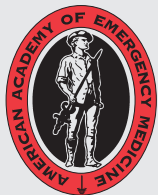


# common SENSE

VOLUME 16, ISSUE 2  
MARCH/APRIL 2009



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THE NEWSLETTER OF THE AMERICAN ACADEMY OF EMERGENCY MEDICINE



## PRESIDENT'S MESSAGE

### Our International Mission

Larry D. Weiss, MD JD FAAEM

Our Mission Statement now includes an important clause reflecting our commitment to international emergency medicine. It states "[t]he 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." On the one hand, our international activities may not directly relate to the clinical work of most AAEM members, but on the other hand, emergency physicians around the world face many of the same problems we continue to face in the United States. Our rapidly growing relationships with emergency physicians in other countries will accelerate the development of emergency medicine and vastly strengthen our specialty.

Thus far, our efforts in the international arena received much support from our membership and our colleagues abroad. The Mediterranean Emergency Medicine Congress (MEMC) jointly offered biennially by AAEM and the European Society for Emergency Medicine (EuSEM), attracts more registrants than any other international emergency medicine meeting. Barring unforeseen circumstances, we expect more than 1,500 registrants for the upcoming meeting in Valencia, Spain, in September. You may easily learn more about this meeting through a prominent link on the home page of the AAEM website [www.aaem.org](http://www.aaem.org).

In January 2009, we held the first Caribbean Emergency Medicine Congress (CEMC) at the Hilton resort near Bridgetown, Barbados. In an absolutely beautiful setting and near-perfect weather, we held a highly successful meeting widely attended by physicians from the CARICOM countries of Barbados, Jamaica, Trinidad and Tobago and the Bahamas. We had physicians from other Caribbean, Latin American and European countries. The event received daily attention in the national newspapers in Barbados, as well as a visit by the Minister of Health and interviews on national television. Joe Wood and other AAEM members held a satellite course on ultrasonography at the Queen Elizabeth Hospital in Bridgetown. This course sold out and had a waiting list.

We expected far more American physicians to attend CEMC, as a recent survey of our membership reflected a high level of interest in future meetings in the Caribbean. Disappointing attendance by our membership gave us reason to pause before planning any future CEMC meetings. Please let us know by emailing [info@aaem.org](mailto:info@aaem.org) of your interest in a future CEMC.

As emergency medicine rapidly expands throughout Europe, many other national societies request AAEM endorsement of their meetings. Please see our list of endorsed meetings in every issue of *Common Sense* and on our website. Many of these societies face challenges very similar to issues that we continue to face. For example, European anesthesiologists recently published a core curriculum for emergency medicine, claiming emergency medicine should exist as a subspecialty of anesthesiology. We still face similar problems in the US. We began working cooperatively with EuSEM by responding to this proposal by European anesthesiologists.

Certainly, every country has its unique social and political issues, but human nature being essentially similar around the world, AAEM expects international emergency physicians to face similar challenges to their practice rights and control of their practices by non-physicians. We stand ready to work cooperatively with our international colleagues to promote the development of emergency medicine around the world.

Of course, we have much to learn from our international colleagues. AAEM members have begun to join EuSEM and other international emergency medicine societies in greater numbers, and we have seen an increase in international members of AAEM. This trend can only strengthen our society.

While we will always focus our efforts on the education and clinical practice of emergency physicians in the US, we do not exist in isolation and will continue our efforts in the international arena in a manner entirely consistent with our Mission Statement. We will continue these efforts as long as our membership tells us they have a strong interest in these programs. I hope to see many of our members in Valencia in September.

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Job Bank

The American Academy of Emergency Medicine  
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 for his years of dedication to AAEM as  
*Common Sense* editor 2006–2009.



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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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# Big Challenges for Next CMS Administrator

Kathleen Ream, Director of Government Affairs

In light of the Obama Administration's plans for significant changes in the way Medicare, Medicaid and the State Children's Health Insurance Program (SCHIP) are run, the President's choice for administrator of the Centers for Medicare and Medicaid Services (CMS) will be facing major issues from day one. In addition to the task of implementing such changes, the new CMS administrator will play a role in the new Administration's push to overhaul the entire healthcare system. All the while, he or she will be responsible for the day-to-day operations of a massive agency with 4,400 employees, a \$676 billion annual budget and the duty to provide healthcare to 44.6 million people enrolled in Medicare, 51 million in Medicaid and 6.3 million in SCHIP.

In commenting on possible candidates for the position, several of the agency's former chiefs agreed that Obama will look for a candidate who has experience managing a large organization, knowledge of the healthcare system and good political relationships. Speculation has centered on a handful of Obama insiders, Clinton White House veterans and longtime Democratic healthcare experts. Among the names thought to be under consideration are: Obama transition team member and Center for American Progress senior fellow, Jeanne Lambrew; Avalere Health President, Dan Mendelson; Urban Institute scholar, Robert Berenson; Georgetown University Professor and failed congressional candidate, Judy Feder; and Emory University Professor, Ken Thorpe. But Nancy-Ann DeParle, who ran the agency during President Clinton's second term (when it was known as the Health Care Financing Administration), and Tom Scully, who was President Bush's first CMS administrator, both cautioned against putting too much stock into such speculation. Their names, they pointed out, were not on any public "short lists" before they were nominated.

Based on their experience, the former administrators had similar views about the position's importance and challenges. DeParle said, "The wonderful and terrifying thing about running CMS is that you never know what's lurking around the corner. There's just so many things that can go wrong." Good relationships with key people on

Capitol Hill are vital, she added. "You spend well over half your time working with Congress." Scully stated, "The challenges of running that place are unbelievable in a slow time. It's just a huge place." Gail Wilensky, who ran the agency during the George H.W. Bush Administration, said, "It's a terrific job because it marries policy and operations in a way almost no other position does." And, Mark McClellan, who succeeded Scully at CMS after heading the Food and Drug Administration for two years, said, "You need management skills and leadership skills...[and] experience in leading reform efforts" in the government or private sector.

The former officials also noted that one of the busiest areas of ongoing business – and difficult management challenges – will be devising the payment rates for physicians, hospitals, nursing homes and other medical providers that serve beneficiaries. Doctors, they said, present a particular challenge. Without congressional action, doctors' payments face a 20% cut in 2010, and CMS will have the task of helping Congress figure out how to fix that problem without breaking the bank. McClellan predicted that the Obama Administration would continue the Bush Administration's efforts to reform the payment system to reward more efficient, higher-quality care. "There's a lot of momentum now . . . to put more emphasis on paying for value in Medicare," he said.

Under the Democratic health reform plans circulating, CMS could see its responsibilities increased further. For example, if the private health insurance plans that operate under Medicare Advantage and Part D are reined in, insurers could see their Medicare Advantage payments slashed by up to \$50 billion and face more stringent oversight of their activities in both programs. States are already angling for new federal money to shore up their Medicaid budgets during the recession, but CMS will have to address other thorny Medicaid and SCHIP issues, such as how much flexibility to give states to redesign their benefits. On SCHIP, Congress' reauthorization of the program includes a significant expansion of the program, bringing millions of new children onto the rolls.

## TO THE EDITOR OF COMMON SENSE:

I would like to compliment Dr. Michael Pulia for his article "Bring On the Pain: A New Tool to Combat Drug Seeking in the ED" in the November/December 2008 issue of *Common Sense*. The article is a nice review of state-based computerized databases which help emergency physicians detect which patients may be exhibiting drug-seeking behavior. I have long desired such a program in my state (Massachusetts), and after becoming inspired by the article, I contacted the Department of Public Health. Coincidentally, a meeting had just been scheduled to discuss a similar program, and I was able to attend and represent the voice of emergency medicine at the meeting. At the end of the meeting, I gave a copy of Dr. Pulia's article to the director of the program as it nicely summarizes how valuable such a tool is for the practicing emergency physician.

Sincerely,  
Scott G. Weiner, MD MPH FAAEM

*The American Academy  
of Emergency Medicine would like  
to congratulate the 2009 YPS Board of Directors  
on their new positions.*

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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 12/16/2008–2/11/2009.

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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# EmCare Partners With Hospital Chain

Mark Reiter, MD MBA FFAEM  
AAEM Board of Directors

EmCare's parent company recently entered an agreement to become a national provider of hospital-based physician services to Community Health Systems (CHS), one of the largest national hospital chains. As a result, EmCare will offer "preferred pricing"<sup>1</sup> to CHS, and the agreement may lead to a significant increase in EmCare contracts at CHS hospitals.

Where is EmCare's "preferred pricing" going to come from? Like all emergency groups, the great majority of EmCare's expenses are physician staffing costs. EmCare has been criticized in the past for taking a hefty administrative fee and earning large profits from physician professional fees. EmCare's parent company anticipates ~ \$230 million profit for the year before interest, taxes and depreciation and amortization.<sup>2</sup> I hope cost concerns do not provide an incentive for EmCare to understaff their EDs, decrease compensation or increase their reliance on non-board certified emergency physicians.

This development is also concerning for our patients, as it may lead to a further loss of control for emergency physicians at these hospitals. AAEM assisted many emergency physicians who have been threatened with termination or fired without due process after advocating for their patients or raising legitimate patient safety concerns. The emergency physician can be considered expendable if he or she is thought to compromise the contract and its profit stream in any way.

AAEM believes there is much value in the locally-run, democratic groups of physician-owners who are invested in the long-term success of their local communities and local hospitals. Still, the days may be numbered for private, democratic groups providing services at CHS hospitals.

Ownership of medical practices by lay shareholders, commonly referred to as the corporate practice of medicine (CPOM) is restricted or banned in most states, although enforcement is quite variable. The Office of the Inspector General of the Department of Health and Human Services issued an advisory opinion that notes many arrangements between contract management groups and physicians violate the Federal Anti-Kickback statute. In addition, AAEM and the American Medical Association have strong policies opposing CPOM. AAEM believes lay shareholders should not employ physicians – rather physicians should employ lay contract management groups if they feel their services are of value. Physician control of medical practice, rather than corporate control, is in the best interests of our patients.

As always, AAEM stands ready to assist our members in any way we can. In some instances, we may only be able to offer advice. In other instances, such as our two active cases in Texas, we may be able to offer significant legal, logistical and financial support. As per the AAEM Vision Statement, "the welfare of our patients and the brightest future for emergency medicine depend on restoring control of our practice to emergency physicians."

## References:

1. EMSC Press Release: EMSC Announces National Provider Agreements with Community Health Systems Professional Services Corporation and Quorum Health Resources, LLC. 8/14/08. <http://biz.yahoo.com/bw/080814/20080814005045.html?.v=1>
2. EMSC Press Release: Emergency Medical Services Announces \$.43 diluted EPS and Increases 2008 Guidance. 8/5/08. <http://biz.yahoo.com/bw/080805/20080805005498.html?.v=1>

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### April 1-2, 2009

- AAEM Pearls of Wisdom Oral Board Review Course  
Las Vegas  
[www.aaem.org](http://www.aaem.org)

### April 25-26, 2009

- AAEM Pearls of Wisdom Oral Board Review Course  
Chicago, Dallas, Los Angeles, Orlando, Philadelphia  
[www.aaem.org](http://www.aaem.org)

### September 14-17, 2009

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

### October 14-15, 2009

- AAEM Pearls of Wisdom Oral Board Review Course  
Las Vegas  
[www.aaem.org](http://www.aaem.org)

### October 17-18, 2009

- AAEM Pearls of Wisdom Oral Board Review Course  
Chicago, Dallas, Los Angeles, Orlando, Philadelphia  
[www.aaem.org](http://www.aaem.org)

### May 12-15, 2009

- 16th World Congress on Disaster and Emergency Medicine (WCDEM 2009)  
Victoria, British Columbia  
[www.wcdem2009.org](http://www.wcdem2009.org)

### May 14-17, 2009

- Public Health in the ED: Surveillance, Screening and Intervention (SAEM Consensus Conference)  
New Orleans, LA  
[www.saem.org](http://www.saem.org)

### May 21-22, 2009

- The Argentine International Symposium on Emergency Medicine  
Buenos Aires, Argentina  
[www.emergencias.org.ar](http://www.emergencias.org.ar)

### May 21-23, 2009

- High Risk Emergency Medicine  
San Francisco, CA  
[www.highriskem.com](http://www.highriskem.com)

### June 5-7, 2009

- The Difficult Airway Course-Emergency™  
Boston, MA  
[www.theairwaysite.com](http://www.theairwaysite.com)

### June 8-10, 2009

- The Heart Course-Emergency  
Cambridge, MA  
[www.theheartcourse.com](http://www.theheartcourse.com)

### June 13-25, 2009

- Expedition Medicine 2009  
Kilimanjaro  
[www.expedmed.org](http://www.expedmed.org)

### July 20-23, 2009

- Giant Steps in Emergency Medicine  
San Diego, CA  
[www.giantsteps-em.com](http://www.giantsteps-em.com)

### July 21-24, 2009

- High Altitude Medicine 2009  
Ashford, WA  
[www.mmmedicine.com](http://www.mmmedicine.com)

### August 17-21, 2009

- Expedition Medicine 2009  
Washington, D.C.  
[www.expedmed.org](http://www.expedmed.org)

### September 18-20, 2009

- The Difficult Airway Course-Emergency™  
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### October 23-25, 2009

- The Difficult Airway Course-Emergency™  
Las Vegas, NV  
[www.theairwaysite.com](http://www.theairwaysite.com)

### October 26-28, 2009

- The Heart Course-Emergency  
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[www.theheartcourse.com](http://www.theheartcourse.com)

### November 13-15, 2009

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### November 15-19, 2009

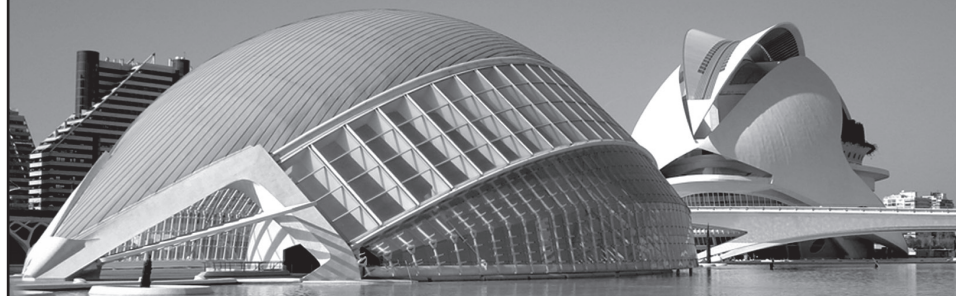
- ACTION09—The Annual Scientific Meeting of ACEM  
Melbourne, Australia  
<http://acem09.eventplanners.com.au/Home/tabid/816/Default.aspx>

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](mailto: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**



Early Bird Registration deadline  
**30 June 2009**

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**31 May 2009**

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**30 June 2009**

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Indrani Sheridan, MD FAAEM

Academic Co-Chair, CEMC Barbados 2009

AAEM Board of Directors, AAEM Education Committee and Chair of the ACCME Subcommittee

"You never told me there'd be so many beautiful women here!" I smiled at Joe Lex, world traveler, connoisseur of music, art, fine food and culture. We were standing in a lecture hall at the First Caribbean Emergency Medicine Congress (CEMC), a joint venture between the University of the West Indies and AAEM. I honestly never thought about that aspect of holding a conference in Barbados.

In so many respects, CEMC was a huge success. The conference brought together faculty from the United States, Canada, the United Kingdom, Europe and all across the Caribbean. While the tropical setting, good food and vibrant, friendly people lent itself to the perfect mid-winter break, the conference also offered an unparalleled opportunity for academic and scientific exchange, providing physicians from around the globe a venue at which to interact, exchange ideas and present the latest research in the field of emergency medicine.

With 50 invited faculty from around the world, the program ran the gamut, from problems of crowding to bioterrorism, to a panel discussion on "Establishing a Caribbean Federation of Emergency Medicine." The clinical topics highlighted a broad range of interests including helpful hints for educators on "Resident Remediation" and "Getting Published." There were phenomenal tips for the experienced practitioner on "Difficult Vascular Access" and "Interactions of Commonly Used Medicines." There were also numerous reviews of important topics such as "Pediatric Head Trauma" and "Non-Traumatic Joint Pain."

There were memorable moments during the conference, too numerous to mention them all. The winners of research prizes had the honor of receiving their awards from Professor Steve Hayden, editor of the *Journal of Emergency Medicine*. Professor Michelle Biros, past-editor of *Academic Emergency Medicine* gave several impassioned lectures and taught us a thing or two about how to be a great academician, a wise physician, and she shared with us her personal perspectives on being a patient. Following the main conference, there were two days of hands-on ultrasound training, led by Dr. Paul

Sierzenski and Dr. J. Christian Fox. With 30 participants and a waiting list at least as long, the enthusiasm to learn was clear. Dr. Joseph Wood commented, "Teaching the ultrasound course was a joy."

CEMC made daily front page headlines in the local newspapers and drew numerous television and radio interviews. These served to heighten awareness of the scope of emergency medicine in the eyes of the government, private sector and general population. Dr. Harold Watson, Chief of Emergency Services on the island and Academic Co-Chair for CEMC is quoted as saying, "This conference has energized my department. There is now greater enthusiasm among the faculty and residents in their approach to all aspects of work." The Chief Medical Officer, Chairman of the Hospital Board and the board member in charge of the EM department at Queen Elizabeth Hospital had the opportunity to attend the sessions on Thursday, January 8, 2009. This resulted in useful discussions and links being established with Professor Gunnar Öhlén (President of the European Society for Emergency Medicine) in connection with designing a new state-of-the art hospital in Barbados.

In this idyllic setting, it is hard to imagine that the problems facing patients and practitioners in emergency medicine are real - but they are. Overcrowding, poor access to care, turf wars, limited resources - the everyday, universal problems of emergency medicine - are punctuated by local disasters, epidemics, people quitting, getting ill or having family emergencies that take them out of an already strained workforce. This much is clear: they cope in the same ways we cope.

For four exciting days, we lectured, we listened to lectures, we commiserated, and we exchanged stories of personal and professional triumphs. We made ambitious, idealistic and practical plans to help advance the cause of emergency medicine. We expanded our network of respected colleagues and friends and made promises to keep in touch. We got to know each other face-to-face. After all, that's what international EM is all about.

## *The American Academy of Emergency Medicine congratulates the 2009 AAEM Award winners.*

*Wagner Award* ..... Ron M. Walls, MD FAAEM

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*Young Educator Award* ..... Erik B. Kulstad, MD MS FAAEM

Michael E. Winters, MD FAAEM

*Resident of the Year Award* ..... Megan M. Boysen, MD

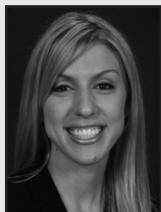
*Program Director of the Year Award* ..... Christopher I. Doty, MD FAAEM

*Joe Lex Educator of the Year Award* ..... Kevin G. Rodgers, MD FAAEM

*International Award* ..... Amin Antoine Nabih Kazzi, MD FAAEM



# Resident & Student Association



## RESIDENT PRESIDENT'S MESSAGE

### Opportunities for Involvement in AAEM/RSA

Megan Boysen, MD  
AAEM/RSA President

It has been an exceptional year at AAEM/RSA. Our membership has grown by almost 20%. We have more than thirty-five 100% member residency programs. We published a "written board" review book, organized symposia and planned the remodeling of our AAEM/RSA website. We have been fortunate to have a tremendous team of board members, committee members and Medical Student Council representatives. Hopefully, you joined us at the Scientific Assembly in Phoenix this month. I am already looking forward to next year's Scientific Assembly, February 15-17, 2010, in Las Vegas.

In the coming year, there are several opportunities for you to become involved in AAEM/RSA. We recently had nominations for the AAEM/RSA Board of Directors positions. Voting will end April 10, 2009, at midnight CST. AAEM/RSA positions include president, vice president, secretary/treasurer and five at-large board member positions. The five at-large board members will be the committee chairs for the four AAEM/RSA committees and the editor for the RSA section of *Common Sense*. I encourage you to vote in these elections.

If you missed the opportunity to run for an AAEM/RSA Board of Directors position, there are several other ways to become involved in the coming year. One way is committee membership. In July, there will be a call for applications for the AAEM/RSA committee positions. There are four AAEM/RSA commit-

tees: education, communications, advocacy and membership. Additionally, you may consider becoming a member of the Vice President's Council. The Vice President's Council includes one representative from each residency program to act as a liaison between each program and AAEM/RSA. Typically, the Council representative is chosen in August. Please contact your residency director if you are interested in this position, or email [info@aaemrsa.org](mailto:info@aaemrsa.org).

The AAEM/RSA committee positions are also open to medical student members. Medical students may also serve on the Medical Student Council or as an EMIG Site Coordinator.

As residents and medical students, we have a unique opportunity to become influential leaders in a growing field. Emergency medicine, despite being relatively new in its recognition as a specialty, molds the front doors of America's hospitals. Becoming involved in AAEM/RSA helps to protect the unencumbered access of individuals to quality emergency care, board certification, a fair practice environment for emergency physicians, quality medical education and the expansion of emergency medicine internationally.

Please contact me or any of the current board members if you have questions about AAEM/RSA opportunities; our contact information can be found at <http://www.aaemrsa.org/leadership/>.

## CHANGE OF ADDRESS

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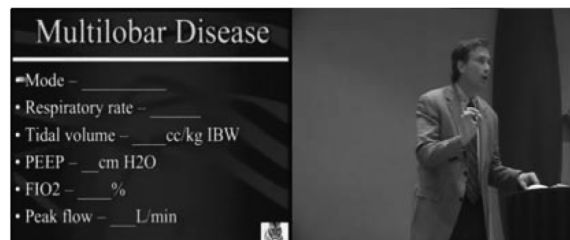
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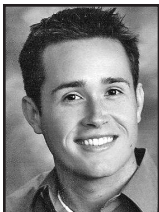
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## Healthcare in America: The Bottom Line

### RESIDENT EDITOR'S LETTER

Michael Ybarra, MD  
AAEM/RSA Resident Editor



To care for sick patients, Americans have developed an incredibly complex delivery system that is a hybrid of public and private providers and payers. In past articles, we discussed Medicare, Medicaid, SCHIP, the different types of healthcare coverage and those who are uninsured in this country. Regardless of the arguments made for or against the many facets of our country's system, the fact is healthcare in

America is incredibly expensive. What follows are facts and figures on the bottom line – how much we spend and what we spend it on.

The cost of all healthcare in the United States in 2008 was approximately \$2.4 trillion dollars or 17% of the Gross Domestic Product. That staggering dollar amount is 4.3 times the amount spent on national defense.<sup>1</sup> It is sobering to note that America now spends more money on healthcare than it does on food.<sup>2</sup> Moreover, if growth in healthcare costs continue at roughly the same rate of the last decade, economists estimate that by 2012, costs will rise to \$3.1 trillion, and by 2016, to \$4.3 trillion.

The cost of healthcare has risen faster than inflation or wages. In 2001, 50% of all bankruptcy filings in the United States cited healthcare expenses as the reason for seeking protection.<sup>3</sup> The United States spends more than any other country, but healthcare service utilization is lower per capita and concentrated among a small group of individuals.<sup>4</sup> One percent of the US population accounts for 27% of all spending - 5% of the population accounts for 50% of all spending.<sup>5</sup> These are the sickest patients, requiring the most expensive care, and therefore utilize the majority of resources.

As costs rise, employers are spending more money on insurance premiums, but they shift much of the burden to employees.

Year	Individual Cost	Family Cost
1999	\$2,196	\$5,791
2007	\$4,479	\$12,106
Percent change	103% increase	109% increase

In 1998, companies paid 90% of employee's premiums.<sup>6</sup> That number has now fallen to approximately 73%. A Corporate Executive Board survey of 350 large corporations suggests this trend will not change, as employers save money by switching to higher deductible plans where the employee pays a larger percentage of the premiums.<sup>7</sup>

The last two years of life are the most expensive. As an age group, the elderly make up 12% of the total US population, but account for 34% of healthcare costs. Working age individuals are 62% of the US population, but only account for 52% of the costs. Children are 26% of the US population, but only account for 13% of the costs.

The bulk of healthcare associated costs are from hospitalization (31%) and physician services (21%). Prescription drugs make up 10%, and administrative costs make up 7%. Administrative costs account for \$168 billion dollars annually – an incredibly impressive dollar amount not matched by many other countries. Interestingly, the government-operated programs, Medicare and Medicaid, frequently described as large, inefficient programs, have administrative costs of less than 2%. If the entire industry matched Medicare and Medicaid's relatively low administrative costs, the country would save roughly \$120 billion.

A 2008 McKinsey report noted that America spends at least \$480 billion more than any other developed country in the world on healthcare. Their analysts determined through population data studies that severity of disease does not explain the increased expenditures. In other words, McKinsey analysts argue Americans are not sicker.<sup>2</sup>

There are countless explanations for the staggering costs of healthcare in America. The Congressional Budget Office wrote in a 2008 report, "About half of all growth in health care spending in the past several decades was associated with changes in medical care made possible by advances in technology."

The 2007 McKinsey Global Institute report suggested, "The overriding cause of high U.S. health care costs is the failure of the intermediation system — payors, employers, and government — to provide sufficient incentives to patients and consumers to be value-conscious in their demand decisions, and to regulate the necessary incentives to promote rational use by providers and suppliers."<sup>2</sup>

Despite the bleak outlook, there are a number of intelligent individuals working hard within the government, at think tanks, and non-profit organizations across the country to come up with solutions to our expensive problem. The majority of solutions fit into three broad categories. The first includes consumer driven health plans that have greater price transparency, rely heavily on "health reimbursement accounts," and allow free market forces to shape a solvent system. The second category argues for greater government regulation to design a system modeled after current social programs like Medicare and Medicaid, which have substantially lower administrative costs than most private programs. The final group argues for promoting a "quality and efficiency" model that improves disease management, finds cost savings in the implementation of new technologies (such as electronic medical records) and bulk buying of medications (similar to the VA).<sup>6</sup>

Healthcare will remain a front-page story for the next few years as policymakers argue the merits of a number of reforms. Any discussion about changes to healthcare will certainly reference the bottom line.

If you have any questions or comments, please email [info@aaemrsa.org](mailto:info@aaemrsa.org).

*continued on page 17*





## Resident Journal Review: March-April 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 November and December 2008.*

### **Appelboam A, Reuben AD, Bengner JR, et al. Elbow extension test to rule out elbow fracture: multicentre, prospective validation and observational study of diagnostic accuracy in adults and children. BMJ 2008;337:a2428**

This prospective study evaluated the performance of the elbow extension clinical decision rule. The elbow extension rule predicts a low likelihood of elbow fracture in patients who can fully extend their arm. The investigators performed an interventional validation study in patients 15 years of age and older and an observational study in pediatric patients. 958 adults and 778 children were enrolled. For adults, if the patient was able to flex the shoulder to 90 degrees and then fully extend and lock their elbows, no further imaging was performed. Management of pediatric patients was left to the treating attending physician; documentation of elbow extension was recorded contemporaneously.

Overall, this clinical decision rule performed well. Of 958 adults, 313 (33%) were able to fully extend their elbow; five (1.6%) fractures were identified in this group of patients, with two requiring operative intervention. 647 adults could not fully extend their elbow – 311 (48%) had fractures, and 84 (13%) had joint effusions. This yields a negative predictive value of 98.4% and a negative likelihood ratio of 0.03. Among the 778 children, 289 (37%) could fully extend their elbow – 12 (4.1%) had fractures, and 6 (2.1%) had effusions. None required operative intervention. The negative predictive value in pediatric patients is 95.8%, and the negative likelihood ratio is 0.11.

Elbow injuries are a common orthopedic complaint in the emergency department. This clinical decision rule can reduce the number of plain films performed in the evaluation of these patients. While this rule performed well, it is important to give clear instructions for return to patients who leave the emergency department without having radiographic imaging performed.

### **Bottiger BW, Arntz HR, Chamberlain DA, et al. Thrombolysis during resuscitation for out-of-hospital cardiac arrest. The New England Journal of Medicine 2008;359:2651-62**

Morbidity and mortality after cardiac arrest are extremely high. As pulmonary embolism and myocardial infarction are believed to precipitate this final common pathway in many patients, there has been speculation that thrombolysis may confer a clinical benefit.

The Thrombolysis in Cardiac Arrest (TROICA) trial was a double-blind multicenter investigation of tenecteplase compared to placebo during cardiopulmonary resuscitation for adult patients with witnessed out-of-hospital cardiac arrest. The investigators had a primary outcome of 30 day survival; secondary end points were hospital admission, return of spontaneous circulation, 24 hour survival, survival to hospital discharge and neurologic outcome. It was calculated that 1,000 patients would be needed to detect a differ-

ence of 7% between groups, with a power of 90%. The trial protocol was modified after enrollment of 443 patients (excluding asystolic patients) and was terminated early for futility by the data and safety monitoring board after enrollment of 1,050 patients. There were no statistically significant differences in the primary or secondary outcome measures.

The findings of this study differ from prior reports of clinical benefit; however, a randomized double-blind methodology had not been used in prior investigations. While it may be true that certain subgroups of patients with cardiac arrest will benefit from thrombolytic therapy, these results do not support routine administration of these agents to an unselected cardiac arrest population.

### **Sillberg VA, Perry JJ, Stiell IG, Wells GA. Is the combination of vasopressin and epinephrine superior to repeated doses of epinephrine alone in the treatment of cardiac arrest – a systematic review. Resuscitation 2008;79:380-6**

While animal studies of combined epinephrine and vasopressin in cardiac arrest have shown improved outcomes, human studies have been less convincing. The investigators conducted a systematic review of human trials that compared epinephrine to the combination of epinephrine and vasopressin in cardiac arrest. The primary outcome was survival to hospital discharge, and the secondary outcome was return of spontaneous circulation.

Three double-blinded randomized controlled trials were identified, including 1,226 patients. Differences in methodologies precluded a pooled analysis of the patient outcome data. For these three studies, there was a trend towards better return of spontaneous circulation, but an unclear impact on survival.

The combination of vasopressin and epinephrine in cardiac arrest is not supported by high quality evidence. The authors identified three additional ongoing trials that will likely inform the ACLS protocol in this regard; until the publication of these studies, this combination cannot be regarded as having a rigorously proven benefit.

### **Singh A, Alter HJ, Zaia B. Does the addition of dexamethasone to standard therapy for acute migraine headache decrease the incidence of recurrent headache for patients treated in the emergency department? A meta-analysis and systematic review of the literature. Acad Emerg Med. 2008; 15:1223-33**

Dexamethasone has been proposed as an adjunct therapy for patients presenting with migraine headaches, particularly to prevent recurrence or severity of headache following ED discharge. While there have been a number of studies examining the efficacy of this treatment, none have clearly indicated a benefit to this therapy. The authors of this systematic review and meta-analysis conducted an exhaustive search of published studies, clinical trials and abstracts

*continued on page 14*



*Resident Journal Review - continued from page 13*

in order to find the highest quality randomized, double-blinded, placebo controlled trials to find their answer.

The pooled analysis of the seven trials they included examined 742 patients, looking at severity of migraine symptoms at 24 to 72 hours after disposition. It should be noted that six of the seven included trials showed only a trend toward benefit and no statistically significant treatment differences, but that the pooled results suggested a modest benefit to treatment with prevention of moderate or severe headache relapse in about one in nine treated patients.

As with any meta-analysis, there is concern for a single conclusion drawn from heterogeneous studies, which the authors consider in their analysis. The included trials varied in their dosing and route of dexamethasone given, their headache severity scoring and duration of follow-up times. In addition, there was variability within and between studies for "standard therapy" for migraine headaches. Despite these inherent difficulties in analysis, the generally safe side-effect profile and the potential benefit seems to indicate that the addition of dexamethasone to standard migraine therapies is an acceptable strategy to prevent headache relapse.

**Strayer RJ, Nelson LS. Adverse events associated with ketamine for procedural sedation in adults. Am J Emerg Med. 2008 Nov;26(9):985-1028**

Ketamine is a drug widely used for procedural sedation in pediatrics, with a number of studies in the emergency medicine literature supporting its safety and efficacy. What is less well-studied is the use of ketamine as a sedative agent for adult emergency patients. The authors of this narrative review conducted an exhaustive study of the available literature on the use of ketamine for sedation in adult patients. A number of databases were searched, and foreign language abstracts were included. Of 5,512 citations, 87 met their criteria for analysis and inclusion. A majority of the included studies came from anesthesia literature and was published in the 1970s. Due to the heterogeneity in study design and quality, the authors did not attempt statistical analysis, but rather presented the results qualitatively.

What is apparent is that ketamine is a dependable medication at dissociative doses for sedation and analgesia in adults. Ketamine demonstrates very high safety, as the authors report coming across one serious adverse cardiopulmonary complication in over 70,000 patients described. A few patients became transiently apneic, but were successfully ventilated with a bag-valve mask. Most of these cases involved patients who received concomitant therapy with other respiratory depressants such as opiates or benzodiazepines. Likely, the most common adverse effect, and probably the most concerning to most emergency physicians, seems to be the presence of emergence reactions. The incidence of this phenomenon seems to be about 10-20%; however, this decreases with the use of other

anxiolytic/sedating agents or with pre-induction counseling. Other less frequent adverse events include vomiting, hypertonus, rash and hypersalivation.

While no large randomized trial exists that compares ketamine to other sedation strategies, these results seem to indicate that this drug is safe and effective, with few respiratory adverse events. The risk of emergence reactions seems to decrease with a number of strategies that may employ predissociative, pre-emergence or PRN medication use.

**Kelly AM, Kerr D, Clooney M. Outcomes of emergency department patients treated for primary spontaneous pneumothorax. Chest. 2008 Nov;134(5):1033-6**

The treatment of spontaneous pneumothorax varies in different international guidelines. While most physicians agree that small pneumothoraces can be managed with observation, the existing literature does not indicate that the management of a pneumothorax should be based on its size. In this retrospective study from two community hospitals, the authors examined the outcomes of 154 patients with 203 primary spontaneous pneumothoraces treated with a variety of strategies – observation, aspiration and tube thoracostomy. Ninety-one patients were treated with observation, 48 with aspiration and 64 with tube thoracostomy. No patient enrolled had signs or symptoms of tension pneumothorax. The treatment groups were not matched for size of pneumothorax; however, there were a higher proportion of large pneumothoraces treated with aspiration or tube thoracostomy. Patients in the observation arm had resolution without further intervention 79% of the time, the remainder requiring non-emergent intervention to achieve resolution. Aspiration alone was successful 50% of the time and tube thoracostomy 73%.

The retrospective nature of this study limits what conclusions can be drawn from these results, as does the fact that treatment groups were not matched for initial pneumothorax size, meaning that comparisons can not be made between groups. What it does set up, however, is the groundwork for future prospective trials that may include an observation arm for patients with primary spontaneous pneumothorax.

*Dana Sajed is an emergency medicine chief resident at SUNY Downstate/Kings County Hospital*

*David Wallace is the emergency medicine/internal medicine (EM/IM) chief resident at SUNY Downstate/Kings County Hospital*

*Christopher Doty is the residency program director for emergency medicine and co-director of combined EM/IM at SUNY Downstate/Kings County Hospital*

*Amal Mattu is the residency program director for emergency medicine and co-director of combined EM/IM at University of Maryland*



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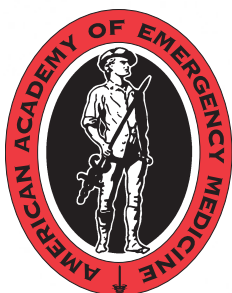
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# Resident & Student Association

## Applying for Residency

### MEDICAL STUDENT COUNCIL PRESIDENT'S MESSAGE

Greg Casey  
AAEM/RSA Medical Student Council President



Driving home from my final residency interview, I reflected on the emergency medicine residency application process. What would I do differently? What helped me the most? Each step of the application process brought multiple questions and difficult choices. For assistance, I obtained advice from classmates, current residents, mentors and Google. Each of these sources provided useful information,

but it is the combination of personal investigative work and insight into my educational, professional and personal goals that will ultimately lead to matching at the right program. To increase your odds of finding and matching at a top program, I recommend three things: start working on your application early, do an emergency medicine rotation at your home institution and take advantage of the interview.

Part one of the application process is preparation. It is vital that you understand the nuances of the application process and are familiar with the specialty of emergency medicine. A great way to start is by reading *Rules of the Road for Medical Students*, by Drs. Antoine Kazzi and Joel Schofer. This book is an excellent guide and includes many chapters that should be read during the third year of medical school. In addition, start researching potential programs and apply for an away rotation at a program that suits your interests.

Emergency medicine rotations are crucial for your development as an emergency physician, but also play a significant role in your ap-

plication. As a program director stressed to me, emergency medicine is a small world. Most of the program directors know and trust each other. Try to rotate at a hospital with a residency program, make known your intention to pursue emergency medicine and work hard. Early in the rotation, ask the clerkship or program director to write you a standard letter of recommendation (SLOR). This letter is unique to emergency medicine and is uniformly accepted as one of the strongest and most accurate ways of assessing an applicant.

My favorite part of the application process, and ultimately the most useful, was hitting the interview trail. If possible, try to schedule light rotations in December or January. During interviews, you will inevitably hear two phrases at each program, "we work hard and play hard" and "we see great pathology." To evaluate the first phrase, attend the applicant dinners to watch the residents interact. Do they get along? Would you enjoy spending time with them? If you have the chance, schedule a shift in the emergency department to see how the faculty, staff and residents mesh. Use your emergency medicine rotations as a baseline to compare other programs, and ask as many questions as you can.

The final common pathway in applying for emergency medicine is formulating your rank list. Luckily, there are many programs for you to choose from, and you will learn emergency medicine no matter where you train. To increase your odds of matching at a top choice, begin planning now. Get an emergency medicine mentor, plan your rotations wisely, work hard and have fun!

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## Ultrasound: Tool of Choice for New Residents?

Sara Kirby, M4  
University of South Carolina

Ultrasound is everywhere. As I travel the interview trail, ultrasound is one of the check boxes for every presentation and tour. Does your emergency department (ED) have machines for residents to use? Do your residents graduate certified in scanning? Do you have an ultrasound fellowship?

My medical school was lucky enough to have a partnership with General Electric. My classmates were the pioneers for the now successful vertical curriculum we have at the University of South Carolina, the first medical school in the country to do so. The program allows students to start learning the ultrasound machines, hands on, from day one. It is used in first year to augment the learning of anatomy and physiology. During second and third year, each rotation has ultrasound scans as a requirement, which made me comfortable and familiar with the machine when I used it on patients during my fourth year. The incoming class will be able to try out the newest portable model that is about the size of an iPod. You can check out our Ultrasound in Medical Education Interest Group and website at <http://uscm.med.sc.edu/ume> to learn more.

I was fortunate enough to work the last several years with our Assistant Dean, Dr. Richard Hoppmann, who has been the catalyst for this program. I assisted him with a workshop at the AAMC national conference, where I saw firsthand the speed with which interested students can learn how to use and apply the machines in clinical settings.

Recent studies from *Elsevier Global Medical News* showed that the success rates for procedures like peripheral and central IV lines are much higher when performed with ultrasound guidance. It is quickly becoming the standard of care in many institutions. I believe it is also reassuring for the nervous intern who has to put in their first internal jugular or subclavian line and is worrying about the lung apices. It can be used to assist lumbar punctures, chest tubes and

other procedures. The applications are endless, and the test is quick and noninvasive, which is good for both the physician and patient.

In the busy ED, FAST exams aid the initial trauma assessment. Scan a gall bladder in five minutes or less to see if there really is a blocked duct. A friend of mine, also a fourth year medical student, was with a resident, who diagnosed a pulmonary embolus from a dilated atrium found on a bedside echo. As government continues to make cuts to Medicaid and Medicare, I believe ultrasound can be an effective, inexpensive diagnostic tool.

Residency programs around the country have a new emphasis on ultrasound. Several departments I visited take machines to underdeveloped countries. Many graduating residents leave their programs with certification in ultrasonography.

Its use is certainly not limited to EDs. More and more primary care offices are using them for screening tests. Physicians can look at bone structure for fractures, check for a sliding lung sign for a pneumothorax and do a quick bedside echo on the heart to check for a valvular vegetation or effusion. The possibilities are endless, and there are volumes of literature for its use. The Palmetto Health Richland Emergency Department in Columbia, South Carolina, has worked closely with our medical school and has ultrasound rotations for third and fourth year students. All their residents also have a month dedicated to ultrasound scanning with certified attending physicians.

As Dr. Hoppmann and others in the field like to say, "Ultrasound is the stethoscope of the 21st century." Certainly, a good history and physical exam are still essential. However, it is definitely nice to have an extra tool. I know I will use it whenever possible. For those students who have the opportunity, get your hands on a machine and practice, as it will help you shine on your rotations in the ED. Happy scanning!

*Healthcare in America: The Bottom Line - continued from page 12*

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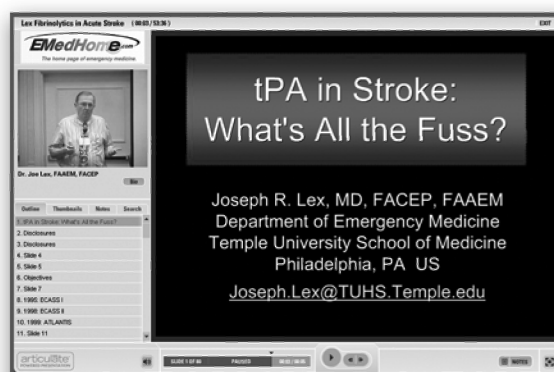
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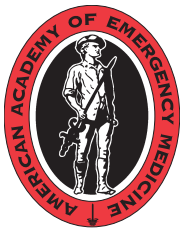
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