to everyone.

One solution the study's researchers recommended was to redesign ED space to make care available to more patients and to increase staffing during busy times. Other recommendations included improving information sharing between clinicians and providing more computer stations for better access to electronic health records. The researchers also said that overall investment in EDs is a key factor. "The requirement for resources to accomplish these changes suggests that third-party players, including government, will have to be involved in any coordinated strategy to address deficiencies in the safety of ED care."

Magid said he is not sure what impact his study will have since ED overcrowding is widely known and yet persistent. He emphasized that people are working on the problem, but increased efforts and new solutions are needed. "Hopefully, results of studies like ours, which go beyond merely showing that the ED is crowded to showing the impact crowding is having on safety issues, might motivate people to do more."

Disparate Screening Claim in Commonwealth of Puerto Rico

On November 13, 2008, the US Court of Appeals for the First Circuit affirmed the Puerto Rico district court grant of summary judgment,

dismissing a claim under EMTALA, that a hospital and physicians did not provide adequate screening in treating a decedent spouse for a fatal coronary condition (*Fratlicelli-Torres v. Hospital Hermanos*, 1st Cir., No. 07-2397, 11/13/08).

The Facts

On June 25, 2003, Guillermo Bonilla Colon, arrived at the Hospital Hermanos Melendez's ED, stating that he had been suffering intermittent severe chest pains and arrhythmia for two days. Following hospital protocols, the ED physicians placed Bonilla on cardiac monitoring, ordered a battery of diagnostic tests and found that he "likely had suffered a myocardial infarction anywhere from nine hours to two days before" presenting at the ED. Determining that the infarction was passed, they did not order any thrombolytic treatment, but admitted Bonilla to the hospital's intensive care unit (ICU) for further observation.

On July 1, hospital physicians conducted a cardiac catheterization, which confirmed a recent myocardial infarction resulting in extensive, irreparable damage to Bonilla's heart muscle. The physicians determined that Bonilla needed to be transferred to another hospital "capable of performing angioplasty or stent implantation." Then two days later, Bonilla began exhibiting symptoms of congestive heart failure. Hospital Hermanos Melendez stabilized Bonilla and with Bonilla's and his wife's informed consent, transferred the patient to another hospital. Bonilla remained at the second hospital until July 14, "when he was transferred to yet another hospital to await heart transplant surgery." Bonilla died two days later of congestive heart failure.

In June 2004, Bonilla's wife Nivia Fraticelli-Torres filed suit against Hospital Hermanos Melendez, its doctors and its insurer, alleging that "defendants had violated EMTALA by treating Bonilla disparately from other similarly situated heart-attack victims." Appellant's EMTALA violations claims included the defendants failure to "subject Bonilla to an adequate cardiac screening examination in accordance with established hospital protocols...to provide Bonilla with adequate medical treatment for his diagnosed heart condition...to immediately transfer Bonilla to another hospital capable of providing the necessary medical care...and to adequately stabilize Bonilla before his July 3 transfer to another hospital." Defendants filed a motion for summary judgment, which was granted by the district court, "finding that appellant had not established a trialworthy EMTALA claim." Fraticelli-Torres appealed the district court decision.

The Ruling

Appellant argued that summary judgment was unwarranted because genuine factual disputes persisted regarding whether "defendants subjected Bonilla to disparate treatment under their established screening/stabilization protocols by refusing to give him thrombolytic treatment" in the ED. The federal appeals court found that Fraticelli-Torres's contentions fell short because "thrombolysis is not a diagnostic tool which would implicate EMTALA's 'screening' criterion, but a treatment option...and therefore, defendants' threshold decision in the ER not to order thrombolysis for Bonilla would implicate only the 'stabilization' criterion."

Fratlicelli-Torres also argued that summary judgment was unwarranted because her husband's myocardial infarction was not a completed event, but continued throughout his one week hospital stay. The ongoing myocardial infarction, according to appellant, thus generated a genuine factual dispute – of whether defendants failed

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to adequately stabilize Bonilla before transferring the patient to another hospital on July 3 – precluding any summary disposition of her EMTALA claim.

The federal appeals court stated that this argument also failed because appellants did not provide any evidence that defendants disparately treated Bonilla. “For EMTALA purposes,” wrote the court, “defendants properly initiated an extensive protocol...and the inferences which defendants drew from Bonilla’s test results might have been faulty or even negligent, but while these matters legitimately might form the grist of appellant’s state-law medical malpractice claim, they normally will not trigger EMTALA liability.”

Appellant next argued that summary judgment was not warranted because EMTALA imposes on a hospital, which cannot provide necessary treatments, the obligation promptly to transfer the patient to a hospital that can do so, “and thus defendants should have ordered

Bonilla’s transfer one week earlier than they did.” Again the court found the appellant’s contention insufficient because, by the time Bonilla was transferred, there was no evidence that the patient was unstable. “By its express terms, EMTALA – which is solely an “anti-dumping” statute – does not impose any positive obligation on a covered hospital to transfer a critical patient under particular circumstances to obtain stabilization at another hospital. Rather, EMTALA merely restricts the conditions under which a hospital may transfer an unstabilized critical patient.”

For these reasons, the US Court of Appeals concluded that the district court properly granted summary judgment and determined that the proper venue for pursuing a medical malpractice claim is in the commonwealth courts of Puerto Rico.

To read the court decision, go to <http://op.bna.com/hl.nsf/r?Open=psts-7lgn7e>

President’s Message - continued from page 1

eligible ABEM diplomates. Our policies consistently support the proper recognition of board certification and the requirement of such certification for the attainment of fellowship status within our Academy.

In conclusion, AAEM does not take a position on who should work in every emergency department, but we strongly support the process of legitimate board certification. This process requires residency training in emergency medicine, similar to the requirements of all legitimate primary specialty boards. In the United States, we only recognize ABEM and AOBEM diplomates as “board certified” in emergency medicine. To act otherwise would only undermine the academic legitimacy of emergency

medicine. For that reason, legitimate board certification in emergency medicine will always be a requirement for fellowship status in AAEM, and we will continue our advocacy in defense of the academic integrity of emergency medicine. You may proudly list the title of FAAEM after your name, identifying you as a board certified specialist in emergency medicine and as a member of the organization in emergency medicine that advocates for the academic integrity of our specialty.

1. *Daniel et al v. ABEM et al.*, 428 F.3d 408 (2nd Cir. 2005).
2. Unless noted otherwise, references to ABEM also apply to the American Osteopathic Board of Emergency Medicine (AOBEM) and the Royal College of Physicians and Surgeons of Canada (RCPSC).

AAEM would like to recognize the outstanding academic and professional achievements of its members.

Future issues of *Common Sense* will feature a section acknowledging these accomplishments, as submitted by AAEM members.

If you have an announcement you would like to see listed in this section, please send details to info@aaem.org. Submissions will be reviewed for accuracy and appropriateness prior to being accepted for publishing.

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The 15th Annual AAEM Scientific Assembly was held March 2-4, 2009, in Phoenix, AZ.



Stephen Hayden, MD FAAEM (right), Editor-in-Chief of the *Journal of Emergency Medicine*, with the winners of the AAEM/ JEM Resident and Student Research Competition, from left, Brian Geyer, PhD, Erin Griffith, DO and Roxana Yoonessi, MD.



Attendees walking through the exhibit hall.



J. James Rohack, MD, Keynote Speaker, opens the Scientific Assembly on Monday, March 2, 2009.



Attendees walking through the exhibit hall during the Opening Reception on March 2, 2009.



Attendees enjoying the evening at the RSA & YPS Social sponsored by Pepid, LLC.



Amal Mattu, MD FAAEM, lectures on Emergency Cardiology.



Larry D. Weiss, MD JD, AAEM President, presenting Megan Boysen, MD, with the Resident of the Year Award.



Larry D. Weiss, MD JD, AAEM President, presenting the David K. Wagner Award on March 2, 2009.



Pre-Conference courses were held February 28 and March 1. The Advanced Ultrasound Course featured both didactic and interactive hands-on sessions with faculty.

Elections for the AAEM Board of Directors and the Awards Ceremony were held at the 15th Annual AAEM Scientific Assembly in Phoenix, AZ. The 2009-2010 AAEM Board of Directors and Award Recipients are listed below.

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Stephen R. Hayden, MD

Special Recognition

Departing Board Member

David Kramer, MD FAAEM

Departing Board Member

James Li, MD FAAEM

AAEM/JEM Research Competition

First Place – Erin Griffith, DO

Second Place – Brian Geyer, PhD

Third Place – Roxana Yoonessi, MD

2008 AAEM Service Awards for Oral Board Examiners

This year the award was renamed the Mitchell Goldman Service Award to recognize Dr. Goldman for his devotion and commitment to AAEM's Oral Board Review Course and its educational programs.

20 sessions: Mitchell J. Goldman, DO FAAEM

15 sessions: David W. Dabell, MD FAAEM, and Usamah Mossallam, MD FAAEM

10 sessions: Alexandre F. Migala, DO FAAEM

5 sessions: Nabeel M. Alansari, MD FAAEM, Mark W. Donnelly, MD FAAEM, Marc D. Haber, MD FAAEM, Michael N. Habibe, MD FAAEM, Peter C. Hou, MD FAAEM, Sam P. Josvai, MD FAAEM, Paul E. Kleinschmidt, MD FAAEM, Chuma N. Ononye, MD FAAEM, Steven B. Rosenbaum, MD FAAEM, Michael S. Runyon, MD FAAEM, Donald L. Snyder, MD FAAEM, Robert L. Spence, MD FAAEM, Allison M. Tadros, MD, Meredith Tucker, MD FAAEM, and Matthew J. Vreeland, MD FAAEM

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NHLBI Halts Study of Concentrated Saline for Shock Due to Lack of Survival Benefit

The National Heart, Lung and Blood Institute (NHLBI) of the National Institutes of Health has stopped a clinical trial studying the benefits and safety of administering hypertonic saline solution to trauma patients suffering from shock due to severe bleeding. The trial was stopped because more of the patients receiving hypertonic saline died before reaching the hospital or in the emergency department, although patients who received the normal saline solution had equivalent mortality at 28 days, the endpoint of the study.

A parallel study of hypertonic saline for traumatic brain injury without shock continues.

Typically, in the crucial early minutes before blood transfusions can be safely administered in the hospital, trauma patients receive normal saline solution in the field to compensate for blood loss and buy time. Hypertonic saline is believed to compensate for blood loss more effectively, lessen excessive inflammatory responses and prevent brain swelling.

The trials of hypertonic saline solutions are conducted through a network of clinical research sites in the United States and Canada called the Resuscitation Outcomes Consortium (ROC). A major focus of the ROC is to conduct randomized trials of promising new treatments for severe traumatic injury in real-world settings.

“Survival from traumatic injury is a critical public health issue and the large clinical trials under way in this effort are needed to improve the treatment of patients. Of course, it is always disappointing when new therapies, such as concentrated saline for shock, fail to offer added benefit to patients. However, we look forward to results from the other ongoing studies that are part of this important research consortium,” said Elizabeth G. Nabel, MD, director of the NHLBI, the lead federal sponsor of the research effort.

The NHLBI suspended enrollment into the hypertonic saline shock study on August 25, 2008, due to concerns raised by ROC’s Data and Safety Monitoring Board (DSMB), an independent group monitoring the study. In the shock trial, the DSMB observed no difference among the treatment groups in 28 day mortality. However, more of the patients receiving hypertonic saline died before reaching the hospital or in the emergency department, while more of the patients receiving normal saline died during the remainder of the 28 day follow-up period.

The DSMB requested further analysis of these observations. The additional analysis looked at in-hospital data (following saline administration in the field) from 545 patients in the largest enrolling hospital from each site. The results, presented to the DSMB on February 25, 2009, confirmed the previous findings that deaths occurred earlier in patients who received hypertonic saline and that there was no significant difference in cumulative mortality between the hypertonic and normal saline groups at 28 days. However, the new analysis did not fully explain the mortality findings. The investigators are completing analyses of these results and will submit them for publication in a peer-reviewed scientific journal.

Although there were no similar concerns about earlier mortality in the traumatic brain injury trial, this trial was also temporarily and voluntarily suspended last August so that emergency medical service (EMS) personnel could be retrained to enroll only brain injury patients, not those who would have been eligible for the shock study. The traumatic brain injury study resumed in late November 2008.

ROC is a research network of nine major regional clinical centers in the United States and Canada focusing on the treatment of patients who collapse with cardiac arrest or with life-threatening traumatic injury before they reach the hospital. Under the various research protocols, participating EMS providers give standard emergency care to all patients, with some patients eligible to receive the experimental treatment in addition to usual care. The clinical trials are conducted under strict FDA and well-defined Canadian guidelines that allow for patients in life-threatening situations to participate in research under an exception to informed consent, according to US and Canadian law.

In both the shock and traumatic brain injury ROC hypertonic saline trials, patients were randomly selected to receive either approximately eight ounces of intravenous normal saline, which has nearly the same concentration of salt as blood and is considered standard care; approximately eight ounces of hypertonic saline, which has a higher salt concentration; or about eight ounces of hypertonic saline with dextran, a carbohydrate which can prolong the effect of the hypertonic saline. The trauma shock study (which was suspended) tested whether hypertonic solutions improve survival by 28 days after injury, compared to the usual care with normal saline.

The now-resumed trial of brain injured patients continues to investigate whether the hypertonic solutions improve both survival and brain function in patients six months after traumatic injury. As the traumatic brain injury study continues, ROC investigators hope that hypertonic saline will prove beneficial for this application. “Patients with traumatic brain injury have significant swelling of the brain, and hypertonic fluids are known to be very effective at reducing this swelling, which may improve recovery,” said Eileen Bulger, MD, the University of Washington, Seattle, and co-principal investigator of the hypertonic saline studies.

“Hypertonic saline has also been shown to improve blood flow to the brain after injury and to protect nerve cells from increased intracranial pressure,” added David Hoyt, MD, University of California, Irvine, the other co-principal investigator of the hypertonic saline studies.

The NHLBI is the lead sponsor of the ROC studies with additional funding provided by the NIH’s National Institute of Neurological Disorders and Stroke, the Institute of Circulatory and Respiratory Health of the Canadian Institutes of Health Research, U.S. Army Medical Research & Materiel Command, American Heart Association, Defence Research and Development Canada, and the Heart and Stroke Foundation of Canada.

Recognition Given to Foundation Donors

Levels of recognition to those who donate to the AAEM Foundation have been established.

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AAEM established its Foundation for the purposes of (1) studying and providing education relating to the access and availability of emergency medical care and (2) defending the rights of patients to receive such care, and emergency physicians to provide such care. The latter purpose may include providing financial support for litigation to further these objectives. The Foundation will limit financial support to cases involving physician practice rights and cases involving a broad public interest. Contributions to the Foundation are tax deductible.

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Due Process, a California Sequel

Drew Fenton, MD FAAEM
dfenton@aol.com

I recently filed suit in the Los Angeles, CA, Superior Court after I lost my medical staff membership and clinical privileges without the benefit of a fair hearing. As a founding fellow and lifetime member, past director and secretary-treasurer, former editor of *Common Sense* and past presidential candidate of AAEM, I filed suit because of a violation of my due process rights.

My case, *Fenton v. Shea et al*, will reinvigorate a little known and mostly forgotten California Supreme Court opinion, *Anton v. San Antonio Community Hospital*, 567 P.2d 1162 (Cal. 1977). The *Anton* case affords physicians in California due process rights. In my case,

I made formal written requests for fair hearings at two hospitals. Both hospitals denied my requests. My case is in the discovery phase.

I recently began law school at the Abraham Lincoln University (ALU) School of Law in Los Angeles. The California State Bar fully recognizes this unique school, with a four year curriculum designed for students who work full time. ALU allows students to complete studies and examinations both in real time and/or via the internet using real time or archived lectures. I hope to use my law degree to advocate for physician practice rights, to include not only due process rights, but to defend medical-malpractice cases.

The Perspective

James Li, MD FAAEM

In leaving the AAEM Board of Directors after eight years, having served with four presidents, some of you may be interested in my perspective on the organization and its development.

The Academy today is mature, resource-rich and robust, as evidenced by the recent roster of superb board candidates both ready and qualified to fill the positions that Dave Kramer, MD FAAEM, and I are vacating. In the same way that we are advocates for our patients, I can confidently report that over these past eight years, the Academy has developed sufficiently to become a direct and powerful advocate for us, as practicing emergency physicians.

However, the combination of means and principles (even those that solidly represent patient and physician-based ethics) has not made the Academy popular or guaranteed its future success. As a member-driven organization, the Academy is involved in multiple simultaneous endeavors. Some of these, such as its educational forums, are low-risk extensions of its mission. Others, such as its litigation cases, represent thoroughly considered high-risk efforts to radically

improve the emergency care environment for us and our patients. As a participant in the debate over whether or not to commit resources to these high-risk endeavors, I can assure you that we will feel the impact of these efforts no matter what the eventual outcome.

Following a great deal of growing pain, I am proud that the present Academy is healthy and strong. Yet, I must warn you that we cannot take its continued existence and success for granted. If history is any measure, the Academy will not prevail simply on principle.

So, my message is this: in the busy, full life that we live, make the Academy part of your consciousness. Be an active member. If you have the means, make measured periodic donations to the Foundation. Believe me, it's money well spent.

Both Dave and I thank you for the opportunity to serve on the board.

Just another member now,

James Li, MD FAAEM

Current news and updates can now be found on the AAEM website



www.aaem.org

Editor's Letter - continued from page 2

promotion of the principles espoused by AAEM. I would encourage you to read through the AAEM website (www.aaem.org), learn more about the history of emergency medicine and AAEM and decide where you can help support the organization.

Having an active life outside of emergency medicine, I can understand the challenges to balancing one's personal and professional lives. So if you are finding it difficult to commit to service with AAEM right now, consider making a contribution to the AAEM Foundation instead. How about working one extra shift and donating the money earned to the Foundation? Your tax-deductible contribution will help with AAEM's involvement in pivotal cases related to the professional control of the practice of emergency medicine.

Regardless of how you do it, now is the time to get more involved with AAEM. Learn the issues. Educate your colleagues. Invest a bit of your time and money towards guaranteeing the future of our specialty. After all, AAEM is unequivocally dedicated to supporting you as a specialist in emergency medicine!

Upcoming AAEM–Endorsed or AAEM–Sponsored Conferences for 2009-2010

AAEM is featuring the following upcoming endorsed, sponsored and recommended conferences and activities for your consideration. For a complete listing of upcoming endorsed conferences and other meetings, please log onto <http://www.aaem.org/education/conferences.php>

AAEM–Sponsored Conferences

August 27-30, 2009

- AAEM Written Board Review Course
Newark, New Jersey
www.aaem.org

September 14-17, 2009

- The Fifth Mediterranean Emergency Medicine Congress (MEMC V)
Valencia, Spain
www.emcongress.org/2009

October 14-15, 2009

- AAEM Pearls of Wisdom Oral Board Review Course
Las Vegas, NV
www.aaem.org

October 17-18, 2009

- AAEM Pearls of Wisdom Oral Board Review Course
Los Angeles, Dallas, Philadelphia, Orlando, Chicago
www.aaem.org

February 15-17, 2010

- AAEM Scientific Assembly
Las Vegas, NV
www.aaem.org

June 5-7, 2009

- The Difficult Airway Course-Emergency™
Boston, MA
www.theairwaysite.com

June 8-10, 2009

- The Heart Course-Emergency
Cambridge, MA
www.theheartcourse.com

June 13-25, 2009

- Expedition Medicine 2009
Kilimanjaro
www.expedmed.org

June 15-19, 2009

- 5-Day Advanced Emergency Department Operations Course
Vancouver, WA
www.X32healthcare.com

July 20-23, 2009

- Giant Steps in Emergency Medicine
San Diego, CA
www.giantsteps-em.com

July 21-24, 2009

- High Altitude Medicine 2009
Ashford, WA
www.mmmedicine.com

August 17-21, 2009

- Expedition Medicine 2009
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www.expedmed.org

September 18-20, 2009

- The Difficult Airway Course-Emergency™
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www.theairwaysite.com

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October 26-28, 2009

- The Heart Course-Emergency
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www.theheartcourse.com

November 13-15, 2009

- The Difficult Airway Course-Emergency™
Atlanta, GA
www.theairwaysite.com

November 15-19, 2009

- ACTION09 – The Annual Scientific Meeting of ACEM
Melbourne, Australia
www.acem09.eventplanners.com.au/Home/tabid/816/Default.aspx

November 23-26, 2009

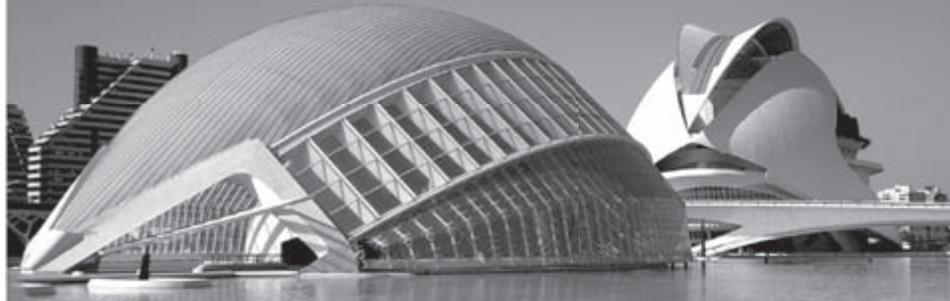
- Emergency Medicine in the Developing World Conference –
Disaster and Mass Gathering Medicine in a Developing World
Setting
Cape Town, South Africa
www.emssa2009.co.za

Do you have an upcoming educational conference or activity you would like listed in *Common Sense* and on the AAEM website? Please contact Kate Filipiak to learn more about the AAEM endorsement approval process: kfilipiak@aaem.org. All endorsed, supported and sponsored conferences and activities must be approved by AAEM's ACCME Subcommittee.

Registration Now Open!

for the Fifth Mediterranean Emergency Medicine Congress

MEMC *Valencia, Spain*
14-17 September **2009**



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31 May 2009

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For additional information,
or to register for this event,
please visit www.emcongress.org

**The American Academy of Emergency Medicine would like to congratulate
the 2009-2010 AAEM/RSA Board of Directors and Medical Student Council on their new positions.**

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AAEM 100% Hospital/Group Membership

AAEM has instituted group memberships to allow hospitals/groups to pay for the memberships of all their physicians. A 10% discount on membership dues is offered to each hospital/group that participates in this program. Full voting membership in AAEM normally comes at a cost of \$365 per year, and Associate membership at \$250 per year. With this discount, you are paying \$328.50 and \$225 respectively.

In order to take advantage of this discounted membership, please remember that all board certified and board eligible physicians at your hospital/group must be members. For this membership, we will invoice the group directly. If you are interested in this membership, all you need to do is follow a few simple steps:

1. Have each member of your group give you the appropriate information for their membership file (required information is seen below).
2. Create an Excel spreadsheet, send it to the AAEM office (either by email or mail) and we will send an invoice to you for the group.
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Membership File – Required Information is in italics

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RESIDENT PRESIDENT'S MESSAGE

Welcome to the new AAEM/RSA Board of Directors

Megan Boysen, MD
AAEM/RSA Immediate Past President

First, I would like to welcome the new president of AAEM/RSA, Michael Ybarra, MD. Dr. Ybarra served on the AAEM/RSA Board of Directors for the past two years, initially as the Medical Student Council president and last year as our *Common Sense* editor and at-large board member. You may have read several articles he has written on Medicare, health insurance and healthcare in America. Additionally, Dr. Ybarra has taken the lead on several projects in AAEM/RSA and acted as a liaison to the Medical Student Council. He is currently a resident at the Georgetown University emergency medicine residency program. I cannot imagine a candidate more qualified to lead us into the coming year. I look forward to all the good he will continue to do for AAEM/RSA.

Dr. Alicia Pilarski, currently a resident at the University of Las Vegas, Nevada EM residency program will serve as the board's vice president. She has done an outstanding job as this past year's education committee chair. She took the lead on several events for AAEM/RSA, including the resident track at the Scientific Assembly in Phoenix, the Midwest Medical Student Symposium, and she helped to organize the resident track at the CORD Academic Assembly in Las Vegas this year.

Dr. Cyrus Shahpar from Johns Hopkins emergency medicine residency program will be serving his second term as secretary-treasurer of AAEM/RSA and his third year on the board of directors. We will benefit from the experience he brings to the board of directors.

In addition to Drs. Ybarra, Pilarski and Shahpar, I would like to welcome the newest members of the AAEM/RSA Board of Directors: Dr. Jeff Pinnow (York Hospital), Dr. Ryan Shanahan (Johns Hopkins) and Dr. Sandra Thomasian (University of Las Vegas, Nevada). We are also welcoming back Dr. Heather Jimenez (Indiana University) and Dr. Jennifer Kanapicki (Stanford/Kaiser Programs). They were both tremendous assets to our board of directors and will continue the excellent work they started this past year. I would also like to welcome the incoming AAEM/RSA Medical Student Council president, Jamie "Akiva" Kahn from the University of California, Irvine.

All of our board members have played a critical role in stimulating the growth of AAEM/RSA, as well as ensuring that our

mission is kept. I have appreciated all the contributions of the board of directors and all of our committee members this year. Dr. Kalpana Narayan helped to organize our Vice President's Council. Dr. Brian Ostick helped our membership increase by 15%. Dr. Andrew Pickens helped us with his experience as immediate past president. Greg Casey did a tremendous job as our Medical Student Council president, as well as did the entire Medical Student Council: Jennifer Monroe (vice president), Daniel Bartgen and Melissa Hudson (midwest regional representatives), Mary Chopard and Kenneth Marshall (northeast regional representatives), Sara Kirby and Ellana Stinson (south regional representatives) and Malia Bender and Rachele Callenback (west regional representatives).

I'd also like to thank all of our committee members for their important role in AAEM/RSA. Our advocacy committee members were: Dr. Jonathan Hemmert, Dr. Clayborn Morris, Dr. Sanobar Shaikh, Dr. Sarah Stewart de Ramirez, Dr. Jason Tanguay, Dr. Nathan Trueger, Pedram Behzadi, Baruch Fertel, Daniel Giltner, Evan Johnson, Teresa Matejovsky and Syed Ali Rizvi.

The communications committee included: Dr. Veronica Bonales, Brian Byrne, Tomislav Jelic, Jaime Jones, Crystal Terrill and Jonathan Trager.

The education committee included: Dr. Jessica Brooks, Dr. Priya Kuppasamy, Dr. Dina Seif, Dr. Sneha Shah, Dr. Brian Sharp, Dr. Sandra Thomasian, Daniel Bartgen, Abra Berg, Richard Doyle, Gustavo Flores, Brian Geyer, Deena Ibrahim, Jamie "Akiva" Kahn, Kathleen Moorhead and Glenn Skow.

And finally, the membership committee included: Dr. Munawar Alhoda, Dr. Erin Griffith, Dr. Joshua Lynch, Maxim Ben-Yakov, Todd Burgbacher, Aisha C. Jennings, Helen Levey, Barbara Jean Santos, Chanel Shaw, Elliott Tenpenny and Scott Weitzel.

I'm excited to serve another year on the board of directors as the immediate past president. I look forward to continuing the projects we have started this year: a website redesign, a local and national advocacy forum, the written board review book and our membership expansion. Thank you for the opportunity to serve the AAEM Resident and Student Association this past year.

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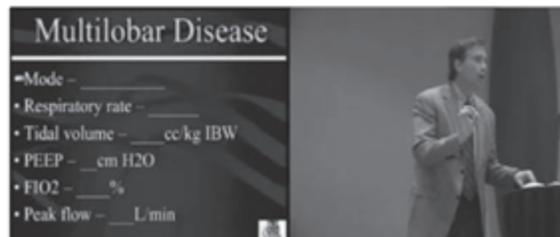
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The American Way: Employer Sponsored Health Plans

RESIDENT EDITOR'S LETTER

Michael Ybarra, MD

AAEM/RSA Resident Editor and AAEM/RSA President-Elect



Healthcare benefits often comprise the center of discussions between individuals and potential employers. Often times, even more critical than the base salary, healthcare benefits have a huge influence on an individual's decision to take or walk away from an employment opportunity. Over the last eighty years, health insurance has become intricately linked to employment for most Americans.

The link between health insurance and employment (often referred to broadly as "employer based health insurance") has tremendous implications for businesses and is unique to the United States. As healthcare costs rise, they become a larger component of a company's operating costs. Many argue this steady, steep increase has made American companies less competitive in the global markets. In 2004, healthcare costs accounted for approximately \$1,500 of every car that was produced by General Motors. That means GM spent more on healthcare than it did on steel.¹ This compares to as little as \$100 per car for foreign carmakers who manufacture their cars at US factories (such as Toyota, which operates plants in five states).

The US health insurance system is based largely on employers buying group insurance for their employees. US companies' competitiveness can be severely hindered by the high cost of providing health insurance for their employees and retirees. As is the case with General Motors, costs are highest for employers with a workforce composed of individuals in their 40s and 50s, who require more healthcare or that cover a large number of retirees. These companies are also at a distinct disadvantage if they want to compete on the world market against those that hire younger employees or employ workers in countries where healthcare is provided by the public sector.

David Blumenthal, Director of the Institute for Health Policy at Massachusetts General Hospital wrote, "The heavy reliance on employer-sponsored insurance in the United States is, by many accounts, an accident of history that evolved in an unplanned way and, in the view of some, without the benefit of intelligent design." Blumenthal cites two historical landmarks as laying the foundation for the system we have today, the first being President Roosevelt's decision not to nationalize healthcare in the 1930s when he signed the Social Security Act, and the second, a series of changes to the tax code allowing healthcare benefits to be excluded as taxable income.²

Employer sponsored health plans provide insurance to approximately 2/3rds of all individuals under the age of 65. This system is voluntary – employers offer the benefit as part of a larger compensation package to attract employees.³ Tying health insurance into benefits packages means the employee will often sacrifice base compensation or other benefits as the cost of healthcare rises. Of all private sector employers, 88% offered health insurance in 2002.⁴

Larger firms offer health insurance more often than smaller firms, because they are able to absorb the costs more easily.

To battle the rising cost of providing health insurance to their employees, private sector firms have adopted a number of cost containment strategies. Because the relationship between employer and employee is a partnership, the cost is often passed from employer to employee in the form of co-insurance, premiums and deductibles. Companies have started forming "purchasing coalitions" to secure lower rates from insurance companies. This strategy has been particularly helpful for smaller firms which otherwise lack the ability to "bulk buy" insurance plans.⁵

Employers have also started to treat hospitals and insurers as they treat any supplier – providing information to their employees about cost and quality on the web and through benefits information. The hope is that this information will allow employees to comparison-shop their healthcare much as they would do for any other consumer product. Flexible spending accounts, which have tax-associated benefits, have been used as a tool to encourage employees to choose reduced medical coverage.

A newly emerging theme is at work health promotion outreach. Employers see value in reducing disease in their employees from a cost perspective. Keeping employees and their families healthier will limit healthcare claims, which in turn lowers the cost of premiums to the company. Many companies increase coverage for routine checkups and preventive care visits and increase copayments and deductibles for emergency care, while others spend money directly in the work place to educate employees about preventable chronic diseases (such as diabetes and hypertension).

As with any system, our unique employer-based system has benefits and downsides. The privatization of health insurance, unique to the United States, introduces competition, demands innovation and is flexible to frequent changes and new approaches to coverage. By the same token, putting health insurance in the hands of the private sector means an individual's health coverage and our health system as a whole are inextricably linked to the successes and failures of US business. It is apparent this year, more than any other in the past decade, that as a business fails and jobs are cut, income is lost along with an individual's access to affordable healthcare. The government has stepped in to bridge the gap by enacting laws such as COBRA and HIPAA, but it does not ultimately provide unencumbered protection against the cost of illness. As a new administration debates the future of our system as a whole, the biggest question that remains to be answered is how our employer-based system will figure in to these reforms.

It has been a pleasure to write and edit for *Common Sense* over the last year. My hope is that this series on Healthcare in America

continued on page 19



Resident Journal Review: May-June 2009

David Wallace, MD MPH; Dana Sajed, MD; Christopher Doty, MD and Amal Mattu, MD

This is a continuing column providing journal articles pertinent to EM residents. It is not meant to be an extensive review of the articles, nor is it wholly comprehensive of all the literature published. Rather, it is a short list of potentially useful literature that the busy EM resident may have missed. Residents should read the articles themselves to draw their own conclusions. This edition will include articles published over a two month period. These selections are from papers published in January and February 2009.

Campbell CF, Chang AM, Sease KL, et al. Combining thrombolysis in myocardial infarction risk score and clear-cut alternative diagnosis for chest pain risk stratification. Am J Emerg Med 2009;27:37-42.

Identifying emergency department patients with chest pain that can be evaluated in the outpatient setting is challenging. The Thrombolysis in Myocardial Infarction (TIMI) risk score is a stratification tool that predicts 30 day adverse events in a broad range of chest pain populations. Unfortunately, even when this risk score is at its nadir, the adverse event rate is too high for a safe discharge. The investigators postulated that the adverse event rate might be lowered further in patients with a low TIMI score if there was a clear alternative noncardiac explanation for their chest pain.

This prospective cohort study enrolled 3,169 adult chest pain patients who presented to a single emergency department. 991 patients had a noncardiac diagnosis for their chest pain, and 1,808 had a TIMI score of either 0 or 1. Follow-up was conducted to capture the 30 day adverse event rate (death, myocardial infarction or urgent revascularization).

In patients with a TIMI score of 0 and an alternative diagnosis for their chest pain, the 30 day event rate remained nontrivial (2.9%), essentially equivalent to those without an alternative diagnosis (2.0%). Among those with an alternative diagnosis and a TIMI score of 1, the event rate was 5.5%; for those with a TIMI score of 2 the rate was 9.8%. 12 patients (2.7%) had an alternative diagnosis for their chest pain and a TIMI score of 0, yet went on to have myocardial infarction in the next 30 days.

This cohort study tells us that we're not there yet when it comes to identifying the subset of patients who come to the emergency department with chest pain that can be worked-up as outpatients. Local resources will dictate the setting, if not the tempo of the work-up; undoubtedly, there continues to be a role for chest pain units in some of the patients.

Liapikou A, Ferrer M, Polverino E, et al. Severe community-acquired pneumonia: validation of the infectious diseases society of america/american thoracic society guidelines to predict an intensive care unit admission. Clin Infect Dis. Jan 13 2009.

There are several risk stratification tools available for predicting mortality in community-acquired pneumonia (e.g., PSI, CURB, CURB-65). While each score classifies a subset of patients with a high predicted mortality, the instruments were not developed specifically to identify patients with severe disease or guide their disposition (i.e., ward vs. intensive care unit). The most recent ATS/IDSA guidelines support ICU admission for patients in septic shock or with respiratory failure – a practice that is undoubtedly the norm at most hospitals; however, these guidelines also delineate a set of “minor”

criteria that have not been validated.

The authors studied all adult pneumonia admissions at a single hospital over a seven year period to quantify the importance of the minor criteria in the ATS/IDSA guidelines. Patients with major criteria (i.e., intubated and/or on vasopressor infusions) were not included in their main analysis; mortality was compared for patients with different numbers of minor criteria based on whether they were admitted to the ward or an ICU.

Overall, mortality correlated with an increasing number of minor criteria (increasing relative risk of mortality by 1.97 for each successive point). Perhaps surprising, however, for patients with equivalent numbers of minor criteria, admission to the ICU did not confer a survival advantage.

This study is the first to specifically attempt validation of the minor criteria in the ATS/IDSA pneumonia guidelines. While it is not clear that minor criteria alone should be the sole basis for admission to an ICU, this study showed that an increasing number of minor criteria correlated with mortality, and therefore may contribute to the decision for admission to a more closely monitored setting. Further studies are needed to see if the current guidelines can be improved to better guide the use of often-scarce ICU beds.

Kimia AA, Capraro AJ, Hummel D, Johnston P, Harper MB. Utility of lumbar puncture for first simple febrile seizure among children 6 to 18 months of age. Pediatrics. 2009 Jan;123(1):6-12.

An AAP consensus statement released in 1996 on the management of first simple febrile seizures recommends that lumbar puncture (LP) be considered as part of the diagnostic work-up. The authors of this study sought to evaluate the rate of bacterial meningitis in infants between 6 and 18 months of age presenting with simple febrile seizures. In addition, a second endpoint examined was in compliance with the AAP recommendation for LP in children of this age group presenting with first febrile seizures. In this retrospective cohort study, over ten years worth of pediatric patients presenting to a pediatric emergency department were reviewed. 704 cases of febrile seizures in otherwise healthy children were found, of which 260 had lumbar punctures performed. CSF pleocytosis was found in ten cases, and no pathogen was identified on CSF culture. Of the 704 patients, none returned to the study institution with a diagnosis of meningitis.

Of note, greater than 90% of the children in this study had been vaccinated with Haemophilus influenzae type B vaccine and with pneumococcal conjugate vaccine. The authors suggest that in the era of conjugate vaccines, the well appearing febrile child aged 6 to 18 months with first simple febrile seizure is at very low risk for menin-

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gitis, and therefore, LP is not indicated. As always, clinical judgment should be used in interpreting any study - an ill appearing child with altered mental status, lethargy or other clinical signs suggestive of CNS infection necessitates a complete diagnostic work-up.

Panickar J, Lakhanpaul M, Lambert PC, Kenia P, Stephenson T, Smyth A, Grigg J. Oral prednisolone for preschool children with acute virus-induced wheezing. N Engl J Med. 2009 Jan 22;360(4):329-38.

Oral and inhaled steroids are often used to treat children with wheezing due to viral respiratory tract infections. While evidence favors this therapy in children with asthma or atopy, there has not been any clear proof of benefit in the general pediatric population. This randomized, double-blind, placebo controlled study from the UK looked at 687 children (age range, ten months to five years) who were hospitalized with viral infection-associated wheezing. Patients were all given albuterol then randomized to receive a five day course of once-daily oral prednisolone or placebo. No differences were noted between groups for the primary outcome of time to discharge from the hospital or for the secondary outcomes of number of albuterol administrations, delayed respiratory scores or rates of rehospitalization for wheezing at 30 days. The authors conclude that oral steroids do not have a role in the treatment of preschool children with viral-induced wheezing and no history of asthma or atopy.

Although steroid treatment is frequently used in all children with wheezing, another article in the same issue of the *New England Journal* (Preemptive use of high-dose fluticasone for virus-induced wheezing in young children. Ducharme FM et al. N Engl J Med 2009 Jan 22; 360:339) suggests that high dose inhaled steroids may cause reduced growth in children of this age group. A similar concern is theoretically possible for children with frequent viral infections who are repeatedly placed on oral steroid therapy. As such, it would be advisable to limit exposure to these medications to the population that seems to have the greatest benefit, those with asthma and familial atopy.

Haman L, Parizek P, Vojacek J. Precordial thump efficacy in termination of induced ventricular arrhythmias. Resuscitation. 2009 Jan;80(1):14-6.

The precordial thump is a dramatic maneuver advocated for years as a method for the rapid termination of ventricular tachycardia and ventricular fibrillation. The evidence for this intervention is limited to case reports that show return of spontaneous circulation, primarily in asystolic patients. In this study, the investigators performed a precordial thump on 155 of 485 patients who had a ventricular arrhythmia induced while undergoing an electrophysiological study. The subjects were initially awake and conscious, but became unresponsive after the induction of arrhythmia (mean time 26 seconds). After this span of time, a precordial thump was applied by one of two study cardiologists who estimated the amount of force necessary to be applied with clenched fist from the height of 20–30cm to the junction of the middle and lower third of the patient's sternum. In the meantime, external defibrillators were placed on the patient in case the thump was unsuccessful.

Of these 155 patients, only two had termination of ventricular arrhythmia after precordial thump; both had polymorphic ventricular tachycardia and a good underlying ejection fraction. The authors conclude that this technique has very little utility for the termination of ventricular arrhythmias and that while it is generally safe with few if any harmful complications, the maneuver is not really productive.

What should be taken into consideration is that the patient with pulseless ventricular arrhythmias should receive high quality chest compressions and rapid defibrillation - this should never be delayed for the sake of thumping a patient on the chest.

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answers a number of questions, though at times I know that I probably evoked even more. I look forward to continued involvement in AAEM/RSA over the next year and working with many of you to further our mission and evaluate the pressing questions that will shape our careers and impact our lives. Please send comments or suggestions to info@aaemrsa.org and make a difference in our specialty and in our profession by getting involved!

1. Hirsch, Stacey. "GM plant a sign of decline: as the carmaker's fortune dip, this week's closing in Baltimore sparks deep concern among workers." Baltimore Sun 9 May.2005, natl. ed. : A1+.
2. Blumenthal, David. "Employer-Sponsored Health Insurance in the United States — Origins and Implications." N Engl J Med. 2006 Jul 6;355(1):82-8.

3. Center for Financing, Access, and Cost Trends, Agency for Healthcare Research and Quality. MEPS HC-064: 2003 P7R3/P8R1 Population Characteristics. Website: <http://www.meps.ahrq.gov/>
4. Center for Financing, Access, and Cost Trends, Agency for Healthcare Research and Quality. Health Insurance Component Analytical Tool (MEPSnet/IC) {online database}. Website: http://www.meps.ahrq.gov/mepsweb/data_stats/MEPSnetIC.jsp. Accessed Aug. 4, 2004.
5. Cascio, Wayne F. Managing Human Resources: Productivity, Quality of Work Life, Profits. New York: McGraw-Hill Higher Education, 2003.



Emergency Medicine Clerkships

STUDENT PRESIDENT'S MESSAGE

Greg Casey
AAEM/RSA Medical Student Council President



The unique milieu of the waiting room and steady stream of patients arriving via ambulance makes for a hectic and intense learning opportunity for rotating medical students. During clinical shifts, you will need to recall information gleaned from any and all of the following specialties: internal medicine, surgery, psychiatry, obstetrics and gynecology. To further test your medical and interpersonal skills,

you will see patients from all socioeconomic classes, ages, genders and race, all while being interrupted by traumas, codes and other thrills. The breadth of medical knowledge needed and the independence many departments give students are two reasons why many medical schools and emergency departments reserve clerkships for fourth year students.

Working in the emergency department will be different from all of your previous rotations. Often, you will be given more responsibility and will interact directly with your attending. Before you start rotating, do some investigative work. Find out which attending physicians have a reputation for being "good teachers," and try to schedule your shifts with them. Make sure that your presentations are precise and thorough. If your attending is not too busy, show interest by asking questions and volunteering to do any and all procedures. Each patient encounter is rich with teachable moments, and usually your clerkship director and the teaching faculty are more than willing to share their expertise with you.

Some residency programs also have a block during which senior level residents are scheduled to be in the department solely for teaching medical students. This is a phenomenal opportunity, and you should take advantage of it! In addition to asking them questions about your patients and working on your presentation skills, ask them questions about the residency program and the application process. Maximizing your experience during your initial rotation will prepare you for success during your other "audition" rotations.

If you are reading this, there is a good chance you're applying for residency in emergency medicine. Make a good impression on all of your emergency medicine rotations by showing up early, staying late and working hard during your shifts. Make friends with the nursing staff early, and they will be great allies! They have often worked in the department for years and can help you with anything from getting supplies and preparing for procedures to making a diagnosis!

Emergency medicine clerkships are unique due to their timing in medical school as well as when they occur in the application process. You will likely rotate early in your fourth year with many other students seeking spots in emergency medicine residencies. Do not worry about other students; stay focused on maximizing your educational experience. Competition is inevitable, but effort is not. Work hard, but also ensure that you enjoy the environment of the emergency department before applying! Good luck and have fun!

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AAEM Young Physicians Section

Are You Ready?

Michael L. Epter, DO FAAEM
President, Young Physicians Section

Are you ready? These three words can conjure up a vast spectrum of emotions ranging from fear and apprehension (think about your first single coverage night shift in the emergency department (ED) after residency) to excitement and inspiration (think of landing your destination job). The Young Physicians Section (YPS) of the Academy was founded in 2006, under the leadership of David Vega, MD FAAEM, to do everything possible to have you answer that emotion-laden three word question with a resounding "Yes." Entering into its third year, YPS continues to grow in membership and importance within the organization due to the unique set of issues that graduating residents and physicians in the early years of practice face. To this end, the Section has developed three major member benefits: the *Rules of the Road for Young Emergency Physicians* book, curriculum vitae review and virtual mentoring program.

The Rules of the Road for Young Emergency Physicians is an invaluable reference which includes information on professional development (e.g., career paths), personal development (e.g., financial planning, loans, investments, wellness) and the ever changing challenges we face in the ED on a daily basis (e.g., difficult consultants, patient satisfaction, overcrowding).

The CV and cover letter review offers members a rare (and free!) opportunity to ensure that you are "showing off your credentials" as you enter or re-enter the job market in order to give yourself the best chance of securing that coveted job. You only get one chance to make a first, and right, impression and this invaluable service will be a great step to making sure that you do just that.

The virtual mentoring program is an exciting opportunity to interact with your peers in perhaps the most critical period of all – post residency. In addition to clinical work, young physicians are faced with continual questions concerning job opportunities (e.g., academic versus community based practice, group versus hospital employee, geographic practice areas), advancement, contracts and successful board passage, as well as the stressors of practicing in a high-

paced field. Imagine having access to an experienced, knowing voice that has already successfully traveled the same path you are currently embarking on. The value of having a mentor during these early years cannot be understated. YPS mentors are from different regions of the US and include those actively involved in community practice as well as academic emergency medicine, so you can find the right match for your situation.

In addition to the aforementioned, YPS members often publish articles in *Common Sense*. And, at the Scientific Assembly in Phoenix, the Section celebrated its first annual lecture by Jesse Pines, MD FAAEM, "ED Overcrowding: Causes, Consequences and Solutions."

As the newly appointed president of YPS, I am personally 110% committed to making the Section grow, flourish and provide meaningful resources. This same vision was started by David Vega, MD FAAEM, continued with this past year's president, Marc Haber, MD FAAEM, and shared by the newly elected leadership (vice president - Brian Potts, MD FAAEM; secretary-treasurer - Damon Dietrich, MD FAAEM; board of directors - Kate Getzewich, MD FAAEM; Elizabeth Hall, MD FAAEM; Michael Pulia, MD, and Warren Wiechmann, MD).

As a YPS member, you will have the chance to be a part of an exciting time in the Section's history. Not only will you enjoy the benefits of membership we've talked about here, but you will also have the opportunity to participate in the development and maturation of how the Section unfolds. You are unlikely to find a group that will be more receptive and responsive to both your needs and suggestions. We are on a path toward becoming one of the premiere and valued sections within AAEM and know that we'll get there faster by encouraging and valuing the feedback of every YPS member while helping them grow into the best physicians they can be.

Accept nothing but the best, as do we, from yourself and our Section. I invite you to become a member of YPS...Are you ready?

Please email info@ypsaaem.org for more information.

Attention YPS and Graduating Resident Members

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