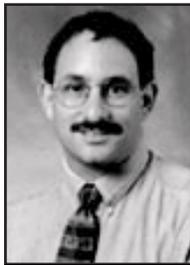




SENSE

THE NEWSLETTER OF THE AMERICAN ACADEMY OF EMERGENCY MEDICINE

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PRESIDENT'S MESSAGE

Howard Blumstein, MD FAAEM

Usually the "President's Message" contains a discussion of political events within the world of emergency medicine, or seeks to explain why some issue is important to our core mission or tries to fire up members to accomplish some goal. But much of my email traffic in the last few weeks has focused my attention on the activities of one of our committees. I would like to share its accomplishments with the rest of our membership.

The Clinical Practice Committee has been around in various incarnations for quite a while. I think the history I am about to relate is reasonably accurate. Its origins came as a taskforce appointed by a former president to address a specific, controversial issue. The committee was to review the literature, provide a brief overview and come up with a statement.

The big issue at the time was the use of tPA for strokes. The NINDS study had been published and some prominent physicians were making bold statements about its use. Others, however, urged caution and restraint, pointing out potential flaws in the single study that showed benefit, the small size of that benefit and the high risks. Some AAEM members told us they felt caught in the middle, trapped between arguing giants. Worse, they felt in legal jeopardy. They feared legal action if they decided not to give tPA. They also feared legal action if there was a bad outcome after giving it.

The resulting statement about tPA wasn't groundbreaking. If I recall correctly, it concluded that there was insufficient evidence to make a definitive statement about tPA and made the usual call for more study. But it did say this: tPA should not be considered the standard of care for the treatment of stroke. The reaction was immediate. Several prominent emergency physicians who were "experts" in neurological emergencies criticized the Academy. One informed the board of directors that we had set the field of EM back twenty years. But the response from the membership was more positive. Members told us that they appreciated the legal "cover" that the statement provided. They felt they were freer to make proper decisions about patient care without the spectre of plaintiff's attorneys hovering over them. We have heard from members and non-members who were able to use this statement to defend themselves in legal actions. That's the sort of positive feedback I love!

There have been a few other taskforces since then. Eventually, a standing committee was formed to continue the work of these taskforces, but it began to meet barriers.

Within medicine as a whole, guidelines were receiving more and more attention. Professional societies began pumping them out like crazy. Guidelines and critical pathways multiplied exponentially. Some were very high quality and represented the outcome of hard work and dedication. Others, well, not so much. Some became as much a political statement as medical document, with authors trying to argue some point (often self serving) under the guise of being a scientific document or expert consensus. Guidelines grew even longer, unwieldy and difficult for the working clinician to use. Guidelines from different sources made conflicting recommendations. Guidelines grew outdated yet weren't updated. Publishing requirements for guidelines, well intentioned and informed by the growing evidence based medicine movement, added to the complexity of the task.

About a year ago, AAEM decided to take a radical change of direction. Seeking to make our clinical statements more member-friendly, we asked the Clinical Practice Committee to change its focus away from broad topics. Instead, the committee was asked to look at focused topics. It was asked to make brief and easily understood statements and to address topics that members might find confusing or controversial. In short, the committee was charged with helping AAEM become a "go to" source of clinical information for the working emergency doc.

The result is now ready. By the time this issue of *Common Sense* is published, the AAEM website should feature several Clinical Practice Guidelines and Statements about a variety of issues (I am looking at the prototype as I write this).

Steve Rosenbaum and his committee have done a great job in developing these statements. They will include key references for those who wish to learn more about a given topic. I am looking forward to hearing feedback from our members about these guidelines as well as suggestions for future topics.

I am excited to be able to offer this service to our members and our colleagues in EM. As we grow, I look forward to making AAEM an ever more valuable clinical resource for the world of emergency medicine.

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Editor's Letter

David D. Vega, MD FAAEM

“Are You My Doctor?”

The American Association of Colleges of Nursing requires that all nurse practitioner degrees be offered only at the doctorate level by 2015.¹ The American Association of Nurse Anesthetists similarly supports requiring a doctorate degree for entry into nurse anesthesia practice by 2025.² This trend towards increasing doctorate-level education is not unique to nursing. It is available in many allied health professions that we deal with every day in the emergency department, including pharmacy, physical therapy, respiratory therapy and others.

The Doctor of Nursing Practice (DNP) movement, in particular, has seen great growth recently. The number of students enrolled in DNP programs increased from 3,415 in 2008 to 5,165 in 2009. There are currently 120 DNP programs in the United States, available in 36 states and the District of Columbia. Florida, Minnesota, New York, Pennsylvania and Texas rank among the states with the most DNP programs. An additional 161 DNP programs are being developed.³

Certainly, the availability of advanced education in any field is a good thing. However, there are a number of inconsistencies in the quality of education that is required to obtain these advanced degrees. The DNP degree is offered in a variety of formats to nurses with varying degrees of clinical experience. New graduates of a bachelor degree program in nursing can even pursue the DNP degree in a completely online program. The University of Massachusetts advertises “The Doctor of Nursing Practice program is a fully online degree program with an optional face-to-face orientation. Other arrangements can be made if you are unable to travel to the face-to-face orientation.”⁴ This is particularly interesting considering that the DNP degree is intended to focus on the clinical aspects of nursing (as opposed to research or teaching), unlike the Doctor of Philosophy (PhD) and Doctor in Nursing Science degrees.

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

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

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*Associate Member: \$250

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

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From the States . . .

California Reaches Settlement over 'Balance Billing'

Kathleen Ream
Director of Government Affairs

On May 24, California's Department of Managed Health Care (DMHC) reached a settlement with Prime Healthcare Services over the hospital system's practice of "balance billing." Under the settlement, Prime Healthcare will audit its billing records from the last six years and provide refunds with interest to patients who paid balance bills. They will also donate \$1.2 million to six community clinics in California. Cindy Ehnes, director of DMHC, said it is unclear how many patients will receive reimbursements or how much Prime Healthcare will need to pay. She said state regulators would pressure the hospital system to deliver the refunds as soon as possible.

Florida Sovereign Immunity Bill Dies in Committee

Legislation that would have limited the liability of doctors, nurses and EMS personnel for ED errors – even in cases of gross negligence – died in the Florida Senate Committee on Banking and Insurance on April 30. The Florida Medical Association and the Florida Hospital Association backed the bill.

SB 1474, sponsored by Senator John Thrasher (R), would have extended what is known as "sovereign immunity" to hospital EDs – giving emergency health care providers the same protection from liability lawsuits as public employees and institutions. The bill would have capped damages from lawsuit awards at \$200,000 per incident, with the state government – not the doctors involved – defending malpractice cases arising from the state's 205 EDs. If juries gave an award in excess of the \$200,000 cap, the state would have assumed the liability. In those cases, however, since the state has sovereign immunity from such lawsuits, plaintiffs would have had to file a so-called "claims bill" in the legislature to get the money.

Florida lawmakers have proposed similar measures extending sovereign immunity to EDs the past three years. Support for and opposition to SB 1474 is not divided along party lines. In agreement with Thrasher's position that the threat of lawsuits is a driving factor behind the shortage of doctors willing to staff EDs, Senator Eleanor Sobel (D) supported the bill. On the other hand, Senator Dennis Jones (R) joined Senate Minority Leader Al Lawson (D) in opposition.

The state's public hospitals already have sovereign immunity protections in lawsuits. After a debate about medical malpractice in 2003, the legislature passed a law that includes some liability protections for ED doctors (e.g., limits on non-economic damages compensating victims for pain and suffering of \$150,000 or \$300,000, depending on the circumstances). However, in extending the sovereign-immunity limits to EDs at all hospitals that provide emergency care and to all ED workers, SB 1474 goes much further. Debra Henley, a lobbyist for the Florida Justice Association, a trial lawyers group, said, "The scope of this bill is massive." Citing a similar view, Lawson called the measure "just too broad."

District Court Allows EMTALA Screening Claim of Excessive Delay in Treatment

On February 5, 2010, the U.S. District Court for the Eastern District of Pennsylvania held that a patient's screening claim under EMTALA could proceed based on the alleged lengthy delay between the time the patient arrived in the ED with chest pains, and the time

he allegedly was examined by a doctor and treated for those chest pains (*Byrne v. Cleveland Clinic, E.D. Pa., No. 09-889, 2/5/10*).

The Facts

William Byrne arrived at the Chester County Hospital (CCH) ED – an affiliate of Cleveland Clinic – at 5:00 p.m. on February 15, 2007, complaining to the ED staff of severe chest pain and shortness of breath. Approximately 20 minutes after his arrival, blood was drawn from Byrne and an EKG was ordered. About 30 minutes later, a chest x-ray was performed. During this period, no physician was in attendance, no oxygen was provided, nor were "clot busting" drugs administered, nor was his heart monitored. Byrne alleges that it took two hours after his arrival for an ED physician to attend to him and to provide Byrne with a choice between a "clot busting" drug or a stent, the latter which was recommended by the physician.

A catheterization procedure was performed on Byrne, and he came out of this procedure at approximately 11:30 p.m. The court record indicated that it was "unclear what the catheterization procedure entailed, and who performed the procedure." Byrne claimed that, owing to the delay in receiving treatment, his heart was damaged and he suffered mental duress.

Byrne filed suit against CCH and Cleveland Clinic maintaining that the ED's delay in treating him was a violation of EMTALA's screening and stabilization provisions. He also alleged that CCH breached an implied contract, under Pennsylvania law, to treat him within 90 minutes of his arrival at the ED. Defendants moved to dismiss the complaints.

The Ruling

The federal court denied the defendants' motion to dismiss Byrne's EMTALA screening claim. The court wrote that "the jury could rationally conclude, absent any explanation or mitigating circumstances, that the Hospital's inaction here amounted to a deliberate denial of screening . . . Similar reasoning has been applied by other courts in cases where plaintiffs alleged that lengthy emergency room delays gave rise to an EMTALA screening claim."

The defendants pointed out that CCH's obligation under EMTALA's screening position was satisfied via the various tests and a catheterization procedure that eventually were performed on Byrne. The court responded noting that the provision of "some testing or treatment to a patient [does not] *a priori* satisfy a hospital's statutory obligation to appropriately screen . . . Based on the case law, as well as common sense, chest pains certainly may constitute an 'immediate and acute threat to life'."

Under the pleading standard for an EMTALA screening claim, claimant "need only allege that . . . a hospital's emergency room failed to screen the plaintiff or did not apply the same standard of screening to the plaintiff that it applies to other patients." The court held that while Byrne's allegations are liberally construed, as he represented himself in this case without benefit of an attorney, the claims reflect that CCH "failed to provide him with an 'appropriate' screening examination, as shown by the alleged lengthy delay between the time Mr. Byrne arrived in the emergency room with chest pains, and the time he allegedly was eventually examined by a doctor and treated for those chest pains."

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The court added that the decision should not be construed “to suggest that an EMTALA screening claim can arise from every delay that occurs after a patient arrives in a hospital emergency room... At this juncture in the life of this case, it is not clear whether Mr. Byrne’s EMTALA screening claim will survive the summary judgment stage (should a defendant choose to pursue such a motion after discovery), but the allegations . . . are at least minimally sufficient to survive a motion to dismiss.”

The motion was granted for the defendants to dismiss the plaintiff’s EMTALA stabilization claim, “[C]aselaw makes it clear,” wrote the court, “that EMTALA mandates stabilization only in the event of a transfer or discharge, and does not obligate hospitals to provide stabilization treatment for patients who are not transferred or discharged.” Since Byrne was not transferred or discharged from CCH prior to receiving a catheterization procedure and being stabilized,

the court determined that Byrne could not bring a stabilization claim under EMTALA. “[A]lthough a hospital’s egregious delay in providing screening may provide the basis for an EMTALA screening claim, it does not provide a basis for an EMTALA stabilization claim.”

The court also granted the defendants’ motion to dismiss Byrne’s state law breach of implied contract claim. Under Pennsylvania law, the court concluded that “Mr. Byrne cannot proceed with a claim for breach of implied contract on the facts alleged, where his contract claim is based on an alleged delay in treatment, and not the treatment or specific result itself.” That is, a breach of contract claim against a health care provider only is permitted when the parties have contracted for a specific result.

To read the decision, go to: <http://www.paed.uscourts.gov/documents/opinions/10D0137P.pdf>

Editor’s Letter - continued from page 2

In some specialties, such as family medicine, patients have some degree of freedom in choosing which provider they will see. In emergency departments, however, patients have less freedom in this regard. They select only the location, and then a caregiver is assigned to them. When a caregiver introduces themselves as a “doctor”, most patients assume they are being cared for by a physician. One can envision a point in the future where emergency department patients will be cared for by a multitude of doctors simultaneously: attending physician, doctor of nursing practice, doctor of respiratory therapy, doctor of social work, et cetera. This certainly could cause confusion for patients in figuring out who is in charge of their care. Opinions may vary among all of these doctors, adding to a patient’s confusion: “One doctor told me this, but another said something different. Who should I listen to?” Patients deserve to have a good understanding of the qualifications of anyone providing a medical opinion.

The point of this article is not to imply that everyone with a doctorate wants to give the impression that he or she is a physician. However, the confusion that this creates for some patients is real. Anyone who has masters-level nurse practitioners in their department can attest to the confusion that already exists among some patients about their caregiver’s credentials. In a 2009 blog, an editor of the journal “Advance for Nurse Practitioners” reported that a pending survey at the time showed 33% of NP’s would use the title ‘doctor’ if they had a doctoral degree.⁵ This suggests that this issue is going to become much more prominent over the next few years.

Nothing in this column should be construed as minimizing the value of nurse practitioners and other providers with advanced degrees. In fact, nurse practitioners fulfill an important role in helping to provide care where physician shortages exist. In an ideal world, every emergency department would be staffed with board-certified emergency physicians. Currently, however, there just are not enough of us to meet the existing need. When used appropriately in the ED, nurse practitioners can provide much needed coverage in busy emergency departments unable to provide adequate physician coverage. Patients, though, deserve to know the qualifications of the persons providing their treatment. In the clinical environment, patients usually equate “doctor” with “physician”. Providers describing themselves as a doctor must ensure that their credentials are correctly represented.

(Endnotes)

- 1 “Frequently Asked Questions, Position Statement on the Practice Doctorate in Nursing.” American Association of Colleges of Nursing Website. American Association of Colleges of Nursing, March 2010. Accessed July 28, 2010. <<http://www.aacn.nche.edu/DNP/dnpfaq.htm>>.
- 2 “AANA Announces Support of Doctorate for Entry into Nurse Anesthesia Practice by 2025.” American Association of Nurse Anesthetists Website. American Association of Nurse Anesthetists, September 20, 2007. Accessed July 28, 2010. <<http://www.aana.com/news.aspx?id=9678>>.
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CONGRATULATIONS to

Mark T. Steele, MD FAAEM

who has assumed the office of
President of the
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(ABEM).

Recognition Given to Foundation Donors

Levels of recognition to those who donate to the AAEM Foundation have been established. The information below includes a list of the different levels of contributions. The Foundation would like to thank the individuals below that contributed from 1/1/2010 to 7/30/2010.

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AAEM State and Regional Chapter Development - Importance of State Chapters

Andy Mayer, MD FAAEM
AAEM Board of Directors

Members of state chapters have an advocate at state and local levels that can rapidly respond to member issues and concerns. These issues can develop quickly, particularly when a state's legislature is in session. Our state chapters have been instrumental in defeating proposed legislation that is not in the best interests of emergency medicine patients and providers. State chapters have also successfully lobbied for emergency medicine before state medical boards. In addition, state chapters allow social and professional connections to blossom that can have a very positive impact on the practice of emergency medicine in a particular region. Too often, emergency physicians can be isolated from other professionals in their own area. A chapter allows for local interactions to discuss issues that are important to members at more than just a national level.

Issues Confronting Individual States

Every state has a unique set of issues and challenges. Some issues are best confronted by AAEM as a concerted national effort. Other issues are best fought at the state level. The current challenge to the status and meaning of board certification as it relates to ABPS is a perfect example. AAEM's national leaders are eager to help, but it is also essential for members to contact their state representatives, senators and state medical board. Having a state chapter president or officer testify in front of a legislative committee or state medical board can make the difference between a positive or negative outcome. It is amazing how much power a small group can have just by showing up and expressing interest.

Other issues of importance at the state level include malpractice reform, balanced billing and much more. Almost every state has an issue that can directly and significantly affect your practice that can only be addressed within your state. Your voice will be much louder if you are able to call your representative and present yourself as a representative of your state chapter rather than as a lone voice. Your elected officials care about numbers, and if you can tell them you represent a large group of doctors they will be more receptive to your cause.

Forming a State Chapter

AAEM has a mechanism by which a group of emergency physicians can form a state or regional chapter with a minimum of headache. The process entails, at a minimum, a small group of dedicated individuals. Often, an issue crops up within a state that initiates the call to form a state chapter. Usually, one or a handful of individuals take the lead and get the ball rolling. Nothing works better than an issue that threatens our specialty in a state. In Louisiana, it was a court decision in a malpractice case. A lower court had created a tort of "intentional dumping" which was not limited by malpractice caps or covered by malpractice insurance. Larry Weiss, AAEM's immediate past president, arranged for one hundred physicians wearing white coats to attend the Louisiana Supreme Court hearing concerning this case. The response of the judges was of amazement and concern

that doctors could actually work together in a political forum. They overturned the ruling and protected the state's malpractice cap. This quickly led to the formation of a state chapter. Act while the iron is hot. It is much easier to motivate people when they are passionate about an issue.

The first step is to call AAEM headquarters and ask for a toolkit. AAEM has created this kit which contains sample bylaws and other needed documents. Once you review the toolkit, a meeting needs to be called. This is best accomplished as an in person meeting but video conferencing and email is also useful. At this meeting, key individuals need to be identified to serve on the initial board of directors. AAEM can help along the way at any time with advice and assistance.

One of the first questions to be answered is whether or not your state has enough members to form a chapter. Some states would probably be better served with a regional chapter. There are advantages to having a single state chapter but there does need to be a critical mass of emergency physicians to make it work. Currently there are discussions about forming a "Carolina" chapter in progress and members from a few southern states are considering a regional chapter for their area.

Organization and Management

A state chapter must have its bylaws approved by the AAEM board of directors, but they are run as separate entities from national AAEM. In fact, one does not need to be a member of AAEM to join a state chapter. AAEM can help manage a state chapter if the chapter so chooses. AAEM can send out dues notices and help with financial record keeping and web pages. The staff at national headquarters is very helpful and makes the nuts and bolts of running a chapter much easier. Alternatively, a chapter can be managed independently of national AAEM.

Each chapter has a board of directors with elected officers. A chapter's activities can take on many facets. Some chapters' main activity is in political activism. Some focus on educational meetings in their respective states. One chapter holds a daylong meeting each year with national and local speakers that allow an opportunity for emergency physicians from across the state to meet and socialize in a relaxed setting. This proves to be a unique mechanism to compare notes in regards to issues facing emergency medicine within the state. There can also be state chapter websites, blogs, newsletters or whatever you decide to make of it.

The Next Step

Where do you go from here? Please consider calling AAEM at 800-884-2236 to request a toolkit. You can also contact me, Andy Mayer at andrewmayer@cox.net. I am the chair of the State Chapter Committee and would be glad to discuss the formation process with you and discuss your questions and concerns regarding this process.



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FEBRUARY 28–MARCH 2, 2011

View from the Fishbowl

Joel M. Schofer, MD, RDMS
Member, AAEM Board of Directors
Lieutenant Commander, Medical Corps, US Navy
Emergency Ultrasound Director, Emergency Department
Naval Medical Center Portsmouth, Portsmouth, Virginia

One of my first duties as a new member of the AAEM Board of Directors is to contribute an article to *Common Sense* introducing myself and talking about what I'd like to achieve during my tenure on the board. I like to write, and one thing that I've always felt AAEM's newsletter needed was a regularly featured column. We need somewhere to laugh about our common experiences and lament over our shared trials and tribulations...

Who am I? What do I bring to the AAEM board?

I'm a white cloud. Always have been. If you get sick, come in on my shift. You'll be fine. Whatever is wrong with you will be relatively straightforward and we'll get it taken care of. I'm not saying you'll be able to go home. You might need admission, but your stay in the ED won't get too crazy.

Some of you are the opposite, the dubious "black cloud". It has always been amusing to me that almost every emergency physician I've known can characterize themselves as one of these polar opposites. You're either a white cloud and blessed by the emergency medicine gods, or you are a black cloud cursed by those same gods, having a lot of fun and doing a lot of procedures at their expense.

One of my friends is the polar opposite of me. He is most definitely a black cloud.

My patients go to CT scan and return just fine, if not better than they were when they left. His patients code in radiology.

My patients with septic shock get a nice, calm, controlled intubation. His require cricothyrotomies.

My pregnant patients with chest pain have pulmonary emboli. His have aortic dissection with pericardial tamponade necessitating a thoracotomy in the obstetrics suite with nothing but a scalpel and gloved hands. Apparently they don't have rib spreaders in OB. I wouldn't know, though. I don't need rib spreaders.

Being a white cloud was good for my sleep schedule during residency, but bad for my training. I did my residency in a Navy hospital, Naval Medical Center San Diego, and during my year as chief resident I spent six months in the Navy emergency department. Navy emergency departments tend to be pretty tame places, but I didn't have a single central line, intubation or code during the entire six months. None. And it wasn't like I was giving them away. I just didn't have any. Such is the life of a white cloud.

Recently the power of my white cloud was put to a test. The Navy decided to send me to a three-week course called the Navy Trauma Training Center. Essentially, you go to USC Medical Center in Los Angeles County, and spend time in their ED and on their trauma service getting ready to treat combat injuries. I guess in the eyes of the military, Los Angeles is officially a war zone.

I listen to Mel Herbert's EM-RAP like everyone else and hear stories of C-Booth, the old USC hospital's resuscitation area, and the seemingly endless stream of gunshot wounds, stabbings and thoracotomies. Got Resuscitation? Well the Navy hospitals might not, but USC certainly does. I figured USC would be the ultimate test of my white cloud, and luckily for me my first night of trauma call

was on a Friday night in LA. Twenty-four hours of trauma call over a Friday night. If anything was going to bring a storm front to my white cloud, a Friday night trauma call at USC was it...

Well, there were no traumas all day. But that was during the day. We all know the real action won't start until Friday night.

It wasn't that long ago that I was a resident. Four years to be exact. "Sleep when you can" was the motto, I seem to remember. I guess I'll go to sleep.

I woke up, checking my pager to see if I had missed a trauma activation. Did I have it on vibrate by accident? Nothing. Hmmm...

Later I woke up again. Still nothing? I wonder if this thing is working? Could they have given me a pager that doesn't get reception in the hospital? My cell phone certainly doesn't work in here. Maybe my pager doesn't either. A quick stroll to the ED and I'll be able to figure this out.

"Have there been any trauma team activations tonight?" I ask the ED clerk.

"No. None yet."

All right. Back to bed, I guess. Sleep when you can.

One final middle of the night pager check...I always have pager anxiety when I'm on call. I feel like I have to wake up and check it. Like I must have missed something and certainly shouldn't be getting as much sleep as I seem to be getting. (This is probably a bigger motivator for my selecting emergency medicine than I realize.)

Nothing on the pager.

After three or four total wakeup pager anxiety checks, it was 0700, or 7:00 AM for you civilians. Time to brush my teeth and go to morning trauma rounds.

"Were there any traumas overnight?" I ask the team of residents, anticipating a "Yeah...where were you?" retort.

"No. None."

Apparently the famed USC-Los Angeles County trauma center and its catchment area of 9,000,000 people on a Friday night had met its match...my white cloud.

In fact, as I type this, I am 17 hours into my second USC-LAC trauma call. And I'm still waiting for my first trauma activation, wondering if my pager actually works.

(Contact Dr. Schofer with any comments at jschofer@gmail.com. Just don't page him. His pager might not work.)

**The views expressed in this article are those of the author(s) 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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Upcoming AAEM–Sponsored and Recommended Conferences for 2010-2011

AAEM is featuring the following upcoming 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

September 22-23, 2010

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

October 2-3, 2010

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

February 28–March 2, 2011

- 17th Annual Scientific Assembly
Orlando, FL
www.aaem.org

AAEM–Recommended Conferences

September 10-12, 2010

- The Difficult Airway Course-Emergency™
St. Louis, MO
www.theairwaysite.com

October 11-14, 2010

- EuSEM 2010 – 6th European Congress on Emergency Medicine
Stockholm, Sweden
www.eusem2010.org

October 22-24, 2010

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

October 26, 2010

- Update on Behavioral Emergencies
Chicago, IL
burtr@sinai.org

November 6, 2010

- Inflammatory Neuropathies: The Impact of Clinical Practice on Outcome
Valley Forge, PA
www.gbs-cidp.org

November 8-11, 2010

- 39th Annual Topics in Emergency Medicine
San Francisco, CA
www.cme.ucsf.edu

November 15-17, 2010

- The Heart Course-Emergency™
Las Vegas, NV
www.theheartcourse.com

November 19-21, 2010

- The Difficult Airway Course-Emergency™
Las Vegas, NV
www.theairwaysite.com

December 2-3, 2010

- Update on Behavioral Emergencies
Las Vegas, NV
burtr@sinai.org

December 3-6, 2010

- Critical Points in Emergency Medicine
Las Vegas, NV
www.criticalpoints.net

December 5-10, 2010

- Current Concepts in Emergency Care 31st Annual
Maui, HI
www.ieme.com

April 8-10, 2011

- The Difficult Airway Course-Emergency™
Las Vegas, NV
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May 13-15, 2011

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

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October 28-30, 2011

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November 18-20, 2011

- The Difficult Airway Course-Emergency™
Las Vegas, NV
www.theairwaysite.com

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

All sponsored, supported and recommended conferences and activities must be approved by AAEM's ACCME Subcommittee.

AAEM Signs Ten Year Working Agreement with Argentine Society

Larry D. Weiss, MD JD FAAEM

AAEM and the Sociedad Argentina de Emergencias (SAE) recently signed a ten year cooperative agreement. The formal signing of this agreement occurred at the opening ceremonies of the recent joint meeting of the SAE and the Third Inter American Emergency Medicine Congress (IAEMC) in Buenos Aires, Argentina, on May 19-21, 2010. This agreement concerns plans to jointly sponsor the biennial IAEMC meeting.

Also at the opening ceremonies, I presented AAEM Honorary International Memberships to several SAE officers: Edgardo Menendez, MD, Immediate Past President; Daniel Gonzalez, MD, President; Liliana Caceres, MD, Administrative Secretary; and Hugo Peralta, MD, Past President. Shortly thereafter, the AAEM Board of Directors also voted to extend the same honor to Matias Fosco, MD, SAE Vice President.

Remarkably, the Argentine Minister of Health attended the SAE-IAEMC opening ceremonies and announced the recognition of emergency medicine as a formal specialty in Argentina. Also, I directly spoke with representatives from several other South American countries who told me about the rapid development of emergency medicine in their countries. Like countries throughout the world, South American countries are currently experiencing an explosion of interest in emergency medicine.

The May meetings attracted more than 2,500 emergency physicians, nurses and paramedics. Most of the attendees came from around Argentina, with significant numbers from other South American countries, and approximately 100 attendees from North America. SAE conducted its meetings in Spanish. The IAEMC lectures, while delivered in English, had simultaneous Spanish translation.

SAE and AAEM agreed to jointly develop the curriculum under the direction of Aaron Hexdall, MD FAAEM. Aaron serves as medical director of the IAEMC meetings. Of course, AAEM's international ambassador, Joe Lex, MD FAAEM, gave several lectures at IAEMC, and helped coordinate the conference.

AAEM provided many speakers at the May meeting. We hope in future years to provide even greater numbers of speakers and registrants to IAEMC, the first international meeting designed for all emergency medicine providers in the western hemisphere. IAEMC serves as a unique opportunity for us to learn from colleagues throughout the Americas. I personally learned much about the various prehospital care models existing in South America. I also learned about a rotation at the Italian Hospital in Buenos Aires for emergency medicine residents who desire an intense Spanish language clinical rotation. Any of our resident members may receive more information about this rotation by contacting info@aaem.org.

The next IAEMC meeting, planned for spring 2012, will also occur in Buenos Aires. Thereafter, the meeting may move to other cities in Spanish speaking countries. Buenos Aires is truly one of the world's greatest cities. Rich in culture and historical significance, visitors to Buenos Aires can see the balcony used by Eva Peron to rouse the masses at the Casa Rosada presidential palace, walk across the Plaza de Mayo to visit the final resting place of "el Libertador" Jose de San Martin, walk the Avenida de Mayo past Spanish colonial architectural masterpieces, stop at the Café Tortoni and drink coffee at the table of Jorge Luis Borges, see tango in the streets in San Telmo, and peruse the endless parks and monuments of the city. We even visited Evita at her tomb in the Recoleta Cemetery.

For those so inclined, you can easily find some of the world's finest leathers. Beef is king in Argentina, but the city also has a large Italian population with fine Italian restaurants. Seafood is harder to find, but we did eat at a great Spanish restaurant with fine seafood.

Those interested in IAEMC and other international meetings in which AAEM actively participates, should consider joining our international committee. You can easily find more information about this committee on our website, or by inquiring at info@aaem.org. All of our members, especially those fluent in Spanish, should consider attending and even speaking at the next IAEMC meeting.



Larry D. Weiss, MD JD FAAEM, and Daniel Gonzalez, MD, sign ten year working agreement.

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AAEM Young Physicians Section

Mentors: Reach Out and Teach Someone

Jeff Pinnow, MD

As I ponder the final days of my emergency medicine residency, the gamut of emotions stream through my mind: pride in the fact that I survived, relief that the long hours and constant sleep deprivation is almost over, hope that I have learned what I needed to be a proficient emergency doctor, sadness in having to leave those who have taught me so much, and fear that I will soon be out on my own without the protective cocoon that was my residency training.

I can still recall the feelings I had prior to my first shift as an intern. I was finally a doctor, and I was sure that I knew how to care for my patients. I walked into that first shift confident, with my head held high. I left that next morning a beaten down shell of a doctor, having just watched a 22 year old, two week postpartum patient become unresponsive from a large subdural hematoma, just as I was patting myself on the back for getting my first LP. That was the first of many lessons I've learned throughout my residency, and I must admit that the thought of enduring more of these lessons on my own as an attending makes fear the strongest emotion I carry with me to my next destination.

I am not a big fan of change, as I'm sure is the case with many people. I have always found comfort in going to work as a resident because I knew no matter how difficult a patient was, I had a safety net. The attending physician had seen these cases before, knew the outcome of the case before I could even finish my presentation, and had all the answers to the questions I hadn't even thought of yet. I knew that everything would work out because I had my own personal Yoda who would impart their knowledge upon me so that I might save my ailing patients.

Knowing that the responsibility now falls upon my shoulders is something I do not take lightly. Will I have all the answers? Will I be able to solve every diagnostic challenge on my own? Do I have enough wisdom to teach others? These are the questions that feed my fear - that wake me up in the middle of the night in a cold sweat. They make me wish (almost) that I was an intern again.

I like to believe this is a healthy fear I carry with me, and hope many of you carry it internally, as well. It is the one thing that will keep us humble, force us to listen to every patient, order the tests that we feel are needed to reach a diagnosis, and will ultimately make us better physicians. I also feel this fear can be subdued if we continue to utilize those fellow colleagues or partners who have seen so much more than us new grads. As a new grad, we cannot be too proud or too naive to ask for help from our senior partners. I have been taught that medicine is an art, and as physicians we need constant mentoring to help us perfect it.

For this reason, I chose to join the Young Physicians Section of AAEM. All of the members are less than seven years from graduation, so they all can remember that sense of self doubt and fear that comes with becoming an attending. It is an instant social support group for new grads, with an exciting core bunch of young physicians who are more than willing to offer their wisdom and guidance to us. It is the reason YPS was formed - to help foster the careers of us new grads - and I encourage all younger AAEM members to take advantage of what YPS has to offer.

By the time this article goes to print, all of us, as former senior residents, will have moved on to our new jobs. I ask that you take the time to touch base with those attendings who made an impact on you - who made you the doctors you are today - to let them know how things are going, and thank them again for everything they've taught you. I also ask you to get involved in AAEM YPS and meet your next set of mentors; those who will help you settle into the career you've worked so hard to create.

Have an opinion about something you've read
in *Common Sense*?

Want to share your views on EM issues with thousands of
other AAEM members?

Send your thoughts to CSeditor@aaem.org and your comments may be published
in a future issue of *Common Sense*!

THE YOUNG PHYSICIANS SECTION (YPS)

VIRTUAL MENTORING PROGRAM

The Virtual Mentoring Program is an exciting opportunity to interact with your peers. YPS mentors are from different regions of the US and include those actively involved in community practice as well as academic emergency medicine. To learn more about becoming a mentor or being mentored, please visit www.ypsaaem.org or contact us at info@yps.org.



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Attention YPS and Graduating Resident Members

CV & Cover Letter Review

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The AAEM Young Physicians Section (YPS) is excited to offer a new curriculum vitae review service to YPS members and graduating residents.

The service is complimentary to all YPS members. If you are not a YPS member, visit us at www.ypsaaem.org to join and learn about the additional membership benefits.

For graduating residents, a \$25 Service Fee is required, which will be applied to your YPS dues if you join AAEM as an Associate or Full Voting Member. This offer is only valid for the year following your residency graduation.

For more information about YPS or the CV Review service, please visit us at www.ypsaaem.org or contact us at info@ypsaem.org.



Your Expertise is Needed

AAEM's board of directors announces the formation of a Practice Management working group.

AAEM members with experience in organizing or running democratic group practices are needed.

The purpose of the working group is to develop guidelines for, and assist in the formation of, democratic group practices.

100% ED Group

AAEM instituted group memberships to allow hospitals/groups to pay for the memberships of all their physicians. Each hospital/group that participates in this program receives a 10% discount on membership dues. 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 pay \$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, please contact our membership manager at info@aaem.org or (800) 884-2236.

Welcome to our Newest 100% ED Groups

Eastern Carolina Emergency Physicians (ECEP)

To view a complete list of all 100% ED Groups please visit www.aaem.org/membership/100_ed_programs.php

Welcome to our Newest 100% Residency Programs

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UNECOM - Kent Hospital
University of California - Irvine
Wake Forest University Baptist Medical Center
York Hospital**

To view a complete list of all 100% Residency Program please visit www.aaemrsa.org/membership/program-membership.php



RESIDENT PRESIDENT'S MESSAGE

Introductory Message

Ryan Shanahan, MD
AAEM/RSA President

Hello and welcome to a new academic year for the AAEM/RSA! I am honored to represent you as the president of the Resident and Student Association and am looking forward to a wonderful year.

At the start of every year there is, naturally, a reevaluation of priorities and a good deal of thinking that goes into focusing our efforts to be of maximum benefit to our members. I know that many of our members have benefited from our excellent board review book. Our "Toxicology Handbook" and "Rules of the Road for EM Residents" book have been handy resources for years. Our Scientific Assembly has always been well attended and the resident track remains a wonderful resource.

This organization could easily rest on its laurels and continue to provide these services with no loss of face. That said, it is better to implement changes from a position of strength. I believe that we can still do better by you. We are currently surveying members to determine your interest in Smartphone applications for the Written Board Review book and the next edition of the "Toxicology Handbook". We will be strengthening our mentorship program through the Young Physician Section (YPS) of AAEM to give graduating residents a leg up when searching for jobs and evaluating potential places to practice. Finally we will be looking to you, our membership, to let us know what you need and what would be useful to you.

Our profession is today facing some of the same challenges that it faced in its infancy. What does it mean to be an emergency physician? What kind of training is required? In most states these questions are being asked and the answers provided by some are not good for our profession and our patients. AAEM was founded on the idea that every emergency physician should be board certified and that board certification should now entail residency training. This is a basic principle that I believe every emergency medicine resident can agree with. This is an interesting time for our field and a great time to be involved with organized medicine. AAEM and the RSA are actively working to protect our profession from both these challenges to our credibility as an independent field and also from the challenge of organized corporate medicine threatening to disconnect the physician from his community.

I would encourage you to look a little harder at AAEM. I know that many residents are signed up by their programs and many students are attracted by the free trial membership. Some would claim that our organization is radical or a fringe group. I would encourage you to go to our website (www.aem.org) and take a look at AAEM's principles for yourself. You might find that you yourself are more "radical" than you think. Our ideals are likely yours as well and together we can work them to fruition. I welcome your comments at shanahan.ryan@gmail.com and look forward to a wonderful year working together.

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RESIDENT EDITOR'S LETTER

HD: The Doctors We Are Becoming

Leana S. Wen, MD MSc
AAEM/RSA Resident Editor



“Excuse me... um... how exactly do I order the Tylenol?”

I look up. In front of me is a young man wearing a pressed shirt and striped tie. “I’m Ben,” he says, introducing himself to me as an intern on his very first day of residency. It’s not really a statement that needed to be said; none of us would have mistaken him for anything but. How to order Tylenol is a seemingly self-explanatory action,

but last year it was me asking that question. As I lead him through the order entry system, I reflect on the past year. How have I grown in this notoriously grueling yet life-changing internship year? What advice would I impart to the new cohort about to impart on this same journey?

Clinically, I am stronger than I was a year ago. Clinical training in a supervised setting is indeed the purpose of residency and why tens of thousands of young people in the prime of our lives devote many long hours to our hospitals. Internship is all about becoming more comfortable with management of everything from routine urgent care presentations to medical resuscitation of very sick patients. Throughout the past year, I’ve seen my classmates and I progress from asking “What next?” to thinking through and acting on most treatment decisions ourselves. Part of that clinical development is knowing how much more there is to learn, and it remains daunting and inspiring to see that, as much knowledge and skills as we have gained, there is still a long way to go.

Professionally, I feel more comfortable in my role as clinician and resident physician. I remember on my first day of internship practicing my introduction in the mirror. “Hello, I’m Dr. Wen, your doctor,” didn’t seem quite right. Too curt, yet oddly redundant. “Hi, I’m Leana, your doctor.” Not right either. Too informal. “Nice to meet you, I’m Leana Wen, one of the doctors.” OK, but who are the other doctors? The struggle with something as basic as introducing myself is symbolic of my biggest challenge in intern year: feeling at home as a resident. My training occurs at two main hospitals and two other affiliated sites. Not only were there dozens of residents and attendings and literally hundreds of ED nurses to meet, each month was a different rotation with more new people and new ways of doing things. It took me until the end of intern year to feel at ease with my colleagues. Being part of AAEM/RSA has been instrumental for me to feel at home in my specialty. Now, not only do I know my 60 co-residents, I am connected with thousands of residents across the country.

Intellectually, this has been a year of alternating disappointment and growth. So much of medical school was about memorization and pattern recognition; I was afraid that residency would teach more of the same. I did not want to be an automaton who did nothing more than input data and run algorithms like a “Choose Your Own

Adventure” book. EM, perhaps more so than other fields, has the potential to turn into an algorithmic exercise. However, there are plenty in our field who believe that EM is far more than figuring out a disposition. As my mentor, Dr. Josh Kosowsky, likes to say, “EM is the modern home of diagnosis.” What other field presents so many diagnostic puzzles in any given day? Checklists have their place, but algorithms should never replace the art of healing. One of my most valuable lessons this year, one that has kept me intellectually challenged and emotionally engaged, is to make sure to hear each patient’s story as their narrative, not just as a chief complaint followed by yes/no answers.

Personally, one of the battles each of my classmates has struggled with is finding balance. Internship is pretty far from a “normal” life: it throws off anyone to work under fluorescent lights for six days a week, to eat nothing but hospital food for three meals a day, and to not see family and friends for a day and a half. Our days are so long that by the end of a shift, it’s often hard to find energy to do the things that used to make us happy. Yet, as busy and as tired as we get, we shouldn’t make residency just about working, sleeping and eating. I’ve watched each of our classmates emerge from survival mode to making time for the things that matter to us, from training for triathlons to watching sci-fi flicks to getting a scuba-diving certificate. As for me, I’m ballroom dancing and playing the piano again, and a much happier person for it.

Despite finding better personal balance, one of my classmates said during our end-of-the-year intern retreat that he wasn’t sure he liked the person he was becoming. This resonated with all of us. In intern year, each of us can recall instances when we’ve become more abrupt with family, short with sales clerks, perhaps impatient or even disdainful with patients. However, as difficult as our lives may be at times, as grueling as it may be to work night shift after night shift, we cannot lose track of our fundamental purpose of being healers and advocates for our patients. It’s a profound privilege that we have to take care of patients in the time of their greatest need. It’s a profound honor that families place care of their loved ones in our hands.

“That was an awesome day. Thanks for showing me around!”

I smile. It’s the end of Ben’s first shift. His hair, impeccably groomed ten hours ago, sticks out in the back and strands point towards the ceiling. His face bears the telltale imprints of mask and eyeshield. His blue tie is flecked with blood. (I feel sure that from now on, his attire will consist of scrubs.) I wonder what Ben’s reflections after intern year will be. I know that he, too, will develop clinically and grow into his professional role. I hope that he finds his intellectual pursuits rewarding and his personal balance satisfying. Above all, I hope he retains his humanism, his ideals for why he chose to enter this healing profession of medicine.



Resident Journal Review: July-August 2010

Trushar Naik, MD MBA; Michael Yee, MD; Christopher Doty, MD; Michael C. Bond, MD

This is a continuing column providing synopses of high-impact 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 important to the busy EM resident. Residents should read the articles themselves to draw their own conclusions. These papers were selected after a review of twenty-two of the most pertinent journals for emergency medicine. This edition will include articles published over a two month period, between March and April of 2010.

Does end tidal CO₂ monitoring during emergency department procedural sedation and analgesia with propofol decrease the incidence of hypoxic events? A Randomized Controlled Trial. Deitch K, Miner J, Chudnofsky CR, et al. *Ann Emerg Med.* Mar;55(3):258-264.

Procedural sedation is widely used in emergency departments to aid in the treatment of a wide range of conditions. Respiratory depression and hypoxic events are among the most common and potentially damaging adverse events related to this type of sedation. Recently, end tidal CO₂ monitoring has come into favor as an adjunctive method of monitoring for respiratory depression and hypoxia. The authors of this study sought to determine if end tidal CO₂ monitoring during procedural sedation would decrease the incidence of these dreaded complications.

This was a prospective, randomized controlled trial of adult emergency department (ED) patients who were selected for procedural sedation with propofol as determined by the treating physician. In total, 132 patients were randomized to have end tidal CO₂ (ETCO₂) readings available during procedural sedation or to have the procedure performed without physician access to the ETCO₂ monitor readings. All patients received 3 liters of supplemental O₂ via nasal cannula and end tidal CO₂ was monitored via a Capnostream 20 monitor with a nasal-oral cannula. Standard, weight based propofol protocols were employed. Respiratory depression was defined as ETCO₂ level of 50mmHg or greater, change in ETCO₂ greater than 10% from baseline, or loss of waveform for greater than 15 seconds. Hypoxia was defined as oxygen saturation level less than 93% for greater than 15 seconds.

Among the two groups, respiratory depression occurred at similar rates. However, hypoxia was significantly more common in the group without capnography readings (42% vs 25%, 95% CI 1.3-33% p=0.035). In the group with capnography, there were 13% more physician interventions to improve respiratory status (24 of 68 (35%) vs 14 of 64 (22%)); however, this did not reach statistical significance (95% CI -2 – 27). All patients who developed hypoxia first exhibited respiratory depression. Respiratory depression was 100% sensitive and 64% specific in predicting hypoxia.

In this study, the use of capnography decreased the rate of hypoxic events. Furthermore, the 100% sensitivity of respiratory depression (capnographically defined) in predicting hypoxia supports the routine use of these measurements to identify those patients at risk for developing hypoxia. It is important to note that the rate of hypoxia in this study (32.5%) was higher than reported in most other studies, providing a basis for a potentially greater treatment effect and limiting generalizability. Despite this fact, this study provides further support for the use of capnography as an adjunctive measure to prevent serious and common complications of procedural sedation.

Passive leg raising is predictive of fluid responsiveness in spontaneously breathing patients with severe sepsis or acute pancreatitis. Préau S, Saulnier F, Dewavrin F. *Crit Care Med.* 2010; 38(3):819-825.

Rapid infusion of crystalloid and colloid solution is often used to treat symptomatic hypovolemia. Many times it is difficult to assess if volume expansion will actually increase left ventricular stroke volume (SV). Cardiac preload assessment with indices such as central venous pressure does not always correlate with fluid responsiveness. The authors propose that maneuvers such as passive leg raising (PLR) can be used to mimic rapid volume expansion and increase SV if the heart is preload dependent.

This study included non-intubated patients with either sepsis or acute pancreatitis in a single French intensive care unit who were candidates for a fluid challenge based on the presence of at least one clinical sign of inadequate tissue perfusion (i.e. mottled skin, tachycardia, systolic arterial pressure (SAP) <90mmHG or urine output <0.5mg/kg/hr for at least one hour). Exclusion criteria were those in whom intravenous fluid was contraindicated, patients with high-grade aortic insufficiency, patients with poor transthoracic echocardiograms, or if they required non-invasive ventilation. All patients had arterial catheters. All patients had baseline measurements of HR, SAP, diastolic arterial pressure, mean arterial pressure, SV (via bedside transthoracic echocardiography), pulse pressure, and peak velocity of femoral artery flow while in a recumbent position. They then underwent PLR, with their lower limbs elevated 30-45° relative to their trunk and all measurements were retaken. The patient was then placed back in the baseline position for at least five minutes and given 500ml of hydroxyethyl starch over 30 minutes. All measurements were again retaken. Outcome measures were comparative changes in SV, pulse pressure, and femoral artery velocity between PLR and colloid infusion.

There were 34 patients enrolled in the study. Results showed a statistically significant increase in SV after PLR and colloid infusion. This correlated positively with changes in pulse pressure and femoral artery velocity as well. Fluid responsiveness was defined as an increase of ≥15% of the initial SV after colloid infusion. Fourteen (41%) patients were found to be responsive. If a patient had ≥10% increase in SV upon PLR, the sensitivity and specificity of the patient being fluid responsive are 86% and 90%, respectively. Similarly, a change in pulse pressure ≥9% or change in femoral arterial velocity ≥8% correlated with fluid responsiveness.

This study attempts to provide physicians a tool in evaluating fluid responsiveness in the hypotensive patient. Often, patients are given significant amounts of intravenous fluids to increase SV and blood pressure but to no avail. Limitations to this study include the small sample size, inclusion of only non-intubated patients, and

continued on page 22

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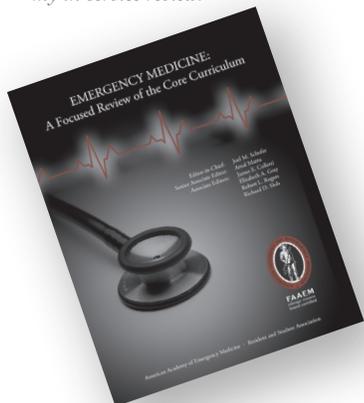
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Resident Journal Review - continued from page 20

an overall lack of blinding in those performing the echocardiogram and collecting the data. In addition, needing a skilled sonographer limits the applicability of these findings since one may not be able to determine the change in SV or femoral arterial flow after performing PLR. Monitoring the change in pulse pressure is the most sensible measure amongst the three. Despite these limitations, this paper provides insight on a novel and easy bedside test that can be done to guide the resuscitation of ED patients. Further work on how PLR affects other simple bedside hemodynamic parameters would increase the practical use of this maneuver.

Impact of time to antibiotics on survival in patients with severe sepsis or septic shock in whom early goal-directed therapy was initiated in the emergency department. Gaieski DF, Mikkelsen ME, Band RA, et al. *Crit Care Med.* Apr;38(4):1045-1053.

In 2008, the Surviving Sepsis Campaign recommended the administration of appropriate antimicrobials within one hour of recognition of severe sepsis or septic shock, primarily based on two recent retrospective studies showing poorer outcomes when appropriate antibiotic administration was delayed. Several recent studies have also tried to ascertain the specific time frame for initiation of antibiotics that would lead to improved outcomes. The authors of this study sought to examine the impact of time to antibiotic administration, at various time cutoffs, on survival in patients in whom early goal-directed therapy (EGDT) was initiated in the ED.

This was a retrospective cohort study of 261 patients treated with EGDT. Various data points were recorded including triage time to antibiotic administration (for both initial antibiotics and "appropriate" antibiotics), qualification for EGDT time to antibiotic administration, appropriateness of antibiotic selection, and in-hospital mortality.

In this study, no relationship was found between triage time to initial antibiotic administration and mortality nor from qualification of EGDT time to initial antibiotic administration. However, when considering appropriate antibiotic administration, mortality was significantly decreased when antibiotics were given within one hour of triage (19.5% vs 33.2%, p=0.02) or within 1 hour of qualification of EGDT (25% vs 38.5%, p=0.03) as compared to those receiving antibiotics after the one hour cut-off. Antibiotics were received within six hours of triage in 97.6% of patients.

This study provides further validation for the administration of antibiotics within one hour of arrival in patients with sepsis. Furthermore, according to this study, recommendations for early antibiotics (within one hour) should further stipulate that antibiotic administration must also be appropriate, based on established guidelines for specific etiologies of sepsis. Despite being a

retrospective study, with its inherent limitations, the use of ED EGDT protocols and administration of appropriate antibiotics within one hour were supported by these results.

Patients Education of a Self-Reduction Technique for Anterior Glenohumeral Dislocation of Shoulder. Dudkiewicz I, Arzi H, Salai M. *J Trauma.* Mar 2010; 68(3):620-623.

Anterior glenohumeral joint (shoulder) dislocation is the most commonly treated joint dislocation in the ED. After initial dislocation, subsequent shoulder dislocations are common due to ligamentous instability and laxity. Many patients can often recognize the signs and symptoms of shoulder dislocations and at times are able to reduce the dislocation by themselves. The majority seek medical assistance promptly, but for those with prolonged time of dislocation to reduction the risk for intra-articular damage and traction-neurovascular injuries increases. Numerous techniques have been described; however, the authors here describe a modified Milch technique in which patients can be taught to self-reduce a dislocated shoulder.

The study included 33 consecutive patients with recurrent shoulder dislocations. Each patient was examined to ensure no neurovascular compromise was present and had pre-reduction radiographs to confirm the diagnosis. The patients all started in the supine position and had the dislocated shoulder abducted and externally rotated until the overhead position of the arm was achieved. The patients could use the contralateral hand for support. When the overhead position is achieved, this alignment should allow the shoulder to be reduced. The arm is then gently lowered back to the side of the body while the contralateral hand is placed on the front of the reduced shoulder applying posterior pressure to prevent redislocation. Thirty-two of the 33 patients underwent successful reduction with a mean reduction time of 10 minutes (range: 6-17 minutes). No anesthesia, sedation, or intra-articular injections were used. Of the 33 initial patients, 25 were contacted after one year. Eleven patients had recurrent dislocations, eight used the modified-Milch technique for self-reduction, and seven were successful.

The authors of this paper show that an education session can teach patients how to self-reduce their shoulder dislocation. In addition to reducing the time of dislocation, more rapid pain relief, and reducing the risk of neurovascular injury, self-reduction may decrease the necessity of patients seeking emergency care for this condition. However, patients should also be taught how to recognize failed attempts and to avoid unnecessary delays in treatment. The authors promote that this technique should be used mainly when medical assistance is not readily available such as those in remote or rural locations.

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MEDICAL STUDENT COUNCIL PRESIDENT'S MESSAGE

Knowing Your Patients in a Busy Emergency Department

Brett Rosen

AAEM/RSA Medical Student Council President



Imagine one of those days in the emergency department when everything goes haywire – multiple traumas, 45 patients in the waiting room, half the patients in the ED waiting for beds upstairs, people demanding their sore throats, runny noses and bruised legs be seen immediately, and you have the entire hospital security force and half of the police department in the hospital accompanying patients or restraining them. This is why many of us go into emergency medicine – the adrenaline rush of controlling and coordinating chaos! As a medical student in the ED, we aren't quite at that level yet – we're happy to see patients, write notes, do some procedures here and there, and get a good sense of the variety that we will get to fully take care of at some point in our lives when we graduate from residency.

But there is one thing as medical students that we do get a chance to see a bit more of than we will in residency. With the extra time we are given to see our patients, we are able to explore a bit more of the human and personal sides of our patients. For students, it's not the number of patients we can see per hour, coding properly to ensure appropriate reimbursement, or managing the stream of ambulances coming from the outside. For us, we get to know our patients just a little bit better. When it's really busy and all of the patients are seen, go back to your patient's room and talk to them. Talk to their family. Find out what's concerning them. See if you can find out if

there is another reason that they're really there (another good way to impress your attending). The patient may be triaged or known as the frequent flier or the homeless guy on the corner, but I guarantee you something that I have learned even on other rotations and by spending just two extra minutes with each patient: every patient means something to somebody.

It gives you a different perspective on the human aspect of medicine, even in the busy ED. Take that two minutes and refer the person to a shelter or give them the name of a free clinic or a primary care doctor. You help the whole system this way and at the same time are advocating for your patient. Remember that the elderly gentleman you are taking care of might mean the world to his daughter. Remember that although the homeless man may not have any family that cares about him, he could have a best friend on the street that knows everything about his life. Remember that the prisoner could have a daughter at home who misses him. When you go to care for each patient, keep these things in mind and remember that every patient means something to somebody.

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