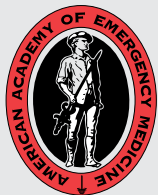


# common SENSE



**FAAEM**  
always means  
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VOLUME 19, ISSUE 2  
MARCH/APRIL 2012

THE NEWSLETTER OF THE AMERICAN ACADEMY OF EMERGENCY MEDICINE



## PRESIDENT'S MESSAGE Moving Forward

*William T. Durkin, Jr., MD MBA FAAEM*

Well, it has been a productive two months since the start of my term as your president. As I stood at the podium during the candidates' forum, I said that I would focus on the community-based physicians, improve the educational offerings, provide tools for independent groups and promote the Academy to other organizations as we continue to grow. New committee chairs have been appointed and charged with making their respective committees productive and reporting to the board on a regular basis. Our strategic planning board retreat was held earlier than usual so that we could all get to work and begin moving forward to formulate and begin new initiatives. All of your representatives worked very hard and we have agreed upon a plan of action.

The Academy has always espoused that independent democratic groups are the most desirable models for the practice of emergency medicine. We understand that we need to better support such groups and demonstrate to interested members how to form, govern and maintain such groups. The Practice Management Committee is working on a handbook to address such issues. We started a practice management track at the last Scientific Assembly and will expand upon that in Las Vegas. Another proposal under consideration is, under the auspices of AAEM Services, to provide MSO services to small groups a take advantage of economies of scale. Providing a practice valuation tool kit to interested members is another project that is being considered. The Practice Management Committee needs those who are leaders of independent democratic groups to share their years of expertise and experience. Of course, the elephant in the room in this discussion is the fate of the Patient Protection and Affordable Care Act. The decision of the Supreme Court and the results of the November presidential election will determine the fate of this piece of legislation. Should it be upheld, there may be more practices bought up by hospitals and we will need to educate everyone as to how independent emergency practices can survive in the ACO world. Due process and physician practice rights will remain a concern even under the hospital employee model.

The Scientific Assembly, through the efforts of those on the Education Committee, continues to be hugely successful. Starting next year, we will add an extra half day to this conference to allow for more talks as well as another evening for networking opportunities. It is my vision this will become the most popular conference in emergency medicine.

Membership growth needs to be more robust than it has been. We need to be relevant to the practicing physician. To do so requires our members to participate in moving the organization forward and to have a dialogue with our leadership if you feel that there is something we should be addressing. Reaching out to the residency programs is the key to our future growth and to the growth of the Resident and Student Association. I have set a goal of an officer or board member visiting every residency program at least once every three years. This will allow us to have contact with every EM resident at least once during their residency. Hopefully, by bringing their attention to our issues, they will be better prepared when they seek employment post-residency and understand the importance of being part of an organization that actively supports them.

We are also going to continue to engage other organizations to make them aware of the Academy and explore working together in different venues. In March, we exhibited at the American College of Healthcare Executives (ACHE) annual meeting. This summer, we will once again be at the American Hospital Association's annual meeting. By increasing hospital administrators' awareness of the Academy and the merits of a local independent group of board certified emergency medicine specialists, it is hoped that they will look to such groups to staff their emergency departments, rather than turn to a contract management group. Another proposal during our planning meeting was

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## EDITOR'S LETTER

### Time for a Change

David D. Vega, MD FAAEM

I began my role as editor of *Common Sense* in 2009. I am ending this role in 2012. Serving in this capacity has been a great experience, and I thank everyone who was involved in helping me get established in this position and who provided assistance with the publication over the past few years. In particular, I would like to thank Dr. David Kramer, previous editor of *Common Sense*, who was key in helping me get involved with AAEM, starting from the days we formed the Young Physicians Section (YPS) and leading to my assumption of the role of editor of *Common Sense*. I also extend special gratitude to AAEM Past President Larry Weiss, MD JD FAAEM, for his assistance and support over the years I served as editor. Jody Bath, our managing editor, deserves much credit for her patience and persistence in producing this publication as well. I also thank all of the various members of the board of directors over the years who have been supportive and helpful in keeping this publication going strong.

It has truly been a privilege to serve as editor of *Common Sense* for the past several years. I look forward to staying very active in AAEM as I transition to new roles in the organization. I thank all of you, my colleagues, for electing me to the board of directors at Scientific Assembly in San Diego. I am fully dedicated to continuing my service to AAEM, the organization that best represents the hard-working, board certified emergency physician. This organization has truly advanced our specialty in ways that many do not even realize.

I am happy to say that Andy Walker, MD FAAEM, will now be taking over the reins of this publication. Andy is a dedicated and experienced member of AAEM's board of directors and a fervent supporter of AAEM's principles. He is a talented author and is a perfect choice to guide this publication into the future. Mark Doran, DO FAAEM, will also continue as assistant editor. I have no doubt that these two will do great things for AAEM through their work with *Common Sense*.



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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 (Limited to graduates of an ACGME or AOA approved Emergency Medicine Program)

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

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: \$150 (Non-voting status)

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

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

Student Member: \$20 or \$50 (voting in AAEM/RSA elections only)

\*Fellows-in-Training membership includes Young Physicians Section (YPS) membership.

Pay dues online at [www.aaem.org](http://www.aaem.org) or send check or money order to: AAEM, 555 East Wells Street, Suite 1100, Milwaukee, WI 53202

Tel: (800) 884-2236, Fax (414) 276-3349, Email: [info@aaem.org](mailto:info@aaem.org).

AAEM is a non-profit, professional organization. Our mailing list is private.

# IOM Review of Nation's GME System Requested

Kathleen Ream, Director of Government Affairs

Seven senators — Michael Bennet (D-CO), Jeff Bingaman (D-NM), Michael Crapo (R-ID), Charles Grassley (R-IA), Jon Kyl (R-AZ), Mark Udall (D-CO) and Tom Udall (D-NM) — have asked the Institute of Medicine (IOM) to do a thorough review of the nation's system of graduate medical education (GME) that funds medical residencies. The request is an indication of Congress' interest in shaping the future of the physician corps as the **Patient Protection and Affordable Care Act** is implemented with its emphasis on coordinated and primary care.

In their letter to the IOM, the senators said they would like to see an independent review of the governance and financing of the GME system, including inequities in funding across states based on their needs and capacity. They wrote, "We believe our GME system is under increasing stress and the projections for our health care workforce are of significant concern. There is growing concern that the United States is failing to adequately match medical training with our medical needs on a national level."

Ever since the Medicare Payment Advisory Commission made recommendations in 2010 on how training could be improved to upgrade the nation's physician corps, GME, with respect to its funding and the training of doctors, has been under scrutiny. Commissioners have raised questions about whether the current education of doctors is effective at producing physicians who focus on information technology, integrated care and other approaches needed for changes in the health care delivery system. This year GME came under scrutiny again when President Obama, in his 2012 budget proposal, eliminated the children's hospital GME program. The program, which provides funds to 56 children's hospitals across the nation and trains pediatricians, as well as pediatric subspecialists, was spared in the 2012 omnibus spending bill (H.R. 2055), but the Association of American Medical Colleges has appealed to lawmakers to avoid further cuts to training.

In September 2011, the Josiah Macy Jr. Foundation issued a report stating that a "compelling case" is made for changes in how training is conducted. It continued, "Changes in demographics and disease patterns and increasing health disparities create new health care needs, requiring new approaches to physician education that emphasize collaboration, communication, and transitions in care." In its conclusion, the report said, "The public expects the GME system to produce a physician workforce of sufficient size, specialty mix, and skill to meet society's needs. Many observers from both public and professional vantage points feel it is currently falling short in each of these dimensions."

In echoing that conclusion, the senators said in their letter to IOM, "It is time to redesign health care workforce education and training in a manner that improves access to and delivery of health care services and enables the future generation of health care professionals to actively participate in creating high-quality, lower-cost health care." They also stated they wanted an analysis of areas including accreditation, reimbursement policy and the care of the underserved, and they would like to see recommendations from IOM by the third quarter of 2012.

## HHS Issues Guidance for Medical Surges

Early in January, the Department of Health and Human Services (HHS) released a planning tool to guide hospitals and health

systems in preparing for medical surges that could result from a bioterror attack, natural disaster or other public health emergency. The guidance spells out eight medical surge capability areas: health care system preparedness, health care system recovery, emergency operations coordination, fatality management, information sharing, responder safety and health, and volunteer management. Those eight capability areas are part of a set of 15 that HHS and the Centers for Disease Control and Prevention included in a broader report detailing national standards for state and local public health preparedness planning that was released in March 2011.

In addition to helping hospitals, health systems and their public health partners prepare for disaster, the release of the guidance had another purpose, i.e., to introduce the new Hospital Preparedness Program and Public Health Emergency Preparedness cooperative agreement that will take effect in July. The agreement annually funds \$350 million to states, four municipalities and eight U.S. territories to build and strengthen their surge response capabilities.

Other federal agencies such as the Federal Emergency Management Agency (FEMA) were involved in developing this surge capability guidance. Various health groups such as the American Hospital Association, the Association of States and Territorial Healthcare Officials and the National Association of County and City Health Officials also provided input.

Based on FEMA preparedness methods and aligned with Presidential Policy Directive 8 of March 30, 2011, which ordered federal agencies to develop a National Preparedness Goal, the guidance is designed to help health facilities and systems identify preparedness gaps, set priorities and develop plans for building and sustaining their specific capabilities. The guidance also includes a six step planning model that is not intended as a prescriptive method, but as a series of suggested activities.

The HHS guidance is available at <http://www.phe.gov/Preparedness/planning/hpp/reports/Documents/capabilities.pdf>.

## Claim of Improper Motive for Failing to Screen Dismissed

Finding insufficient alleged facts to demonstrate that a hospital violated EMTALA screening and stabilization, on November 3, 2011, the U.S. District Court for the Eastern District of Michigan dismissed the claims of the estate of a man who committed suicide fewer than three days after being discharged from the hospital emergency department subsequent to an earlier overdose (*Estate of Lacko v. Mercy Hospital*, E.D. Mich., No. 2:11cv12361, 11/3/11).

### The Facts

Police officers found Michael Shane Lacko in a park saying that he had no place to sleep, was recently homeless, his ex-wife was not letting him see his son, and he was depressed. He told police he "was thinking about getting a hose and ending it all tonight." Police relayed this information to Mercy Hospital's emergency department, where they brought Lacko at 2:07am on June 28, 2009. Lacko told ED staff that he purposefully overdosed by taking, about 13 hours earlier, an unknown amount of methadone for tooth pain and that he had a history of psychiatric illness, including depression and bipolar disorder. Lacko's admitting diagnosis was depression.

*continued on page 4*

Although no specific mental health examination is documented as having been conducted, the initial ED report indicates that at admission Lacko was alert, his chief complaint was nausea, and that he was "kicked out of house. Sleeping at van on the lake, brought in by police. He is not suicidal at this time." On the admission fact sheet Lacko was listed as disabled and on Medicaid of Michigan. Lacko was given Zofran for nausea and Ativan because Lacko was "somewhat agitated and wanted something to help him sleep." A drug test was performed using Lacko's blood and urine, although neither of these tests were used to determine the amount of methadone in Lacko's system. When Lacko suffered respiratory arrest a couple hours later, he was given IV Narcan to which he responded well. He awoke, "became verbal, and his respiration returned back to normal." Lacko was diagnosed with a narcotic overdose, and the ED plan was to "watch patient for a period of time and then medically clear to home."

Discharged on June 28, 2009, at about 8:57am after eating breakfast, Lacko was given a standard form of "Patient Education Materials" for an intentional overdose. The discharge instructions state, "If you are being discharged home, you must stay with a responsible adult until you are evaluated by a psychiatrist. If you are being discharged for immediate evaluation at a psychiatric hospital or clinic on a voluntary basis, you must go directly there in the company of a responsible adult." No responsible adult accompanied Lacko out of the hospital or to the crisis intervention center. Lacko was also advised to follow up with Dr. Dominic Kiomento, MD, in 2 to 4 days.

Lacko's body was found in his van at 11:27pm on June 30, 2009, two and a half days after he was released from the ED. The cause of Lacko's death was determined to be methadone intoxication associated with bilateral pneumonia. Lacko's estate filed suit against Mercy Hospital alleging that the defendant violated EMTALA and that the defendant committed medical malpractice. Defendant Mercy Hospital filed a motion to dismiss, arguing that Plaintiff failed to state a cause of action.

#### *President's Message - continued from page 1*

to give an award to the Hospital Administrator of the Year as nominated by our members. This would be publicized locally as well as in the newsletter of the organizations in which that administrator belongs which also gets our name out there and promotes better relationships with those groups.

One more thing; after being the longest serving editor of *Common Sense*, Dr. David Vega is moving on and Dr. Andy Walker will be assuming the duties of *Common Sense* editor over the coming months. David has done a fine job as editor and has agreed to mentor Andy so the transition is smooth and the quality of our newsletter is consistent.

I intend to keep my promises of being focused on the practicing emergency medicine specialist, forging new alliances with the other groups with whom we work, increasing our name recognition, augmenting and improving our educational offerings and providing quality international meetings. Clearly, there is much to do; I need all of you to become involved in some way, be it serving as an active participant on a committee, attending our conferences and events, or providing ideas and feedback. We need all of your expertise in order to go from a very good organization to a great one!

## The Ruling

### 1. Appropriate Medical Screening

Lacko's estate claimed that the hospital "failed to provide appropriate medical screening, as required by EMTALA." Defendant countered, arguing that it "performed an appropriate medical screening because Lacko received the same treatment as any other paying patient would have received and that the estate failed to properly allege an improper motive." The court noted that the test for an "appropriate" screening "is not meant to require the best possible medical procedure, but only those procedures that the hospital would normally conduct on any other paying patient...Without knowing what Defendant's standard procedures are in a case where a patient presents with depression, nausea, and has intentionally overdosed on a narcotic," the court determined that "dismissal of Plaintiff's claim that Defendant failed to provide Lacko with an appropriate screening by its own standards is not proper at this time."

But acknowledging another prong of the "appropriate medical screening" requirement, the court noted that to properly state a claim under EMTALA for inappropriate medical screening, a plaintiff must satisfy both prongs. The second prong requires that the plaintiff allege an improper motive. While Plaintiff alleged that Lacko received disparate treatment, the court found that no factual allegations were offered that "Lacko's treatment would have been different had Lacko not been on Medicaid...[Plaintiff] simply failed to allege that Defendant had any improper motive...The only indication that Lacko was given disparate treatment is Plaintiff's bare allegation." Thus finding that Lacko's estate alleged, but did not show, that Mercy Hospital had an improper motive, the court granted Defendant's motion to dismiss Plaintiff's claim for inappropriate medical screening.

### 2. Stabilizing an Emergency Medical Condition

Plaintiff claimed that "being acutely suicidal constitutes an 'emergency medical condition' within the definition of EMTALA and that Defendant...failed to stabilize Lacko's emergency medical condition." Mercy Hospital asserted that "it did not determine that Lacko had an emergency medical condition, so the stabilization requirement is not applicable. Alternatively, Defendant argues that if an emergency condition did exist, that Lacko was stabilized before being released, in compliance with EMTALA."

The court found that "to the extent Plaintiff argues that Defendant was negligent in failing to recognize that Lacko had an emergency medical condition, such an allegation does not fall under EMTALA and is reserved for state malpractice law. In the Complaint, Plaintiff alleges that an emergency condition existed but falls short of alleging that Defendant knew or determined Lacko had an emergency condition." The court granted Mercy Hospital's motion to dismiss the stabilization claim because when "Defendant did not determine Lacko had an emergency medical condition, the stabilization requirement does not apply."

### 3. State Law Medical Malpractice Claims

Mercy Hospital asserted that the "medical malpractice claims should be dismissed for lack of subject matter jurisdiction if this Court dismisses the EMTALA claims." While a federal district court may retain supplemental jurisdiction over state law claims after dismissal of the federal claims, this court declined to retain supplemental jurisdiction over the state law medical malpractice claims, and dismissed Plaintiff's state law medical malpractice claims without prejudice for lack of subject matter jurisdiction.

**EMTALA case synopsis prepared by Terri L. Nally, Principal, KAR Associates, Inc.**



# 18th Annual Scientific Assembly Held February 8-10 in Coronado, CA!



Pre-Conference courses were held February 6 and February 7. This photo shows the hands-on instruction during the Ultrasound Course.



William T. Durkin, Jr., MD MBA FAAEM, AAEM president, speaks at the Annual Business Meeting and Candidates Forum.



Stuart Swadron, MD FAAEM, and Mel Herbert, MD FAAEM, speak during a plenary session on February 8, 2012.



Howard Blumstein, MD FAAEM, AAEM immediate past president, presenting the Master of the American Academy of Emergency Medicine (MAAEM) Recognition Award to Joseph Lex, Jr., MD MAAEM FAAEM.



Amal Mattu, MD FAAEM, lectures to a standing room only audience on February 8, 2012.



Stephen Hayden, MD FAAEM, Editor-in-Chief of the *Journal of Emergency Medicine*, with the winner of the AAEM/JEM Resident and Student Research Competition, Usha Periyanyagam, MD.



Past Presidents of AAEM including (from left, clockwise) A. Antoine Kazzi, MD FAAEM, Robert M. McNamara, MD FAAEM, Joseph P. Wood, MD JD FAAEM, Larry D. Weiss, MD JD FAAEM, Tom Scaletta, MD FAAEM, and Howard Blumstein, MD FAAEM.



Attendees networking in the exhibit hall during the Opening Reception on February 8, 2012.



The Candidates Forum was held on February 9, 2012.



Howard Blumstein, MD FAAEM, acknowledges Michael Epter, DO FAAEM, as the Program Director of the Year.

## Certificate of Excellence in Emergency Department Employer Fairness

The American Academy of Emergency Medicine strongly supports fair working practices for emergency physicians. The Academy prefers the democratic ownership model for emergency physicians, but also recognizes those employers who offer a fair workplace for employed emergency physicians. Consequently, it will certify excellence in the ED workplace if employers offer the following workplace conditions:

- Due Process
- No Post-Contractual Restrictions
- Financial Transparency
- No Lay Owners

Please go to <http://www.aaem.org/certificateofemployerfairness/> for more information and to fill out an application for the Certificate of Excellence in Emergency Department Employer Fairness.



## AAEM Position Statement

### Indemnification Clause in Emergency Medicine

Emergency physician contracts should not include indemnification or "hold harmless" agreements regarding the hospital or practice site. These agreements unfairly shift risk to emergency physicians and this risk is not generally insurable.

2/10/12

## 2012 100% ED Groups

We would like to recognize and thank the following ED groups for participating in our 2012 100% ED Group Membership. We sincerely appreciate the enthusiastic and continuous support of these physicians and their groups.

- Amarillo Emergency Physicians – TX
- Campbell County Memorial Hospital – WY
- Cascade Emergency Associates – WA
- Chesapeake Regional Medical Center – VA
- Drexel University – PA
- Eastern Carolina Emergency Physicians (ECEP) – NC
- Edward Hospital – IL
- Emergency Physicians at Sumner, PLLC (EPAS) – TN
- Emergency Specialists of Oregon (ESO) – OR
- Florida Hospital East Orlando – FL
- Fort Atkinson Emergency Physicians (FAEP) – WI
- Fredericksburg Emergency Medical Alliance, Inc – VA
- Memorial Medical Center – IL
- Northeast Emergency Associates – MA
- OSF Saint Anthony – IL
- Physician Now, LLC – VA
- Salinas Valley Memorial Hospital – CA
- Santa Cruz Emergency Physicians – CA
- Southern Colorado Emergency Medical Assoc (SCEMA) – CO
- Space Coast Emergency Physicians – FL
- Temple University Hospital – PA
- University of Louisville – KY
- West Jefferson Emergency Physician Group – LA

### 2012 ED Groups

- Bay Care Clinic LLP – WI

## AAEM ED Group Membership

AAEM instituted group memberships to allow hospitals/groups to pay for the memberships of all their EM board certified & board eligible physicians. Each hospital/group that participates in the group program will now have the option of two ED Group Memberships.

- 100% ED Group Membership - receives a 10% discount on membership dues. All board certified and board eligible physicians at your hospital/group must be members.
- ED Group Membership - receives a 5% discount on membership dues. 2/3 of all board certified and board eligible physicians at your hospital/group must be members.

For these group memberships, we will invoice the group directly. If you are interested in learning more about the benefits of belonging to an AAEM ED group, please visit us at [www.aaem.org](http://www.aaem.org) or contact our membership manager at [info@aaem.org](mailto:info@aaem.org) or (800) 884-2236.

## 2012 Membership Applications Now Being Accepted!

**Plan ahead for your future.** Secure your AAEM membership at the price of \$365 per year. Full voting multi-year memberships now available for up to 10 years or until certification expires.

### Have You Set Up Your Member's Login Account?

- Check your membership status or payment history
- Update your contact information
- Pay your membership dues
- Register for upcoming events

To set up your initial login account,

please visit <http://aaem.execinc.com/edibo/LoginHelp>.

Please contact [info@aaem.org](mailto:info@aaem.org) or 800-884-2236 with any questions.

## Practice Management Committee

In the past year, the Practice Management Task Force has matured into the Practice Management Committee. We have been developing our vision and goals for the upcoming year, which will include refining the practice management track for education at Scientific Assembly, a practice management forum during the Assembly in Las Vegas, and development of a book on tools for democratic groups to obtain and maintain their contracts with hospitals. Drs. Durkin and Zun have manned the AAEM booth at the American Hospital Association and the American Association of Healthcare Executives national conferences. They have recognized that we need to do a better job of educating the health care executives on the benefits of AAEM and democratic groups. This will be evaluated and rolled into the committee goals and vision.

We are looking for those of you who belong to successful democratic groups to participate in the committee as well as provide anecdotes and input into the book. Please contact Tom Derenne at [tderenne@aaem.org](mailto:tderenne@aaem.org) if you would like to contribute on either project.

*In March 2012, the Accreditation Council for Continuing Medical Education (ACCME) reviewed AAEM's CME program and provided the decision of 'Accreditation' to AAEM. The reaccreditation process included a self-study report, evidence of performance-in-practice, and an accreditation interview. AAEM is accredited to provide Continuing Medical Education credits for directly sponsored activities such as Scientific Assembly and Preconference Courses, Oral Board Review Courses and Written Board Review Courses, and jointly sponsored activities. The ACCME accreditation is valid through March 2016.*

## American College of Healthcare Executives

### Leslie Zun, MD MBA FAAEM AAEM Board Member

During mid-March, Drs. Leslie Zun and William Durkin hosted an exhibit at the American College of Physician Executives annual meeting in Chicago. The conference was attended by thousands of health care executives from all over the U.S. Being one of the few organizations exhibiting at this conference in a prime location, we had the limelight of the exhibit hall. We extolled the virtues of board certified emergency physicians and the value of independent democratic groups. We distributed our new brochure on understanding who staffs your emergency department. Many of the health care administrators who stopped by the booth knew little about our organization or AAEM's message. One of the most important contacts we made was with the incoming president of the ACHE. We communicated our desire to collaborate on areas of mutual interest. One of the administrators of CEP was also present at the meeting. A detailed discussion ensued with an open door for building a stronger relationship. Although we hoped the meeting would be more conducive to making contacts for start up of independent, democratic groups at any of the hospitals, we believe that exhibiting at this meeting has gotten out our message, increased name recognition for the organization, and initiated some valuable connections.

## AAEM is Proud to Announce the New AAEM Board of Directors

### President

William T. Durkin, Jr., MD MBA – 2014

### Vice President

Mark Reiter, MD MBA – 2014

### Secretary-Treasurer

Kevin Rodgers, MD – 2014

### Immediate Past President

Howard Blumstein, MD – 2014

### Past Presidents Council Representative

Robert M. McNamara, MD – 2014

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Michael Epter, DO – 2013

David W. Lawhorn, MD – 2014

Robert Suter, DO MHA – 2013

David D. Vega, MD – 2014

Andy Walker, MD – 2013

Joanne Williams, MD – 2013

Leslie Zun, MD MBA – 2013

### YPS Representative

Michael Pulia, MD – 2013

### AAEM/RSA President

Teresa M. Ross, MD – 2011-2012

### Editor, JEM – Ex-Officio Board Member

Stephen R. Hayden, MD

## Call For AAEM Social Media Committee Members

AAEM would like to announce the formation of the Social Media Committee. The Social Media Committee will assist AAEM in getting more involved in venues such as Facebook, Twitter and any other medium that could be used to get our message out to members and potential members. The committee will hold discussions via email and meet via conference call on a quarterly basis.

AAEM members wishing to apply for the Social Media Committee can sign up online at <http://www.aaem.org/committees/> or contact the Academy at [info@aaem.org](mailto:info@aaem.org). Please include a statement describing your interests and a current copy of your cv.







## American Board of Emergency Medicine

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### News Release

Contact: Frances M. Spring, Administrative Coordinator, Communications  
Phone: 517.332.4800 ext. 345  
Email: [fspring@abem.org](mailto:fspring@abem.org)

FOR IMMEDIATE RELEASE

### ABEM Board of Directors Elects Three New Members

**East Lansing, MI <February 16, 2012>**—At its winter 2012 meeting, the Board of Directors (BOD) of the American Board of Emergency Medicine (ABEM) elected three new directors from nominees submitted by ABEM sponsor organizations, the American College of Emergency Physicians (ACEP), and the American Medical Association (AMA). The BOD elected Jill M. Baren, M.D., Mary Nan S. Mallory, M.D., and Robert P. Wahl, M.D. from the two slates of candidates.

Dr. Baren is a Professor of Emergency Medicine and Pediatrics at the Perelman School of Medicine at the University of Pennsylvania; and Chair, Department of Emergency Medicine and Chief of Emergency Services, University of Pennsylvania Health System, in Philadelphia, Pennsylvania. She has served ABEM as an examiner for the oral certification examination since 2000, and as a member and past Chair on the Pediatric Emergency Medicine Subboard. Dr. Baren is also a past President of the Society for Academic Emergency Medicine. Dr. Baren was elected from a slate of nominees submitted by ACEP.



Jill M. Baren, M.D.



Dr. Mallory is a Professor of Emergency Medicine, and Program Director for the Emergency Medicine Residency at University of Louisville School of Medicine, Louisville, Kentucky, where she also serves as Vice Chief of Staff for the University of Louisville Hospital. Additionally, she is an emergency physician for Emergency Medicine Physician Associates PSC at Clark Memorial Hospital in Jeffersonville, Indiana. Dr. Mallory has served ABEM as an examiner for the oral certification examination since 2002, a senior oral certification examination case reviewer since 2011, and an item writer for the qualifying examination since 2008. Dr. Mallory was elected from a slate of nominees submitted by ACEP.

Mary Nan S. Mallory, M.D.

Dr. Wahl is an Assistant Professor and Residency Director in the Department of Emergency Medicine, Wayne State University School of Medicine; and an emergency medicine staff physician at Detroit Receiving Hospital, Detroit, Michigan. He has served ABEM as an examiner for the oral certification examination since 2007, an item writer for the in-training examination from 2001-2010, and a member of the Enhanced MCQ Advisory Panel since 2011. Dr. Wahl was elected from a slate of nominees submitted by the AMA.



Robert P. Wahl, M.D.

Dr. Baren, Dr. Mallory, and Dr. Wahl will attend the 2012 summer BOD meeting as observers and begin their terms as ABEM directors at the close of that meeting.

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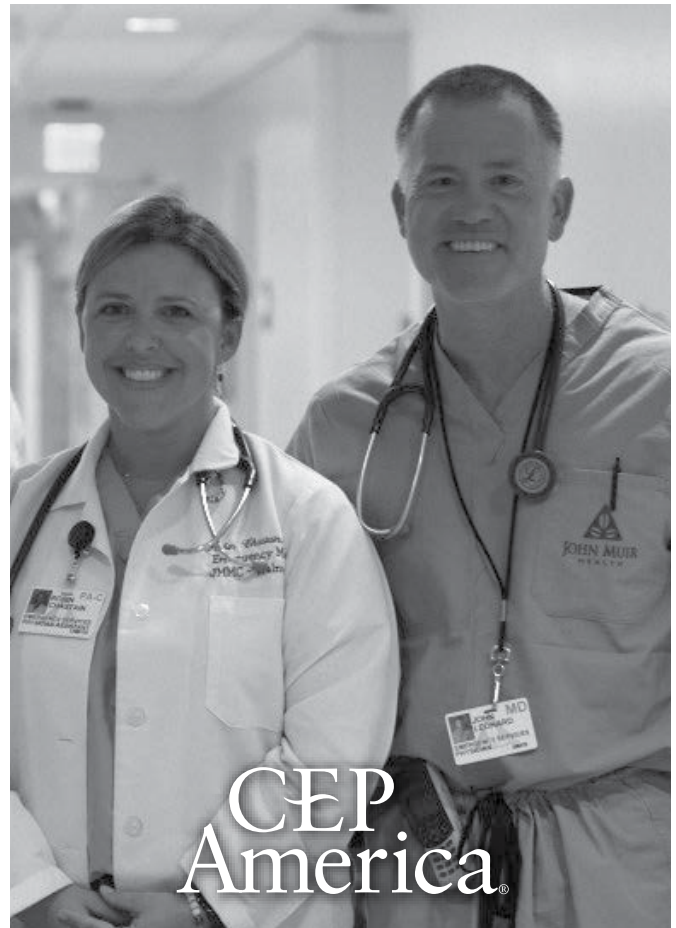
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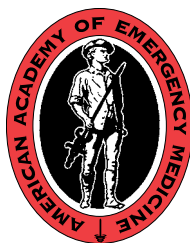
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AAEM is featuring the following upcoming sponsored and recommended conferences and activities for your consideration. For a complete listing of upcoming endorsed conferences and other meetings, please log on to <http://www.aaem.org/education/conferences.php>

## AAEM-Sponsored Conferences

### May 16-18, 2012

Inter-American Emergency Medicine Conference  
Panamericano Buenos Aires Hotel and Resort  
Buenos Aires, Argentina  
<http://www.aaem.org/education/iaemc/>

### August 21-24, 2012

The AAEM Emergency Medicine Written Board Review Course  
Hilton Newark Penn Station  
Newark, NJ  
<http://www.aaem.org/education/writtenboard/>

### October 3-4, 2012

AAEM Pearls of Wisdom Oral Board Review Course  
Embassy Suites Las Vegas  
Las Vegas, NV  
<http://www.aaem.org/education/oralboard/>

### October 20-21, 2012

AAEM Pearls of Wisdom Oral Board Review Course  
Sheraton Suites Hotel - Philadelphia, PA  
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Embassy Suites Hotel - Orlando, FL  
Embassy Suites Hotel - Rosemont, IL  
Embassy Suites Hotel - Los Angeles, CA  
<http://www.aaem.org/education/oralboard/>

### October 23-26, 2012

Pan-Pacific Emergency Medicine Congress  
Coex Convention and Exhibition Center  
Seoul, South Korea  
<http://www.pemc2012.org/>

### February 9-13, 2013

19th Annual Scientific Assembly  
The Cosmopolitan Resort and Casino  
Las Vegas, NV

## AAEM-Recommended Conferences

### May 9-12, 2012

SAEM Annual Meeting  
Chicago, IL  
<http://am2012.saem.org/>

### May 18-20, 2012

The Difficult Airway Course—Emergency™  
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[www.theairwaysite.com](http://www.theairwaysite.com)

### May 23-25, 2012

High Risk Emergency Medicine—San Francisco  
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### June 8-10, 2012

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### June 27-30, 2012

14th Annual International Conference on Emergency Medicine  
Dublin, Ireland  
<http://www.icem2012.org>

### September 21-23, 2012

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The Difficult Airway Course—Emergency™  
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### November 16-18, 2012

The Difficult Airway Course—Emergency™  
Las Vegas, NV  
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### December 6-7, 2012

3rd Annual National Update on Behavioral Emergencies  
Las Vegas, NV  
[www.behavioralemergencies.com](http://www.behavioralemergencies.com)

Do you have an upcoming educational conference or activity you would like listed in *Common Sense* and on the AAEM website? Please contact Marcia Blackman to learn more about the AAEM endorsement approval process: [mblackman@aaem.org](mailto:mblackman@aaem.org).

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

**The Academy recently received the notice below from the American Board of Emergency Medicine. It alerts us to a semantic change, not any actual change in the requirements for maintaining board certification.**

The American Board of Emergency Medicine (ABEM) has changed the name of its maintenance of certification program from Emergency Medicine Continuous Certification (EMCC) to ABEM Maintenance of Certification (ABEM MOC). Candidates and diplomates will begin seeing the new name in printed and electronic communications, including the ABEM website. The changeover to the new name will occur over the coming months on the ABEM website, so you may see the program referred to as ABEM MOC on one page, and EMCC on another. We hope that this will not inconvenience you during this transition phase.

The shift to ABEM MOC represents a change to the program's name only. ABEM, along with the other 23 Member Boards of the American Board of Medical Specialties (ABMS), agreed to adopt common terminology that reflects the continuous nature of the program. It is also hoped that this will make it easier for the public and non-EM physicians to understand that all certified physicians participate in the same type of certification process.

# AAEM Young Physicians Section

## People Power

Michael Pulia, MD FAAEM

AAEM Board of Directors–YPS Director



Flying home from yet another phenomenal Scientific Assembly (SA), I find myself reflecting on my time as Young Physician Section (YPS) president and what makes AAEM such a special organization. One could probably argue it is our values, mission or educational offerings, but I would disagree. Although each of these is an essential part of the Academy, I believe what makes AAEM truly special can be distilled down to one word: people.

From the support staff that makes it all happen behind the scenes to the inspirational board of directors, this organization is overflowing with amazing people. Each year SA is a chance to reunite with my AAEM “family” and bond as we work to further the goals and mission of the organization. During my time in leadership roles with YPS and the Resident and Student Association (RSA), it has been my honor to serve alongside some of the most innovative and inspirational EPs who are already well on their way to becoming leaders in the field. Transitioning to the YPS director position, I plan to continue fostering these relationships and ensure that the needs of YPS are prioritized with the board of directors.

## Someone to Lean On

Elizabeth Hall, MD FAAEM

YPS President



The AAEM Scientific Assembly was once again a huge success. Of course, the warm weather, beautiful sunsets and wonderful environment of the Hotel Del Coronado didn't hurt. Looking at the filled seats during the lectures while the ocean waves crashed on the beach is just a testimony to the high quality of value of these educational sessions.

During the Scientific Assembly, we were fortunate to have our first 2012-2013 Young Physicians Section (YPS) board of directors meeting, which was also a great success. We have many returning members as well as two new physicians to serve on the board. As the newly appointed president of YPS, I am 110% committed to making YPS grow, flourish and provide new benefits to our members. This same vision is shared by the newly elected leadership: vice president Jennifer Kanapicki, MD FAAEM; secretary/treasurer Mike Ybarra, MD; board members Heather Jimenez, MD; Jeff Pinnow, MD FAAEM; Michael Tang, MD FAAEM; and Sandra Thomasian, MD. I would also like to recognize Dr. Michael Pulia who did an excellent job in leading YPS last year and will remain active in YPS this year as immediate past president. I look forward to a productive year with our new board.

There's no doubt that the early years of a career in emergency medicine can be tough. Transitioning to a career while maintaining a balance between one's personal and professional lives is not easy. This is not something one has to do on his or her own, as one

In addition to reuniting with old friends at SA, it is always inspirational to meet the next generation of YPS and RSA leaders. Grassroots development of future leaders is a hallmark of my own AAEM experience, and it is always a pleasure to mentor those following in my footsteps. One of my greatest honors has been to introduce my medical student mentees to this organization early in their careers and foster them into leadership roles.

Beyond RSA and YPS, AAEM also attracts dynamic individuals by offering motivated members opportunities to contribute through advocacy, educational events and leadership roles. Democratic methods and a system that rewards effort and productivity, rather than political ties in determining levels of involvement, are unique attributes among professional organizations. This approach cultivates leadership from within and has repeatedly proven successful at finding those “shining stars” among the membership.

Perhaps Lawrence Bossidy, retired CEO of Honeywell International, said it best, “I am convinced that nothing we do is more important than hiring and developing people. At the end of the day you bet on people, not on strategies.” Fortunately for AAEM, all of our “people” are volunteer members who believe in the organization and its mission. I believe the Academy has embraced the “bet on people” philosophy, and in the future, this will continue to be our greatest asset.

can lean on YPS. This is what fostered the development of YPS a few years ago and what helps keep it active today. YPS is open to physicians in their first seven years post-residency. Our goal is to promote the professional development of our members and provide them with education consistent with the principles and activities of AAEM.

In addition to the annual educational events at Scientific Assembly, we have developed a number of additional benefits to help our members with this transition. Make the right first impression by taking advantage of our **CV and cover letter review service** or participate in our **mentoring program** where you can develop relationships with other physicians to help guide you in your future career. Read our **Rules of the Road for Young Emergency Physicians** and learn how to enhance your personal and professional development while also learning techniques to deal with the challenges we face every day in the ED. We also provide our members with the opportunity to publish in **Common Sense**. Submit your article, and if it is chosen, you will receive a \$25 gift card and complimentary one year YPS membership. Like our **Facebook page**, and take a look at our website [www.ypsaaem.org](http://www.ypsaaem.org) to learn more about us and how we can benefit you.

This year will be an exciting year. We have many dedicated and enthusiastic members, and I know that by working together, we can accomplish many great things. If you would like to get more involved, please go to our website and join a committee.

So what are you waiting for? Get started, and become invested in your future. Get involved, join a committee, and let YPS be the organization that you lean on.

## Attention YPS and Graduating Resident Members

### CV & Cover Letter Review

### Are you ready?

Enhance your credentials.  
Increase your job opportunities.

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](http://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](http://www.ypsaaem.org) or contact us at [info@ypsaaem.org](mailto:info@ypsaaem.org).



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### Rules of the Road

FOR YOUNG EMERGENCY PHYSICIANS

Chief Editor:  
David Hogg, MD, FAAP  
David Hogg, MD, FAAP

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**Now Available!**

## The Young Physicians Section (YPS) of AAEM is proud to announce the new 2012 – 2013 Board of Directors:

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*Invested in your future.*



## Call for Mentors

Interested in shaping the future of emergency medicine? YPS is looking for established AAEM members to serve as volunteers for our virtual mentor program.

For more information, visit <http://www.ypsaaem.org/mentors/> or contact us at [info@ypsaaem.org](mailto:info@ypsaaem.org).



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## RESIDENT PRESIDENT'S MESSAGE

### Consider an Away Elective. Now is Your Chance!

Teresa M. Ross, MD  
AAEM/RSA President



If the only medical world you've ever known is the infinite connecting hallways of a classic teaching hospital, you're not alone. Medical school and residency naturally bring us to these oldies but goodies as the epicenter of our academic and clinical training.

But step away for a while – imagine a world where emergency docs come to work in jeans, know their colleagues (and their families) by name, and can't count on off-hours, in-house consultants except medicine and pediatrics. There is an exciting world out there beyond formal department conferences and journal-quoting consultants.

In the emergency departments of rural hospitals, physicians deliver care to some of the most remote communities of our nation, and they're pretty good at it. Your ED attendings might not be boarding your trauma transfer for eight hours, but they sure are doing their own fracture reductions, nasopharyngoscopy and complicated facial laceration repairs. And they are most likely running the entire show on a single-coverage shift with nothing but a dedicated nursing team backing them up. Whether you imagine yourself practicing rural medicine, or even community medicine, or have committed to research for life, it is an invaluable experience to learn from these opportunities.

Medical school and residency offer the perfect opportunity to travel and appreciate the spectrum of care and resource management that exists in our field. Away from your Level-1 Trauma Center and academic tertiary referral hospital, you will learn to value not only the skill sets of rural physicians but also the magnitude of work that is done with the resources of a smaller hospital.

If you've only ever practiced in a land-locked northern city, here is your chance to treat desert snake bites and coastal drownings. If you've always lived on a southern plain, here is your chance to see frostbite and altitude sickness. Additionally, you'll manage STEMIs without a cath lab and stabilize severe trauma patients for transfer when your hospital doesn't carry platelets for transfusion. You could be paged to the ICU for an emergent intubation. The family medicine hospitalist might call you for a curbside in-patient consult when there is no one else to discuss a new drug rash with except you.

Who are the patients of rural hospitals?

Sixteen percent of Americans live in "rural" communities (2012 U.S. Census), down from 21% in Census 2000. Compare that to 51% of Americans living in the suburbs. (Definition of "rural": population <50,000 in non-metropolitan area.)

Two million American Indians and Native Alaskans are served by 45 hospitals of the Indian Health Service.

The average doctor-patient ratio is one primary care physician (PCP) per 1,300 Americans, versus one PCP per 1,910 rural Americans.

Generalists outweigh specialists. Family medicine physicians outnumber emergency medicine physicians seven to one in rural areas (American Academy of Family Physicians).

Many rural areas are characterized by extreme poverty, high minority population and significant chronic disease.

Fifteen percent of rural Americans live in poverty, compared to 12% elsewhere.

One in five uninsured Americans lives in a rural area.

Rural Americans suffer from more obesity, hypertension, diabetes and heart failure (HHS) than the population as a whole.

In a 2011 study, rural rotations were required in six (5%) of emergency medicine residencies, elective at 92 (83%), and not available at 13 (12%). Overall, 197 (8%) residents completed a rural rotation during residency, and 160 (7%) selected their initial job in a rural area.

If you don't have a mandatory rural rotation, how do you set one up? Talk to your medical school or residency program director. Programs often have a pre-existing arrangement with a government-sponsored program (i.e., Area Health Education Cooperatives (AHEC) for medical schools, or Federal Civil Service, National Health Service Corps, or Indian Health Service for eligible residents and graduates).

No matter where you choose to practice, use your training as an opportunity to appreciate the variety of emergency medical practice in our country – if not in the world. You will see clinical scenarios and pathologies you may never see again and will meet physicians and mentors who exist beyond the horizon of your standard academic program. They are the networks that feed into our large tertiary referral centers. We can learn a lot by going to the source and learning from them.

Coming soon: Visit [www.aaemrsa.org](http://www.aaemrsa.org) for detailed information on international rotations and resources. RSA is With You All The Way!

*Dr. Ross is happy to receive email correspondence at [tmrossmd@gmail.com](mailto:tmrossmd@gmail.com).*

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## Spotlight on Leaders in Emergency Medicine: Dr. Jesse Pines

Interview by Leana S. Wen, MD MSc  
AAEM/RSA Secretary-Treasurer



*This is a new column in Common Sense where Dr. Leana S. Wen, AAEM/RSA secretary/treasurer, interviews leaders in emergency medicine about their experiences, perspectives and insights. The fourth installment is a conversation with another rising star in EM: Dr. Jesse Pines. Dr. Pines is the Director of the Center for Health Care Quality and Associate Professor in the Department of Emergency Medicine and Health Policy at George Washington University. He has authored more than 120 peer-reviewed articles, two books and numerous other articles in both medical and lay publications.*

**LW:** Tell me about your current positions, specifically your leadership posts and what you do in them.

**Dr. Pines:** I'm the Director of the Center for Health Care Quality at George Washington University. I'm also a practicing, board certified emergency physician and associate professor in the department of emergency medicine as well as health policy. In addition to practicing clinical medicine, teaching and research, I am very involved in U.S. health policy and contribute to both the medical and lay literature including writing for Time.com, Slate.com and *Emergency Physicians Monthly*. I also work part time as a senior advisor in the Research and Evaluation Group at the Center for Medicare and Medicaid Innovation Center.

**LW:** Can you tell our readers a bit about where you are from and where you got your training? Why did you choose emergency medicine?

**Dr. Pines:** I'm from Washington, DC originally. I went to Georgetown for medical school and received my MBA there too. In medical school, I was drawn to both surgery and EM. I ended up choosing EM because I like medicine and also like to do other things. I didn't know surgeons who were able to really have multiple careers, but I did know EPs who able to balance clinical with other interests. Then I went to residency at the University of Virginia in Charlottesville. There, along with the faculty, I helped to develop a clinical research program where we had undergraduate students enrolling patients in ongoing studies. This experience was a lot of fun. And it really drew me to focusing on research early on in my career. After residency, I went to Penn and got further training in research with a Master's degree in Clinical Epidemiology.

**LW:** How did you get interested in your particular areas of expertise? Any lessons from your training that you'd like to share with us?

**Dr. Pines:** One of the most important things I learned from my mentors was how to do research, specifically how to ask answerable and important questions, and to focus on a particular niche. Early in my career, I became very interested in the issue of ED crowding. It was a natural fit. I was interested in the administrative aspects of health care, and I saw crowding as one of our specialty's biggest issues. More recently, I've become more interested in research in issues in diagnostic testing and provider variation, but I still love



Jesse Pines, MD MBA FFAEM

thinking about and studying issues related to crowding and patient flow. It's still a problem that's far from being solved.

**LW:** You have significant involvement in shaping health policy. What do you think are the major problems facing health care today, and how would you go about addressing them?

**Dr. Pines:** There are several big problems. One major issue is poor care coordination. We as EPs understand this better than most doctors. Care coordination problems invariably end up on our doorsteps. There also are big issues with how doctors and hospitals are paid, specifically the underlying incentives around what we are paid to do, and not do, and why we get penalized. The big elephant in the room is tort reform, which has unfortunately not been the focus of recent reforms. One specific issue I'm active in working on is how to promote the use of clinical decision rules. Decision rules can help to reduce variation in how we test and treat patients. On a larger scale, decision rules can help us cut down on testing, but only if we decide as a specialty that decision rules are the standard of care. If specialty societies and government agencies start promoting decision rules, this could be a small, but important, step in reducing defensive medicine and costs of care. Because there are so many decision rules in emergency medicine, this is where we can really be leaders and set examples for other doctors.

**LW:** I'm sure you have thought a lot about the future of EM. Are you excited about being an EP in this era?

**Dr. Pines:** I am very excited about being an EP, especially now. The reason is that I think we already do a fantastic job managing patients, but one of our skills—fixing problems through coordinating care—is underused. It will become more significant in the future as controlling costs become a more important consideration in medical decision-making in the future. In the coming years, as systems are built to manage and coordinate care for patients across multiple settings, it will become clear how important EPs are in this equation.

**LW:** You are widely recognized as a leader in your field. Do you have tips for young EPs for getting involved in leadership and advancing in their careers?

**Dr. Pines:** Yes. First of all, find a niche. And find it as early as you can. Second, make sure you have the skills to do what you are asked to. The skills for being a leader – for being a policy person or for doing epidemiology or biostatistics research – are not necessarily skills taught in residency. You may need additional training or experience. The earlier you get the right skills, the quicker you can advance. Extra skills also help to differentiate you. Third, I cannot emphasize how important mentorship is. Just look around at people who succeeded early on, and you will see that there is a mentor behind the scenes who was there to guide them and create opportunities.

*Editor's note: We would love to have your feedback on this column. Please send comments and suggest other leaders you would like to see profiled to [wen.leana@gmail.com](mailto:wen.leana@gmail.com).*



## Residency Program Director

The University of Kentucky Department of Emergency Medicine is seeking to interview exceptional candidates for the position of Residency Program Director. Ideal applicants will have demonstrated successful leadership roles in academic emergency medicine.

The University of Kentucky College of Medicine established the Department of Emergency Medicine in 1982. The UK Department of Emergency Medicine continues to benefit from outstanding institutional support including the recent completion of a new 40,000 square foot Emergency Department in the summer of 2010.

Competitive salary and benefits are offered with this position. Please send CV to:

**Roger L. Humphries, MD**  
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The University of Kentucky is an equal opportunity employer and encourages applications from minorities and women.

## AAEM Antitrust Compliance Plan:

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

**Current news and updates**

can now be found on the AAEM website

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## RSA Election Results

*AAEM/RSA is Proud to Announce the  
New 2012-2013 AAEM/RSA Board of Directors:*

### RSA Board Officers:

#### **President:**

Leana S. Wen, MD MSc – Brigham & Women's Hospital/  
Massachusetts General Hospital

#### **Vice President:**

Stephanie Gardner, MD – Indiana University

#### **Secretary/Treasurer:**

Taylor McCormick, MD – LAC+USC Medical Center

#### **Immediate Past President:**

Teresa M. Ross, MD – Georgetown-Washington Hospital Center

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Rachael Engle, DO – Temple University  
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Megan Healy, MD – Temple University  
Sarah Terez Malka, MD – Indiana University  
Meaghan Mercer – University of Nevada, Las Vegas

### Medical Student Council:

#### **President**

*(also serves on the AAEM/RSA board of directors):*  
Mary Calderone – Loyola University Stritch School of Medicine

#### **Vice President:**

Richard Herold – University of North Dakota

### Regional Representatives:

#### **Midwest:**

William Burns – Loyola University Stritch School of Medicine

#### **Northeast:**

Jason Zeller – Drexel University College of Medicine

#### **West:**

Faith Quenzer – Western University of Health Sciences



\*Terms will run from mid May 2012 through May 2013

We had a very successful election with many qualified candidates.  
Thank you for your participation.

You can still get involved in RSA! We have many other leadership opportunities. In the coming weeks, we will be sending out a call for AAEM/RSA and AAEM committee members.



## Resident Journal Review – Synthetic Cathinones (“Bath Salts”) and Herbal Marijuana Alternatives

Susan Cheng, MD MPH; Jonathan Yeo, MD; Eli Brown, MD; Allison Regan, MD  
Edited by Michael C. Bond, MD FAAEM and Christopher Doty, MD FAAEM

This Resident Journal Review focuses on two popular designer drugs that have made their way into the media as well as our emergency departments: synthetic cathinones, also known as “bath salts,” and herbal marijuana alternatives. Due to the relative novelty of these drugs, not much literature or research exists to help ED physicians manage patients who come in with these acute intoxications. The pharmacology, clinical symptoms and management options, as well as a few case reports, will be discussed in this review.

**Beyond THC: the new generation of cannabinoid designer drugs.** Fattore L, Fratta W. *Frontiers in Behavioral Neuroscience*. 2011; 5:60.

**Here Today, Gone Tomorrow...and Back Again? A Review of Herbal Marijuana Alternatives (K2, Spice), Synthetic Cathinones (Bath Salts), Kratom, Salvia divinorum, Methoxetamine, and Piperazines.** Rosenbaum CD, Carreiro SP, Babu KM. *Journal of Medical Toxicology*. 2012; 8:15–32.

**The toxicology of bath salts: A review of synthetic cathinones.** Prosser JM and Nelson LS. *Journal of Medical Toxicology*. 2012; Mar; 8(1):33-42.

### Herbal Marijuana Alternatives

Herbal Marijuana Alternatives (HMAs) such as K2 or Spice are sold as alternatives to marijuana that provide similar clinical effects but are not detectable by the traditional marijuana screening methods. They are basically blends of herbs adulterated with synthetic cannabinoid compounds. These synthetic compounds were initially designed by pharmaceutical companies when searching for cannabinoid receptor agonists with the same analgesic and anti-inflammatory effects of tetrahydrocannabinol (THC), without the psychotropic effects. HMAs are typically sold on the internet or in head shops as incense products, bath products, air fresheners or meditation potpourri and are sold under such names as *Spice*, *Spice Gold*, *Spice Diamond*, *K2*, *Silver*, *Aroma*, *Arctic Spice*, *Genie*, *Scene* and *Dream*. They are most commonly smoked, but they can also be infused or inhaled. Although these products first emerged on the internet and in specialty shops beginning as early as 2004, it was only in 2008 that synthetic cannabinoids were officially identified as the active ingredients in “Spice,” a compound which had been marketed as an herbal blend. In early 2009, several European countries announced that any compounds containing these substances would fall under the Narcotics Law, making it illegal for them to be sold online and in head shops. That same year, the United Kingdom (UK) amended the Drugs Act of 1971 to list synthetic cannabinoids as controlled substances. However, rather than deterring sale and use of these substances, the ban only spurred development of new synthetic cannabinoid products, such as JWH-073, JWH-019, and JWH-250, among others. In March 2011, the United States Drug Enforcement Administration (DEA) ordered a temporary ban on five synthetic cannabinoids, including JWH-018, JWH-073, JWH-200, CP-47,497 and CP 47,497-C8.

The pharmacological effects of HMAs are likely from both the herbal ingredients and the added synthetic cannabinoids, although there is not much evidence or literature regarding the psychotropic effects of these herbs. Commonly used herbs in the HMAs include baybean, beach bean, blue lotus, dog rose/rosehip, lion's ear/tail, wild dagger, etc. Other substances such as synthetic opioids, monoamine oxidase inhibitors, and oleamide, a fatty acid derivative with cannabinoid-like activity, have also been isolated in many Spice products. The synthetic psychoactive compounds found in many HMA products were initially foreign to most forensic laboratories and presented a challenge to identification and referencing of these materials. Detection of these drugs is further hindered by the variable, unpredictable makeup of each product, particularly as the products are modified in response to ever-changing legal restrictions.

The synthetic cannabinoids are not structurally similar to THC but they are agonists of the cannabinoid receptors (CB1 and CB2) and may even have some effect on other receptors as well including NMDA. It is thought that the euphoric effects of the drug are due to its agonist properties at the CB1 receptor. Though in vitro studies indicate that JWH-018 acts as a full agonist at the receptor, THC is a partial agonist. Furthermore, when compared to THC, JWH-018 has a more than fourfold higher affinity for the CB1 receptor and a 10-fold higher affinity to the CB2 receptor.

Due to the lack of medical literature and research regarding the HMAs, the clinical effects are primarily known from case reports and case series. In addition to the extensive assortment of ingredients found in synthetic cannabinoid products such as Spice, there is also a wide variation in the quantity of substances present, leading to a significant incidence of accidental overdoses requiring hospitalization. Psychiatric effects that have been reported include anxiety, paranoia, avoiding eye contact, agitation, delusions, and psychosis. Common side effects of HMA include tachycardia, diaphoresis, conjunctival injection, and dry mouth. Nonetheless, the desired effects of Spice blends are frequently described as euphoric. Anxiety is one of the main unwanted side effects of acute intoxication, while severe anxiety and depression have been reported during withdrawal. Interestingly, Spice and similar products do not contain cannabidiol, a component of cannabis which antagonizes CB1 and CB2 receptors and is thought to produce anxiolysis. Although there are limited data, several deaths that occurred after taking synthetic cannabinoid products, particularly K2, have been attributed to suicide and coronary ischemic events.

The synthetic cannabinoids are not detectable by current immunoassay lab tests for THC but are detectable by gas chromatography-mass spectrophotometry (GC-MS) lab testing. When product samples are obtained, the parent synthetic cannabinoid may be detected using GC-MS lab testing. However, the metabolites of the synthetic cannabinoids may be the only detectable compounds present in human blood or urine. These are detected with metabolite-based liquid chromatography-mass

*continued on page 20*



spectrometry (LC-MS) lab testing. Currently, commercial testing for synthetic cannabinoids in human samples of blood and urine, as well as HMA samples, is available from some commercial labs.

Any patient with unfavorable symptoms after an HMA exposure should be directed to an emergency room via ambulance as it is difficult to ascertain the exact drugs involved in an HMA exposure. A Regional Poison Control Center should be consulted. Acute management consists of supportive care with the use of benzodiazepines, if needed, for the control of agitation and anxiety. In general, all patients should be observed until the resolution of abnormal vital signs, vomiting, and psychiatric symptoms. It is important to note that the common symptoms described with HMAs such as agitation and tachycardia are not typical of those seen with marijuana exposure, making the diagnosis more difficult. Although there is no antidote for HMA exposure, there are agents being studied. CB1 antagonists, such as SR141716, have been found that may reverse the psychotropic effects of marijuana. Animal models have also shown that naltrexone may attenuate THC's effects. These agents may become more relevant if the use of HMAs and synthetic cannabinoids continue to rise.

## Synthetic Cathinones ("Bath Salts")

Cathinones derived from the khat plant (*Catha edulis*) have been used recreationally for centuries. Chewing the leaves and twigs of the plant produces amphetamine-like euphoric effects. In 2006, there were 10 million khat users worldwide. The list of synthetic cathinones is long: butylone, dimethylcathinone, ethcathinone, ethylone, 3- and 4- fluoromethcathinone, mephedrone, methedrone, methlenedioxypyrovalerone (MDPV), methylone and pyrovalerone, among others. Bupropion is the only cathinone derivative that has a medical indication in the U.S. and Europe. The first synthetic cathinone, methcathinone, was produced in 1928. Methcathinone was previously used in Russia as an antidepressant, also known as "Cat" and "Jeff" when used recreationally. The United Nations Convention listed cathinones as a schedule 1 substance in 1988 and the United States did so in 1993. Mephedrone, another type of synthetic cathinone, came from Europe to the U.S. in 2009. U.S. poison control centers received 12 times as many calls involving "bath salt" exposure in the first six months of 2011 than in all of 2010. The number of seizures from synthetic cathinones increased from 14 in 2009 to 290 in 2010. In September 2011, the DEA scheduled three synthetic cathinones as schedule one (mephedrone, methylone, and MDPV). Manufacturers sell the drugs as bath salts, plant food, insecticides, chicken feed additives, or research chemicals with names like Energy and Meow. They also label them as "not for human consumption" to avoid legal regulation and prosecution. The synthetic cathinones can be found on the internet, in smoke shops, and gas stations. Multiple deaths related to bath salts exposure have been reported internationally and in the medical literature, raising concerns as the drug becomes more popular in the U.S. Synthetic cathinones are usually sold as a white or brown powder, but capsules and tablets are also available.

The method of ingestion varies, but synthetic cathinones are most commonly nasally inhaled or ingested. Rectal administration (known as "booty bombing" or "keystering"), gingival delivery, inhalation and intramuscular or intravenous injection have all been reported.

"Bombing" is wrapping powder in cigarette paper and swallowing it. "Keying" is dipping a key into powder and inhaling it. Synthetic cathinones are mostly excreted via the urine and can be measured via gas or liquid chromatography-mass spectrometry in the blood, urine and stomach contents. They can also be analyzed in hair.

There are limited data on pharmacokinetics and pharmacodynamics of synthetic cathinones. The cathinone stimulant from the khat plant has been manipulated with biochemical substitutions creating a new class of drugs with variable potency. These synthetic cathinones are beta ketophenethylamines, which are structurally similar to amphetamines. Cathinone derivatives, however, tend to be more hydrophilic, which decreases their ability to cross the blood-brain barrier. They have been shown to inhibit the reuptake of dopamine, serotonin, and norepinephrine. Based on animal models, amphetamine derivatives increase synaptic concentrations of biogenic amines (norepinephrine, dopamine, and serotonin) by two primary mechanisms. The first is by inhibiting monoamine uptake transporters. The second is by causing the release of neurotransmitters from intracellular stores via changing the vesicular pH or inhibiting the vesicular monoamine transport (VMAT2) receptor. The mechanism of different synthetic cathinones varies. Methylone acts less on VMAT2 receptors compared to other amphetamine derivatives. It is a competitive inhibitor of norepinephrine reuptake but a noncompetitive inhibitor of dopamine and serotonin receptors. Mephedrone causes a greater increase in brain dopamine concentration and was noted to have a faster return to baseline level of neurotransmitters compared to MDMA. Pyrovalerone inhibits norepinephrine and dopamine reuptake, but has little effect on serotonin uptake.

The symptoms reported by users include euphoria, alertness, energy, talkativeness, increased sexual arousal, and the compulsion to re-dose frequently. Some case reports describe extremely aggressive and psychotic behavior with increased physical strength, as sometimes described in PCP intoxication. The clinical effects of synthetic cathinone intoxication are consistent with sympathomimetic toxicity and include hypertension, tachycardia, hyperthermia, dehydration, and psychomotor agitation. The patients may also report palpitations, headache, chest pain, trismus, bruxism, tremors, insomnia, and paranoia. Although much can be drawn from the structural and chemical similarities between synthetic cathinones and amphetamines, continued studies are needed to understand the particular properties including the long-term effects of synthetic cathinones.

Currently, routine urine drug screening for amphetamines is not able to detect synthetic cathinones, although they may cause false positive methamphetamine screens. However, both GC-MS and LC-MS testing kits are commercially available for some synthetic cathinones including mephedrone, MDPV, and methylone. The synthetic cathinones are mostly excreted via the urine, but can be measured in the blood, hair, urine and stomach contents.

Supportive care is the mainstay of therapy based on management of other sympathomimetic conditions. Aggressive sedation with benzodiazepines is indicated for agitation, seizures, tachycardia, and hypertension. Extreme hypertension that persists despite

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benzodiazepines may be treated with titratable vasodilators. Beta blockers should be avoided due to the potential to cause unopposed alpha-adrenergic stimulation, worsening the hypertension. Significant hyperthermia may require passive or active cooling. All moderately to severe symptomatic patients should have an electrocardiogram (ECG), be placed on a cardiac monitor, and receive serial temperature checks. Lab studies including electrolytes, renal and liver function tests, cardiac markers and creatine kinase should be considered, as should testing for coingestants or adulterants. Asymptomatic patients with no other suspected coingestions or psychiatric symptoms generally may be discharged. In a case series of 35 patients who presented to the ED after using bath salts, 26% were admitted to an intensive care unit.

## Several Case Reports highlighting the dangers of these drugs...

### **Hyperthermia and Multiorgan Failure After Abuse of "Bath Salts" Containing 3,4-Methylenedioxypyrovalerone. Borek HA, Holstege CP. *Ann Emerg Med.* 2012 Mar 2.**

This toxicology case report presents a 25-year old man who after injecting bath salts was found by police running wildly, acting combatively, and foaming at the mouth. His vitals in the ED were significant for a heart rate of 175 bpm and a temperature of 106.5 degrees rectally. On physical exam, he had mydriasis, rightward deviation of the eyes, and extreme warmth. He was agitated until he was intubated with etomidate and succinylcholine. Over the following hour his temperature and pulse normalized with ice packs and cooling blankets. His labs were significant for the following: white blood cell count 17,000/mm<sup>3</sup>, potassium 5.1 mEq/L, serum bicarbonate 14 mEq/L, creatinine 2.88 mg/dL, glucose 45 mg/dL, troponin 3.24 ng/mL, and lactate 7 mg/dL. The urine drug screen was positive for benzodiazepines, which had been administered 90 minutes prior to collection. ECG, computed tomography of his head and cerebrospinal fluid were all normal.

During the next 2 days the patient developed renal failure, fulminant hepatic failure, disseminated intravascular coagulation and rhabdomyolysis. His aspartate aminotransferase peaked at 16,688 U/L, INR 9.3, creatinine kinase 253,377 U/L, creatinine 10.2 mg/dL, and troponin 29ng/mL. He required hemodialysis while in the medical intensive care unit (MICU) because of anuric renal failure, and he remained intubated for 9 days. His mental status returned to baseline by day 13 and his lab values except for his creatinine normalized by day 18. The patient required hemodialysis for 1 month, after which his creatinine normalized and his urine output returned to normal.

Using high performance liquid chromatography, urine from the day of admission was examined and found to have a 3,4 methylenedioxypyrovalerone (MDPV) level of 140 ng/mL. MDPV is a synthetic compound similar structurally to pyrovalerone, which is a potent inhibitor of the dopamine and norepinephrine transporters. Pyrovalerone is 9 times and 13 times more potent than cocaine at inhibiting the uptake of dopamine and norepinephrine, respectively. The exact mechanism responsible for the clinical course of this 25-year-old male is not certain, but it is presumed that MDPV was responsible for causing hyperthermia through a central dysregulation

process. It is also possible that the elevated body temperature was due to an uncoupling effect of MDPV on skeletal muscle proteins and oxidative phosphorylation, or that it was due to increased muscle activity or agitation. Regardless, MDPV is strongly associated with causing hyperthermia. It is unknown, however, whether the end-organ effects seen in this patient were due to the direct cellular toxicity of MDPV or from the marked agitation and hyperthermia that subsequently ensued. Nonetheless, treatment of MDPV intoxication should be similar to the management of other sympathomimetic agents, which is aggressive supportive care and controlling of the patient's agitation with benzodiazepines.

### **Death Following Recreational Use of Designer Drug "Bath Salts" Containing 3,4-Methylenedioxypyrovalerone (MDPV). Murray BL, Murphy CM, Beuhler MC. *Journal of Medical Toxicology.* 8(1): 69-75.**

This toxicology case report presents a 40-year-old male with a history of bipolar disorder who injected and snorted an unknown amount of bath salts containing MDPV. He subsequently became extremely agitated and went into cardiac arrest. It is the first reported case of confirmed isolated recreational MDPV use causing an excited delirium syndrome that ultimately progressed to death.

Shortly after abusing bath salts, a 40-year-old male became delusional and uncontrollably aggressive requiring police restraint. He was taken to the ED and continued to exhibit very aggressive behavior and incomprehensible screaming. The vital signs at triage were blood pressure 100/64 mmHg, heart rate 91 bpm, respiratory rate 12 breaths per minute, and oral temperature of 98.0°F (36.7°C). Within 5 minutes of arrival to the ED, the patient developed bradycardia that subsequently progressed to a pulseless electrical activity (PEA) arrest. Cardiopulmonary resuscitation (CPR) was initiated along with the administration of epinephrine, lidocaine, atropine, naloxone, and flumazenil. After 30 minutes of advanced cardiac life support (ACLS), return of spontaneous circulation was achieved.

Immediately after resuscitation, the patient was noted to be febrile with a rectal temperature of 105.4°F (40.8°C). His post-arrest laboratory evaluation was significant for a potassium of 7.4 mEq/L, creatinine of 3 mg/dL, and creatinine kinase of 234 U/L. His urine drug screen was positive for opiates. Repeat ECG showed peaked T waves and a prolonged QRS of 240 milliseconds. The patient was transferred to a tertiary care center with hemodialysis capabilities.

On arrival to the tertiary care center, the patient's temperature had decreased to 100.2°F (37.9°C) and the blood pressure remained low at 85/41 mmHg despite high doses of dopamine, phenylephrine and intravenous (IV) fluids. His neurological exam was significant for dilated and minimally reactive pupils, normal corneal reflexes, and an intact gag reflex. His ECG was significant for a right bundle branch block with a rate of 53 bpm and hyperacute T waves. A venous blood gas showed a pH 7.2 with a base excess of -11 mEq/L and a lactate of 2.83 mmol/L. Despite medical treatment with calcium gluconate, sodium bicarbonate and insulin, his potassium remained elevated at 8mmol/L.



*Resident Journal Review - continued from page 21*

The patient was admitted to the MICU and treated with a sodium bicarbonate drip, vasopressin, hydrocortisone and normal saline. Despite these interventions, his metabolic acidosis gradually worsened over the following 3 hours to pH of 7.14 and he became anuric. His INR increased to greater than 9.3 and his creatinine kinase was 75,952 U/L. He developed an anemia (hemoglobin of 6.3 g/dL) and thrombocytopenia with platelets of  $11 \times 10^9/L$ . Hemodialysis was started 17 hours after initial presentation and he was transfused 4 units of packed red blood cells, 2 units of platelets, 9 units of cryoprecipitate and 10 units of fresh frozen plasma. Despite improvements in his acidosis and anemia, he deteriorated neurologically and at 42 hours after initial presentation he was declared brain dead by clinical criteria. Supportive care was withdrawn.

Throughout the patient's hospital course, several toxicology screens were performed and all were negative for barbiturates, amphetamines, benzodiazepines, cocaine, marijuana, methadone, opiates, salicylates, lithium, ethanol, ethylene glycol, methanol, and isopropanol. Samples of the patient's urine and serum were later screened using gas chromatography/mass spectrometry and found to be positive for acetaminophen, caffeine, cotinine, lidocaine, trimethoprim (12 mcg/mL), and MDPV (670 ng/mL).

Since 2010, MDPV has been the most commonly detected beta-keto phenylalkylamine found in toxicological analyses of bath salts in the U.S. This case report of MDPV toxicity initially described symptoms consistent with Excited Delirium Syndrome (ExDS). ExDS is a specific type of delirium with agitation, hyperthermia, tachypnea, tachycardia, a period of decreased struggle, and then progressing to cardiac arrest. ExDS is most likely due to a dysregulation of dopaminergic pathways, which can be exacerbated by a recent history of cocaine use. This patient had a chronic history of cocaine abuse and he rapidly progressed from a state of agitated delirium to sudden PEA arrest. A return of spontaneous circulation was achieved, but subsequently there was the development of coagulopathy, rhabdomyolysis, renal and hepatic failure, anoxic brain injury and finally death. This case encourages emergency physicians and toxicologists to consider novel drugs of abuse in the differential diagnosis and test for it when indicated. This would help further characterize the symptoms related to intoxication and improve the understanding of the potential toxicities these newer drugs of abuse may have.

**Centers for Disease Control and Prevention MMWR. Weekly Vol. 60/No 19. May 20, 2011.**

This report summarizes the investigation of 35 people who had ingested, inhaled, or injected bath salts and subsequently visited a Michigan Emergency Department (ED) between November 13, 2010, and March 31, 2011. Michigan state public health agencies, health care providers, poison control centers, and law enforcement agencies coordinated their efforts to rapidly identify this emerging health problem and ultimately enabled an emergency public health order to remove the toxic bath salts from the marketplace.

From November 2010 to January 2011, the Marquette County ED treated 7 patients presenting with hypertension, tachycardia, tremors, motor automatisms, mydriasis, delusions, and paranoia.

These patients had reported using bath salts purchased at a local store for about \$20 per package. The number had increased to 13 by February 3, and on February 4th an emergency public health order was placed by the Marquette County Health Department and the owner of the local store was ordered to turn over all products known to contain MDPV to government authorities.

On February 5th, the Michigan Department of Community Health (MDCH) instituted a mandate requiring hospitals to report all cases of possible bath salts intoxication. The MDCH also started an investigation into bath salt abuse, and ultimately identified 35 patients who visited a Michigan ED during the period between November 13, 2010, and March 31, 2011. The patients ranged from 20-55 years of age: 19 (54%) were men and 16 (46%) were women. Twenty-four (69%) of the patients identified had a self-reported history of drug abuse, with 11 (31%) reporting polysubstance abuse and 12 (34%) intravenous drug abuse. Sixteen patients (46%) had a history of mental illness reported in their medical records including bipolar disorder, schizophrenia and depression. The method of abuse varied as 22 (63%) of the patients injected the drug, 9 (26%) snorted it, and 4 (11%) had ingested it. No relationship was identified between the exposure route and the severity of illness.

The clinical findings in the investigation were consistent with stimulant intoxication. Of the 35 identified patients, 32 (91%) had neurologic symptoms, 27 (77%) had cardiovascular symptoms, and 17 (49%) had psychological symptoms. Agitation (66%) and tachycardia (63%) were the two most common symptoms found in these patients. Delusions/hallucinations were also a frequent symptom seen in 40% of patients. Seventeen of the 35 patients were hospitalized, 15 were treated then discharged from the ED, 2 left against medical advice, and 1 was dead on arrival to the ED. Of the 17 hospitalized patients, 9 were admitted to the ICU, 5 to the general floor, and 3 were admitted directly to a psychiatric unit. Treatment consisted of supportive care, and benzodiazepines were used to control agitation.

Although bath salt abuse has been documented nationwide, this report is the first to summarize the epidemiology of a number of ED cases. The investigation demonstrated collaboration between public health, law enforcement and health care. The Marquette County Health Department issued an emergency order to decrease local bath salt abuse locally. In addition, a statewide system was established to mandate reporting of detected cases in other counties. These methods demonstrate the importance of identifying a potentially dangerous substance in a timely manner and implementing appropriate strategies to reduce further drug-related morbidity and mortality.

**Conclusion:**

Bath salts and synthetic cannabinoids are emerging drugs of abuse of which all emergency providers must be aware. Though treatment consists primarily of supportive care and the use of benzodiazepines to control agitation and anxiety, awareness of these drugs and patients' expected courses of intoxication can help predict complications and allow for the timely initiation of care. An increased awareness of their use in your community can help encourage public health awareness and interventions to remove these products from local stores.



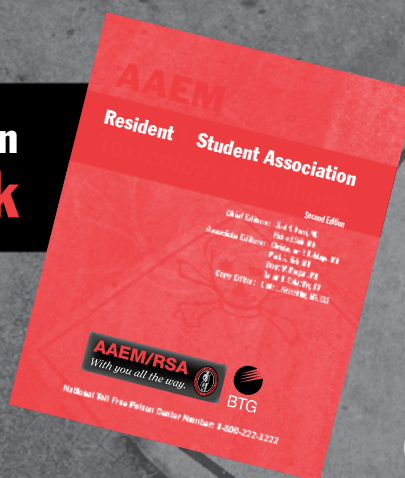
# AAEM

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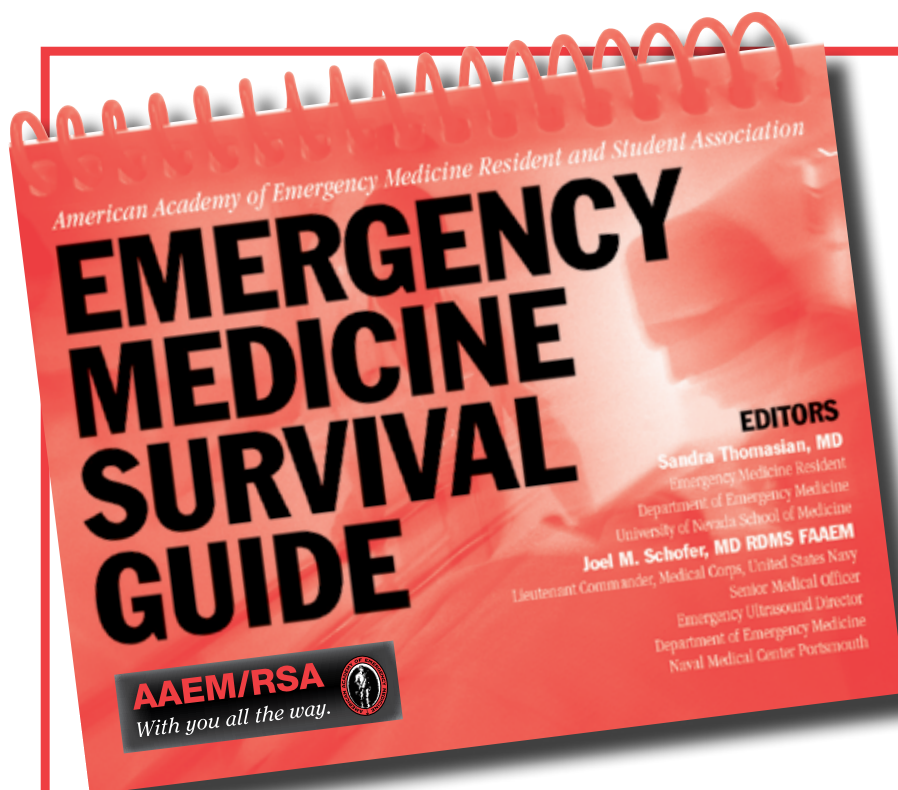
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# Resident & Student Association

## STUDENT PRESIDENT'S MESSAGE The Scientific Assembly

Meaghan Mercer  
AAEM/RSA Medical Student Council President



"Emergency Medicine doesn't eat its young" is one of my favorite statements from this year's AAEM Scientific Assembly. Although amusing, it is grounded in a solid truth. As Dr. Amal Mattu stepped up to the podium on the first day, two hundred emergency medicine students, residents and attendings surrounded me. Being wrapped

in a room full of people who share a passion for the field and a mutual desire for each other's success is an inspiring and empowering feeling.

These experiences have driven both my passion for the field as well as my success. Not only are the lectures cutting edge, but they are also full of knowledge. Quotes such as "learn one thing every day and do it humbly," or "treat people the way they want to be treated" are interspersed in discussions imparting life lessons far beyond current medical therapy.

At the opening reception, I fully realized the lack of hierarchy in the field as I stood deep in conversation with a second-year medical student, an international ultrasound guru, an editor of an extremely prestigious emergency medicine journal, and well-known attendings from across the nation. There was a sense of motivation when I reaffirmed that this specialty is one of the greats. The leaders in this field are not masked in a pretentious light but are full of an encouraging, nurturing nature.

These events are bursting with potential contacts, mentors, and most importantly, life-long friends. AAEM has provided a home in the field, and whether you have been a member for one day or for five years, you are kin. I look forward to each occasion when I have the opportunity to reconvene with my EM family and share my experiences that have helped define my identity in the field.

To everyone that I met in San Diego, it was a joy! My pride in AAEM and AAEM/RSA is largely due to the brilliant and compassionate individuals I am fortunate enough to have worked with. I want to thank all the students, residents and attendings who made the Scientific Assembly a huge success. I hope to see you all next year in Las Vegas for a fun, inspiring and educational event!

I also want to congratulate all the fourth-years who matched. It has been a wonderful journey over the last few years, and I commend you all on your hard work that has led to a well-deserved accomplishment. Remember to approach every day with the fervor for learning that guided you to where you are today. Have an enthusiasm for life that is contagious and inspires others. Trust yourself, but with the virtue of humility. You are the future of this great profession, and you are going to achieve great things!

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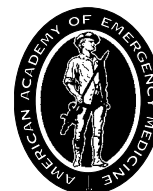
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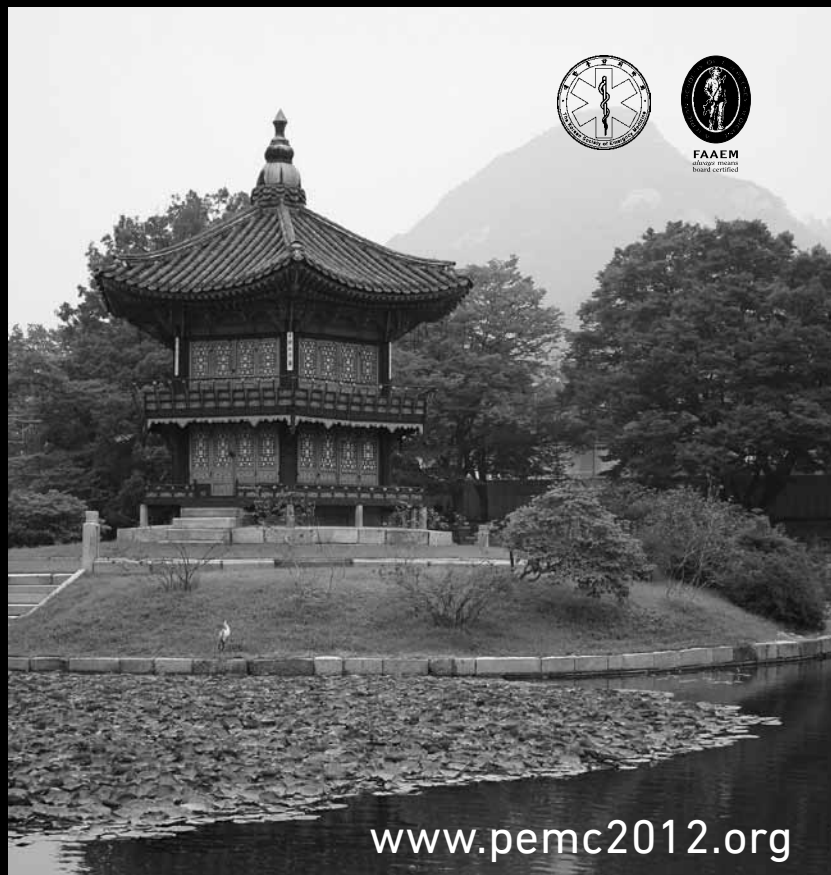
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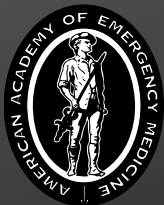


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