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# SENSE

THE NEWSLETTER OF THE AMERICAN ACADEMY OF EMERGENCY MEDICINE



## PRESIDENT'S MESSAGE

Howard Blumstein, MD FAAEM

*At the 2010 Scientific Assembly, Larry Weiss, MD JD FAAEM, gave his President's Address at the Tuesday Afternoon Business Meeting. Then he introduced me as the new president. I spoke for a few minutes. For my first President's Message, I would like to expand on the comments I made during that introductory presentation.*

First, a few words about Larry Weiss, MD JD FAAEM, as president of AAEM. Over the last two years, Larry has worked tirelessly on behalf of the Academy. Here is just a short list of issues he has addressed:

- Calls for assistance from any number of members and non-members;
- Countering efforts of alternative boards to gain inappropriate recognition from state boards;
- At least fifty visits to residency programs around the country;
- Intimate involvement with numerous legal issues, most importantly our efforts to combat the illegal involvement of lay corporations in medical professional activities;
- About a zillion calls and complaints from emergency doctors around the world.

He has handled all this with grace and patience. Not once have I heard him complain about the workload. Larry deserves our collective thanks for his tireless service. He certainly has my appreciation for being a mentor and role model. Thanks, Larry, for all you have done for us.

Now, about the future:

We are members of this Academy because we all share an ideal. That ideal is integrity.

This year's Scientific Assembly has shattered attendance records. AAEM's membership numbers are on a pace to reach new highs. We are accomplishing these feats at a time when most medical professional organizations struggle to maintain their current numbers.

I believe this represents our success in helping our fellow emergency physicians understand that our collective integrity is under attack. I intend to make integrity the watchword for my term as president.

Our professional integrity is under threat because our primary duty is to our patients. We cannot, however, always fulfill that duty when threatened by bosses who have the absolute power not only to fire us at will, but also to manipulate us after we have been fired.

Our academic integrity is under attack by alternative boards, which have gone before licensing bodies and argued that training in emergency medicine is not necessary for a physician to practice high quality emergency medicine. They argue, in essence, that our specialty is not defined by a unique body of knowledge or collection of procedural skills. That is a slap in the face of everyone who did an EM residency or has ever been involved in training residents in the ED.

As corporations establish close ties to residency programs, or even take them over, can faculty members really talk with their residents openly and honestly about the pitfalls of that practice model? Will they be punished for doing so? As chair of the AAEM Education Committee years ago, I had faculty members from such programs pull out of speaking engagements because of "political considerations." Where is the integrity?

Whenever we sign a contract that violates the law by either supporting the corporate practice of medicine or designing financial schemes that constitute kickbacks, we are putting ourselves at risk for losing our licenses. Thus, our personal integrity is also threatened.

I do not understand, frankly, why so many emergency physicians fail to understand this. Perhaps it is my failure as a debater. Maybe I am not effectively educating my peers about the issues central to the AAEM mission. But I don't think so. I think too many of our peers are afraid or unwilling to ask the hard questions. They do not want to stir up trouble.

Still, our membership grows, and I continue to hear from emergency physicians who have come to realize that complex issues threaten our specialty in ways that other specialties are just beginning to experience. They are learning that they need to add their voices to the growing call for reform from the Academy. Just like the founders of our specialty, we are blazing new trails and fighting new battles. I am excited to help lead that charge.

## INSIDE THIS ISSUE

- 1 President's Message
- 3 Scientific Assembly
- 4 AAEM Activities
- 7 Washington Watch
- 14 AAEM Endorsed & Sponsored Conferences
- 15 Young Physicians Section
- 20 AAEM/RSA Activities
- 27 Job Bank



## Editor's Letter

David D. Vega, MD FAAEM

### Scientific Assembly – What Happened in Vegas Cannot Stay in Vegas

Once again, AAEM's Scientific Assembly was a tremendous success. With record-setting attendance, the meeting featured some absolutely outstanding lectures by speakers from across the country. My only regret is that I could not attend all of the excellent talks in the various tracks occurring simultaneously. The quality of this conference was truly second-to-none. Notably, in a time when many organizations are increasing prices for their activities, Scientific Assembly remained free for AAEM members. Mark your calendar now for next year's scientific assembly to be held February 28 – March 2, 2011, in Orlando, FL.

The energy of our ranks of dedicated members at Scientific Assembly was palpable. I heard a number of members offer excellent ideas for projects and activities with which AAEM can be involved. I also heard many members voicing a commitment to making a difference in our specialty through their own increased involvement with AAEM. My hope is that this enthusiasm will continue now that Scientific Assembly is over and that every member will take a few moments to decide how to contribute to the continued growth and success of AAEM.

Serving on one of AAEM's committees is a great place to increase your involvement with the organization. Through the guidance of our immediate past president, Larry Weiss, MD JD FAAEM, and now under the leadership of our new president, Howard Blumstein, MD FAAEM, AAEM's committees have been re-energized and are looking for members who are ready to make a difference. Take a minute right now to review the list of AAEM committees (<http://www.aaem.org/committees/>) and decide where your interests and abilities can be used.

*continued on page 7*

Your new 2010-2011  
AAEM Board of Directors



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#### AAEM Mission Statement

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

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

#### Membership Information

**Fellow and Full Voting Member: \$365 (Must be ABEM or AOBEM certified in EM or Pediatric EM)**

\*Associate Member: \$250

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

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

International Member: \$150 (Non-voting status)

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

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

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

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

# The 16<sup>th</sup> Annual AAEM Scientific Assembly was held February 15-17, 2010, in Las Vegas, NV.



Pre-conference courses were held February 13 and February 14. Michael Winters, MD, lectures at the Resuscitation Course for Emergency Physicians.



Larry D. Weiss, MD JD, AAEM president, welcomed attendees to the Scientific Assembly on Monday, February 15, 2010.



Larry D. Weiss, MD JD, AAEM president, presenting the Peter Rosen Award to Gus Garmel, MD, on February 15, 2010.



Attendees walking through the exhibit hall during the Opening Reception on February 15, 2010.



A full house during the Plenary sessions on Monday, February 15, 2010.



Larry D. Weiss, MD JD, AAEM president, presenting Michael Ybarra, MD, with the Resident of the Year Award.



Stephen R. Hayden, MD (left), Editor-in-Chief of the *Journal of Emergency Medicine*, with the winners of the AAEM/JEM Resident and Student Research Competition, from left, Roberta Capp, MD, Jennifer Woodward and Steve Aguilar, MD.



Attendees view and discuss the photos from the AAEM Photo Competition.

## *The American Academy of Emergency Medicine Congratulates the 2010 AAEM Award winners.*

- Peter Rosen Award* .... Gus Garmel, MD FAAEM
- James Keaney Leadership Award* .... Anthony DeMond, MD FAAEM
- Young Educator Award* .... Jesse Pines, MD FAAEM
- Resident of the Year Award* .... Michael Ybarra, MD
- Joe Lex Educator of the Year Award* .... Richard Shih, MD FAAEM
- International Leadership Award* .... Professor Gunnar Öhlén
- Program Director of the Year* .... David S. Howes, MD FAAEM
- Program Director of the Year* .... Stuart P. Swadron, MD FAAEM

# What It Means to Have Been Given the James Keaney Award for 2010

Tony DeMond, MD FAAEM  
Emeritus Member

First, it is not often that you find an organization to join where the mission and the style match your own. When I first heard about AAEM, I immediately felt a bond with the mission. So at my first AAEM Scientific Assembly, I went to a table of board members and just started talking. I had no teaching credentials and no research credentials. I can't say I was terribly wronged by an EM corporation or a contract holding dictator, but I have worked for both. So I didn't have that much of a beef or a chip on my shoulder. I just had a belief in the mission of AAEM, and I just started talking to the board members at the table. I knew that I was being looked at as "who is this guy?" and I was told the biggest contribution I could make to AAEM would be to tackle membership recruitment. I said okay, and I ran with it. Nothing glamorous, nothing frontline, but I felt a kindred spirit with others at that Scientific Assembly, and I wanted to better the practice of my profession.

Second, it is not often that you find an organization that grows without losing its democratic process. It started with my first meeting with George Schwartz, MD. Bob McNamara, MD FAAEM, was running for president unopposed, and George and I discussed how that reflected on a young organization. George knew he

was going to run because there needs to be choices to stimulate debate. We both agreed that one of the many problems of ACEP is the entitlement program of advancing someone to the presidency unopposed. I don't think Bob's and George's policy views were much different. They both can be firebrands, but the message to membership should be that elections are open, controversy is welcome, and entitlement is disputed.

Third, it is not often that you find an organization where you can have direct access to the leaders and pester them with email or stand up in a board meeting and promote your agenda. I have never figured out how to convey this access in membership recruitment mailings, but it is one of the great features of AAEM.

Therefore, it means a great deal to me that AAEM would award the James Keaney Award to me, because it is based on my advocacy. I still haven't published. I still don't have an academic appointment. I have begun to teach in my current work as EMS medical director. I have retired from the pit and have had to transition to an FAAEM emeritus member with the expiration of my ABEM certification. But, I will not give up my advocacy for AAEM and its mission.

## The Expert Witness in Emergency Medicine

Michael H. LeWitt, MD MPH FAAEM  
Senior Core Faculty, Emergency Medicine Residency  
Conemaugh Valley Memorial Hospital

Many emergency physicians are asked at some point in their careers to review medical malpractice cases by an attorney. These reviews may be requested on behalf of a plaintiff bringing a malpractice claim against a physician or for the defendant in such a claim. The nature of the legal system in the United States is such that it usually requires experts, generally medical, on both the plaintiff and defense sides in medical tort (injury) cases. In other cases involving injury without medical malpractice, there are also experts who explain the type of injuries of the plaintiff, perhaps in the field of aviation design, building construction, product liability or traffic patterns, depending on the nature of the legal action. All these types of issues fall under the civil aspect of the legal system. By contrast, criminal litigation generally does not involve physicians, except as forensic experts, generally in psychiatry or pathology, where the experts are not directly involved in a person's care, except peripherally as an examiner of an individual or evidence such as tissue samples. Occasionally, emergency physicians are called upon to provide expert testimony if a crime such as rape, assault and battery or other types of injuries are involved.

Under the Federal Rules of Evidence,<sup>1</sup> an expert is defined as an individual qualified by knowledge, skill, experience, training or education to provide scientific, technical or other specialized opinions about evidential or factual issues. An expert witness should be impartial and disinterested; this does not mean uninterested, but rather, that one should have no financial interest in the outcome of a legal action, such as a contingent fee arrangement. The expert is paid for time, not testimony. The expert should be honest, presenting opinions without prevarication or distortion, and should be objective. False testimony is perjury. In the case of medical

malpractice, the expert should have training, experience and practice comparable to that of the physician being sued or the other expert who will testify in the case. The expert should limit testimony to his or her area of expertise. For example, an emergency physician may comment about the management of a patient in hypovolemic shock, whether managed by a trauma surgeon, intensivist or other specialist. It would be inappropriate, however, to comment on a particular surgical procedure without the requisite background to do so. Additionally, an expert is far more credible if he or she actively practices medicine, rather than being employed full-time providing testimony.

When preparing testimony, the physician should review all available records. The situation has risen where an attorney does not provide everything available, causing the physician to be blind-sided when additional material is provided for last-minute analysis or used for impeachment (discrediting of testimony) during a cross-examination or trial.

The emergency department is a high-risk environment. Though most non-emergency physicians have spent some time in the ED as part of their training, the high density of cognitive demands for very sick individuals, with the multiple distractions of noise, interruptions, time pressures, and need for timely and progressive decision-making are best understood by physicians working in the ED regularly.

Courts use different standards in their acceptance of medical testimony. The original standard of what testimony would be allowed arose in *Frye v. United States*<sup>2</sup> in 1923. In this case, the Court determined that testimony must reflect what is generally accepted

*continued on page 5*

in the particular field in which it belongs. As with much of the law, it has a conservative approach to change. Judges had the authority to exclude testimony that was either not relevant or inappropriate and allowed the jury to determine which evidence they considered credible.

In 1993, however, the rules of evidence, a game plan for how expert testimony can be provided, changed dramatically with *Daubert v. Merrell Dow Pharmaceuticals*,<sup>3</sup> a landmark case ultimately decided by the U.S. Supreme Court. This case involved a medication used for nausea and vomiting in pregnancy, Bendectin, which was alleged to have caused birth defects. The Court held that the Frye test was superseded by the Federal Rules of Evidence and originally stated, "if scientific, technical, or other specialized knowledge will assist the trier of fact to understand the evidence or determine a fact in issue, a witness qualified as an expert by knowledge, skill, experience, training or education, may testify thereto in the form of an opinion or otherwise."

There are five elements to the Daubert analysis: (1) has the theory put forth been tested (Testability), (2) has it been published (and peer reviewed), (3) is there "general acceptance" of the theory or method discussed in the medical community (Scientific Knowledge), (4) does the expert's testimony fit the facts of the case at hand (Relevance and Reliability), and (5) is there a known "Rate of Error" of the particular theory or method discussed. Under Frye, the element of "general acceptance" was the only relevant criterion. A subsequent case, *Kumho Tire Co. vs. Carmichael*, determined that the judge's gate-keeping function, as defined in Daubert, would apply to all expert testimony, including non-scientific testimony.

There have been enhancements to the Daubert standard by the Courts and by legislation. In 2000, Rule 702 of the Federal Rules of Evidence was amended to codify and add additional provisions – expert testimony must be based upon sufficient facts or data, the testimony must be the product of reliable principles and methods, and the witness must apply these principles and methods reliably to the facts of the case.

Once testimony has been excluded as inadmissible under a Daubert ruling, it would apply to other courts within that jurisdiction, though not necessarily to courts outside that jurisdiction. The importance of Daubert is twofold. First, by excluding some expert testimony, the plaintiff may fail to meet the burden of proof, and the complaint might be dismissed through a process known as summary judgment (though the exclusion of testimony could happen for defense witnesses as well). As the plaintiff would not have met the burden of proof, the case may be dismissed at this point, subject to appeal, as it is the plaintiff who must prove the case. Second, it holds out

a higher standard of testimony for expert witnesses who must be (more) honest and must comply with the standard of care (in medical malpractice) or other current standards, depending on the context of the legal action.

A physician's testimony may be novel, under Daubert, but must "make sense" to the judge who is making the determination. Physicians whose testimony has been determined to be "exceptional" -- that is, sufficiently outside the normative experience of what is commonly practiced by others in that specialty -- have been sanctioned by their specialty society and, at times, lost membership. Several years ago, a neurosurgeon lost licensure for such testimony. These instances have involved witnesses for the plaintiffs.

Some examples of how *not* to be an expert witness:

Lie about your credentials. If you are not board certified, say you are. If you didn't pass your boards the first time around, say you did. If you are not familiar with a particular branch of medicine or surgery, say you are. Once your credibility is subject to question, everything you say will be viewed through the same tainted glass.

Don't read all of the material involved in the case. Don't read pertinent medical literature on both sides of the question. Base your opinions on what the attorney hiring you wants to hear, rather than the facts in the case.

Make outrageous statements. For example, say that the decision to use tPA is as easy as cooking a pork loin. Say that the emergency physician should have made the diagnosis of acute appendicitis (when she made the diagnosis of acute abdomen and contacted a surgeon for further care). Say that an ECG showed an obvious MI when it didn't.

Make contingency arrangements, where you will be paid more if the case has a favorable result. Forget that you are to be paid for your time, not your opinion.

In summary, being an expert witness requires one to review the material at hand, honestly report on conclusions drawn, and avoid any financial impropriety.

#### References:

1. United States. The Committee on the Judiciary. House of Representatives. Federal Rules of Evidence. Washington, DC: U.S. Government Printing Office, 2009. Committee Print No. 4. 111th Congress, 1st Session.
2. Frye V. United States. 293 F. 1013 (D.C. Cir. 1923).
3. Daubert v. Merrell Dow Pharmaceuticals. 509 U.S. 579 (1993).
4. Kumho Tire Co. v. Carmichael. 526 U.S. 137 (1999).

### Your Expertise is Needed

AAEM's board of directors announces the formation of a Practice Management working group. AAEM members with experience in organizing or running democratic group practices are needed. The purpose of the working group is to develop guidelines for, and assist in the formation of, democratic group practices.

If you are interested in helping with this project, please contact AAEM at [info@aaem.org](mailto:info@aaem.org) or call 1-800-884-2236.

Did you know that AAEM's new

### Code of Ethics

are now in effect?

<http://www.aaem.org/aboutaaem/codeofethics.php>



To view the

### AAEM Policy on Expert Witness Testimony,

please go to

<http://www.aaem.org/positionstatements/ethicalexpert.php>

## In Memoriam — Christopher J. Minas, MD FAAEM

We are all saddened to learn of the passing of Dr. Christopher Minas. Chris was a founding fellow of the Academy and was one of our first board members, serving from 1995-2001. Dr. Minas was a community emergency physician in the New York/New Jersey region. After witnessing the abuses occurring in his area by the contract management groups, Chris became concerned. The Academy was forming at this time, and Chris joined with a passion for defending the community physicians against these abusive practices. A good and decent man, Dr. Minas was an

active and enthusiastic board member who was ardent in his support of the practice rights of community physicians. He also helped in establishing our PAC fund.

After leaving the board, Chris founded Belmar Medical Offices Urgent Care Center in Belmar, NJ. He is survived by his mother, his fiancé Georgiann, two brothers and a sister. Those wishing to leave online condolences may do so online at [www.wersonfuneralhome.com](http://www.wersonfuneralhome.com). He will be missed by all of us.

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

## An International Medical Experience

*Marc Pollack, MD PhD FAAEM*

Venturing outside the familiar, yet dysfunctional, U.S. health care system is an enlightening experience that all U.S. providers should consider. Health care is provided in a myriad of ways throughout the world depending on local customs, values and, most importantly, the financial commitment of the society. There exist wide disparities in access to health care services both within and between countries.

The objective of this article is to describe an international medical experience in rural Honduras and the benefits of this experience to U.S. health care providers.

The York Hospital Emergency Department participates in a one week, once or twice yearly, medical excursion to the Santa Barbara area of Honduras. Santa Barbara is a very mountainous rural, interior region of Honduras. It is also one of the largest coffee growing regions in Honduras. The medical team consists of 6-10 physicians, nurses and non-medical persons. We travel each day to a different remote village that has been determined to have medical care needs. We utilize various modes of travel to the villages that include four-wheel drive vehicles, horseback and hiking. The village populations are 100-200 people without established medical care facilities. The villagers would not seek medical care at the regional hospital unless they were critically ill. We bring along a limited pharmacy consisting of mostly donated medications, that are carried in our backpacks or by horseback. Translators assist us with interviewing and instructions. Since most of the villagers are unable to read or write, verbal communication is of utmost importance. Upon arrival in the village, we set up a medical clinic in a school, under a tarp, or under trees on a river bank. We evaluate all who seek medical attention. There is no charting.

We have no availability of diagnostic tests and no IV availability. Patient evaluation is limited to history and physical examination. Virtually none of the villagers are on chronic medications, and none have a significant past medical history. Treatment is limited to our pharmacy and our creativity. Patients can be sent to the regional hospital in Santa Barbara where the ED is literally "an emergency room" staffed by a newly graduated physician. The hospital care depends on the financial resources of the patient, and much of the bedside care is provided by the family. There are chronic shortages of supplies. Some patients are sent to the hospital, and we can arrange for some patients to get medical care in the U.S.

At first this seemed frightening, utilizing only history and physical examination to make a diagnosis. I am 30 years out of medical

school and can remember a time when the history and physical examination provided the most important, and frequently, the only data in making a diagnosis. I have, of course, become dependent on easy access to CT scans, rapid lab testing and the availability of a myriad of treatment options. The week before I left, I reviewed my old physical exam textbook. There was no reference to the sensitivity or specificity or predictive values of the various physical findings.

After the first morning of seeing patients, I felt liberated. No electronic medical record, no laundry list of past medical problems, chronic medications, allergies, social problems, ungratefulness of patients and families and "defensive" medical practice. There certainly were different treatment options that required getting accustomed to. The febrile neonate did not get the "full work-up," but was treated with antibiotics for the most likely serious infection. The anginal patient did not get a heart catheterization, but was instructed to take one aspirin per day and rest immediately if the chest pain returned. The dehydrated patient did not get IV fluids, but was patiently rehydrated with oral fluids. I spent virtually all of my time with the patients.

We did have teamwork. We discussed the patients and their diagnostic and treatment possibilities. At the end of the day we were tired. Physically tired. We had a great family style dinner and talked and laughed before going to bed. I slept soundly, despite the roosters and heat. Prior to this, in my real life, I would come home exhausted, mentally and emotionally, and often slept poorly.

We went to a different village each day. We were up at sunrise and in bed by sunset. After a week, I felt great. I was physically challenged, experienced a slice of the world that one rarely sees, and felt truly appreciated by the patients.

As I enter my 30<sup>th</sup> year of being a physician, I reflect on the current joys and stressors on being an emergency physician in the U.S. With each year of practice, I accepted the small intrusions into my time with the patient for "the greater good." I now reflect back on the sum of all these intrusions. I spend time documenting in front of a computer, utilizing incredible diagnostic technology, and trying to incorporate evidenced-based medicine into my medical decision making on a regular basis. All of this occurs at the expense of spending time with the patient. It is not exactly what I expected when I decided to become a physician many years ago. My experience in rural Honduras is more closely aligned to my expectations.

*continued on page 15*

*Editor's Letter - continued from page 2*

Remember, too, that your thoughts and ideas are highly valued by AAEM. You may want to start by sending some comments to us here at *Common Sense* as a letter to the editor or by submitting an original article for publication. Feel free to contact me directly at [cseditor@aaem.org](mailto:cseditor@aaem.org) with your opinions about anything you read in *Common Sense*. In addition, direct communication with the leadership of AAEM is merely an email away (<http://www.aaem.org/boardofdirectors/boardlisting.php>). Serving on the board of directors, I can say that the entire board is completely dedicated to the promotion of AAEM's mission and willing to go far beyond what is necessary to respond to the needs of individual members.

You can also serve the Academy by remaining vigilant for issues arising at the state level. Individual states' recognition of emergency medicine boards that do not require EM residency training requires our particular attention. *Emergency Medicine News* quotes the director of governmental affairs for The American Association of Physician Specialists (AAPS) as saying, "We have a very aggressive and active governmental affairs program for 2010... Our strategic plan for 2010 includes Alaska, Montana, Idaho, Utah, and North and South Dakota. It will put us on the path of achieving the goal of being recognized

in every state."<sup>1</sup> AAEM (i.e., each one of us) must continue to monitor the activity of our state medical boards and make sure that our concerns about non-residency trained individuals being designated as "board certified" are recognized.

Inaction is our adversary and will lead to the erosion of our rights as specialists in emergency medicine and lessen our ability to effectively care for our patients in the emergency department. If we do not take action, others will act on our behalf. These others often do not have the best interests of us or our patients in mind, sometimes intentionally and sometimes by simple lack of knowledge or understanding.

There is no doubt that AAEM is *the* specialty society for board certified emergency physicians. Keep the excitement and enthusiasm from Vegas with you throughout the year. Commit now to making your specialty society even better!

1. SoRelle, Ruth. "AAPS Ramping Up Campaign for Recognition." *Emergency Medicine News*. Lippincott Williams & Wilkins, Mar. 2010. Web. 12 Mar. 2010. <[http://journals.lww.com/em-news/Fulltext/2010/03000/AAPS\\_Ramping\\_Up\\_Campaign\\_for\\_Recognition.1.aspx](http://journals.lww.com/em-news/Fulltext/2010/03000/AAPS_Ramping_Up_Campaign_for_Recognition.1.aspx)>.

## Petition to U.S. Supreme Court Challenges Appeals Court Decision to Extend EMTALA Reach

*Kathleen Ream, Director of Government Affairs*

As reported in the July/August 2009 issue of *Common Sense*, on April 6, 2009, the U.S. Court of Appeals for the Sixth Circuit overruled a Centers for Medicare and Medicaid (CMS) interpretation of EMTALA. This appellate court instead found that admission to the hospital does not end the EMTALA requirements to stabilize and treat a patient (*Moses v. Providence Hospital and Medical Centers Inc.*, 6th Cir., No. 07-2111, 4/6/09).

While the federal sixth circuit ruled that EMTALA only allows for suits against a hospital, not a practitioner, it also decided that third parties, such as an estate on behalf of a deceased patient harmed as a direct result of an EMTALA violation, possessed standing to sue pursuant to EMTALA's private enforcement provisions. Moreover, the appellate decision held that a mental health emergency could qualify as an "emergency medical condition" under the plain language of the EMTALA statute. (For case facts, see article titled "Estate of Murdered Woman Allowed to Pursue EMTALA Claims," at <http://www.aaem.org/commonsense/commonsense0709.pdf>.)

### Unresolved EMTALA Interpretations

Since its enactment in 1986, the differing interpretations of EMTALA's requirements by various courts and CMS have resulted in conflicts. Several of these conflicts remain unresolved, such as the concept of "stabilization" compared to mere "admission to the hospital." As in this case, the court stated that CMS misinterpreted the intent of the statute, thus infringing on the responsibilities of Congress to rewrite those statutes that are unclear.

There is a possibility that resolution of some EMTALA issues may occur in the near future. On October 13, 2009, Providence Hospital

and Medical Centers Inc. filed a petition with the U.S. Supreme Court, contending that the appellate court for the sixth circuit misconstrued EMTALA in *Moses* (*Providence Hospital and Medical Centers Inc. v. Moses*, U.S., No. 09-438, petition filed 10/13/09).

In the petition, the hospital argues that the appellate court erred when it held that federal law was not limited to ED screening and stabilization, but that the hospital's legal duty may continue to apply even after a patient has been admitted to the hospital for inpatient care. The hospital's petition maintains that the court should have stayed with the 2003 CMS regulations holding that EMTALA ends once the patient has been formally admitted to the hospital. Furthermore, the petition reasons that to the extent the appellate court found the 2003 CMS regulations should not be applied retroactively, such as to the issue at incident in *Moses* which occurred in December 2002, that appellate court determination should be reviewed by the high court.

At present, only hospitals in the sixth circuit (i.e., in Michigan, Ohio, Tennessee and Kentucky) must comply with the court's decision in *Moses*. However, should the Supreme Court affirm the appellate court's opinion, the concept of stabilization prior to discharge will have to be further defined for hospitals across the nation.

### Claims of Flawed Screening and Improper Transfer Pursued in New Mexico

On November 17, 2009, the U.S. District Court for the District of New Mexico denied a hospital its motion for summary judgment. This decision gave the plaintiff the opportunity, under EMTALA, to

*continued on page 11*

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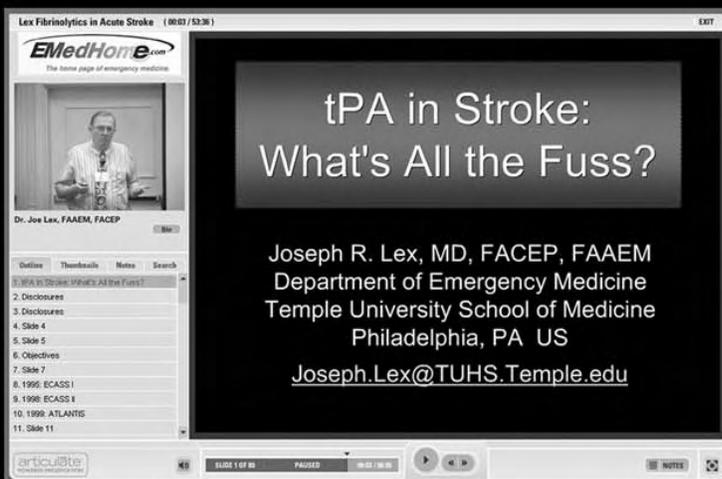
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pursue claims absent testimony of a medical expert that the hospital failed to adequately screen her father and discharged him without stabilizing his emergency medical condition (*St. John v. Wilcox*, D.N.M., No. 08-cv-229, 11/17/09).

### The Facts

Steve St. John lost consciousness the evening of June 13, 2007. He was transported via ambulance to the Gila Regional Medical Center (GRMC) ED, where he was examined by Dr. Robert Wilcox. Although St. John was unresponsive upon arrival at the ED, shortly after placed in a bed, he regained consciousness, becoming "very aggressive and disoriented. He fought with hospital staff and his family and had to be restrained."

Allegedly, prior to establishing the cause of his behavior or making an attempt to stabilize his condition, and despite urging from St. John's family that St. John be kept overnight for further observation and testing, Wilcox ordered St. John's release from the hospital. St. John remained "violent and agitated upon his return to the family home," and in less than 24 hours after release from the hospital, St. John committed suicide.

On March 4, 2008, St. John's wife filed suit against Wilcox and GRMC, alleging that the physician's treatment "fell short of the standard of care required by state negligence statutes and that GRMC violated the Emergency Medical Treatment and Active Labor Act." On January 28, 2009, the plaintiff filed an amended complaint, containing the same allegations, but substituting St. John's daughter, Jennifer, as plaintiff in place of the initial plaintiff. The Court issued its scheduling order on January 5, 2009, listing May 15, 2009, as the deadline for the plaintiff's disclosure of expert witnesses.

The plaintiff failed to name an expert witness by the deadline. Attempting to circumvent this failure, the plaintiff moved to "either stay the litigation or to dismiss the claims against Dr. Wilcox without prejudice with leave to refile after acquisition of a medical expert." On September 10, 2009, the Court denied the plaintiff's motion, leaving the plaintiff to proceed without a medical expert. Both Wilcox and GRMC moved for "summary judgment on the ground that Plaintiff cannot succeed in her claims without the testimony of a medical expert." On June 2, 2009, the Court stayed discovery, pending resolution of the two motions for summary judgment.

### The Ruling

In order to prevail on a state claim of medical malpractice in New Mexico, typically the plaintiff must produce expert medical testimony "to establish the relevant standard of care and any deviation from it." The Court decided it was "not able . . . without expert testimony, to determine what the standard of care is with respect to screening a patient brought into the emergency room unconscious or with respect to releasing that patient after he regains consciousness. Without expert testimony on this issue, Plaintiff cannot prove her negligence case against Dr. Wilcox." "With no response to Defendant's motion," wrote the court, "Plaintiff has essentially failed to contest the issue." With the malpractice claims against Wilcox failing, the district court ordered that defendant Wilcox's motion for summary judgment be granted.

The plaintiff claimed that GRMC violated both EMTALA's "appropriate medical screening" requirement and the failure to stabilize prior to discharge/transfer requirement. Defendant GRMC contended that, just as St. John cannot prevail on her medical malpractice claim without expert testimony, "Plaintiff cannot demonstrate a violation of EMTALA without presenting expert medical testimony." The court disagreed, writing that "EMTALA is not a negligence or malpractice

statute . . . In fact, its requirements impose a 'strict liability' on a hospital . . . [I]t is this higher bar that actually enables a plaintiff to succeed without expert medical testimony, because the standards of proof require a demonstration of facts rather than opinion."

A hospital violates EMTALA's appropriate medical screening requirement "only when it does not follow its standard screening procedures with respect to a particular patient, regardless of the adequacy of those screening procedures . . . Thus, to demonstrate an EMTALA violation, a plaintiff need only present evidence establishing the hospital's standard screening procedures and evidence that those procedures were not followed in the particular patient's case." Questions of fact, not expert medical opinion, also are the basis for determining whether "a defendant hospital violated EMTALA's restriction against transferring an individual with a diagnosed emergency medical condition prior to stabilization." Likewise, EMTALA only covers "actions taken by hospitals that have actually diagnosed an emergency medical condition. Actual knowledge is subject to factual proof rather than opinion testimony, so a medical expert is not required to prevail on this portion of the claim."

The court, determining that plaintiff may proceed with her EMTALA claim in the absence of expert medical testimony, stated that "Plaintiff will have an opportunity to attempt to prove her claims through further discovery. Defendant GRMC may again seek summary judgment at the close of discovery if Plaintiff fails to uncover factual evidence that the hospital did not follow its standard screening procedures in this case or that it had actual knowledge that Mr. St. John was suffering from an emergency medical condition." The federal district court denied defendant Gila Regional Medical Center's second motion for summary judgment.

As to the matter of proving damages in the absence of expert medical testimony, "the statute requires a plaintiff to demonstrate that he or she suffered 'personal harm as a direct result' of the hospital's violation." The district court suggested that for medical cases, "proof of a causal link between the alleged violation and the alleged injury generally requires expert testimony," thus necessitating opinions based on direct treatment of the patient. "Opinion testimony not drawn from personal care and treatment of the patient, such as an opinion based on the reports of other physicians, is still subject to [rules of] disclosure." "Because the deadline for such expert disclosure has passed," noted the court, "any testimony from Mr. St. John's treating physicians will be strictly limited to conclusions drawn from their own treatment and personal observations of him. Whether Plaintiff can develop testimony sufficient to demonstrate causation, given these limitations, remains to be seen."

### First Circuit Appeals Finds No Error in PR District Court's Dismissal of Failure to Stabilize Claim

On September 4, 2009, the U.S. Court of Appeals for the First Circuit affirmed the decision of the U.S. District Court for the District of Puerto Rico, dismissing a suit alleging violation of the Emergency Medical Treatment and Labor Act (EMTALA), brought by the surviving family of a man whose condition they claimed was not stabilized (*Alvarez-Torres v. Ryder Memorial Hospital*, 1st Cir., No. 08-2351, 9/4/09).

### The Facts

On January 16, 2001, at 6:45p.m., Adalberto Martínez López (Martínez) arrived at the Ryder Memorial Hospital, Inc. (Ryder) ED complaining of chest pain and bleeding from a femoral dialysis catheter site. Martínez was fifty-seven years old at the time and an end-stage renal disease dialysis patient. His vital signs were

*continued on page 12*

taken, and at 6:50p.m. ED physician Dr. Griselle Pastrana examined Martínez. Documenting that Martínez was actively bleeding and that he was weak and dizzy, Pastrana described Martínez's condition as "alert, oriented [and] mildly pale." Pastrana ordered tests, including a chest X-ray, an EKG, and a "type and cross for four units of Packed Red Blood Cells."

At 7:30p.m., Pastrana discussed Martínez's case with Dr. Enrique Ortiz-Kidd, a nephrologist at Ryder, who ordered Martínez's admission to Ryder's "Medicine Floor" as well as completion of the tests. Martínez was admitted at 7:39p.m. with orders for bed rest, testing of vital signs every four hours, and hemodialysis and a blood transfusion the next morning. Martínez, arriving in his room on the Medicine Floor almost two hours later at 9:30p.m., was described as "alert, but pale, feverish, and complaining of chest pain . . . [and the] catheter site remained bloody." The on-duty nephrologist, Dr. Baquero, was contacted at 10:00p.m. and informed of Martínez's vital signs. Among other things, Baquero prescribed an antibiotic and Tylenol which were administered at 10:20p.m. Two hours later, Ortiz-Kidd gave a telephone order to "change the bandage on Martínez's catheter site, apply pressure, and prepare for a blood transfusion in the morning." However, Martínez continued to bleed throughout the night, requiring several changes of his bandages.

Finding the bleeding "profuse," a relative who accompanied Martínez complained to nursing staff at 4:55a.m. Staff contacted Ortiz-Kidd, who requested a consultation with Ryder surgeon Dr. Sotomayor. However, at 5:00a.m., when Martínez's blood pressure had dropped and his temperature had increased, nurses called on-duty physician Dr. Juan R. Gómez López, who examined Martínez and ordered a blood transfusion. Via telephone, Gómez López then discussed Martínez's condition with Ortiz-Kidd. At 5:30a.m., staff contacted Ortiz-Kidd again to inform him that Sotomayor was not available, at which point Ortiz-Kidd requested that another Ryder surgeon, Dr. Luis Canetti, conduct the evaluation.

Nurses noted that when Cannetti removed Martínez's bandages, "bleeding continue[d] profusely and abundantly." Canetti determined that Martínez required surgery, but that he could not perform it. Canetti recommended that Martínez immediately be transferred to Auxilio Mutuo Hospital for an "A-V fistula revision." Notified at 7:00a.m. of Canetti's recommendation, Ortiz-Kidd "order[ed] [the] patient to be transferred as soon as possible." The blood transfusion ordered by Gómez López began at 7:05a.m. Sometime between 7:00a.m. and 8:00a.m., nurses discovered that Martínez was not breathing. CPR was performed, but Martínez could not be revived.

Martínez's wife and children brought suit against Ryder alleging violation of EMTALA and bringing malpractice claims against the physicians. On November 19, 2007, the federal district court granted the defendants' motion for summary judgment on all of the plaintiffs' claims. The plaintiffs appealed, arguing that the district court "erred in dismissing the EMTALA claim for failure to stabilize, that no EMTALA claims were brought against individual physicians, and that the district court retained jurisdiction over state-law claims."

**The Ruling**

The plaintiffs argue that EMTALA "imposes an unqualified duty to stabilize once it is determined that the patient has an emergency medical condition, and this duty begins upon admission to the hospital and follows the patient to any hospital department." They argue in the alternative that "even if the duty to stabilize applies only when a patient is transferred, 'transfer' does not require a patient to physically leave the hospital, but only for a physician to enter

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an order of transfer." In the plaintiffs' view, Ortiz-Kidd triggered a stabilization duty by entering an order of transfer for Martínez. The First Circuit agreed with the district court that the duty to stabilize under EMTALA "does not impose a standard of care prescribing how physicians must treat a critical patient's condition while he remains in the hospital, but merely prescribes a precondition the hospital must satisfy before it may undertake to transfer the patient."

Explaining further, the appellate court found Ortiz-Kidd's order that Martínez was "to be transferred as soon as possible" did not effectuate a 'transfer' for purposes of EMTALA. The summary judgment record clearly establishes that Martínez never left Ryder's facilities, and indeed died in the room on the Medicine Floor where he was admitted the night of January 16. Because no transfer occurred, plaintiffs have not established a stabilization claim under EMTALA."

The First Circuit also agreed with the district court's ruling to dismiss EMTALA claims against individual physicians, recognizing that EMTALA applies only to hospitals, not individual providers of care. Likewise, the appellate court affirmed the trial court's decision regarding state law malpractice claims brought against all of the defendants, finding that the district court "did not abuse its broad discretion in dismissing the claims arising under Puerto Rico law without prejudice to refiling in state court."

*Case synopses prepared by Terri L. Nally, Principal, KAR Associates, Inc.*

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### What Can YPS do for You? Musings from Vegas

Brian Potts, MD MBA FAAEM  
YPS President



I just returned from the AAEM Scientific Assembly in Las Vegas and wanted to express how excited I was to meet so many enthusiastic AAEM members at this latest meeting. The general mood around Caesars Palace for the three day conference was full of energy and ideas. The educational lecture offerings were top-notch. The section and committee meetings were productive. One can't forget that Las Vegas also offered up

tremendous opportunity for nightlife and play at the end of the day.

The Young Physicians Section (YPS) has made tremendous strides over the last four years since becoming a new section of AAEM. I want to take this time to thank Dr. Michael Epter who did a fantastic job in his year as YPS president and also thank each member of last year's YPS board of directors for their service. They have laid an excellent foundation that we can work and build upon for the coming year.

Our new 2010–2011 YPS board of directors had their first meeting in Las Vegas. We discussed different strategies and plans to create more member benefits. I feel that our incoming board has tremendous experience and good insights as to how we can best serve the young physician members of AAEM to the fullest. The board comes from a variety of backgrounds, a balance of regions around the country, and represents both community and academic practice. This diversity will be one of our strengths. I look forward to working with the board throughout the year.

In addition to our board meeting, YPS also hosted our second annual YPS lecture entitled "Career Building – Where Do I Go from Here?" featuring Barbara Katz. It was a well-attended and well-received lecture and discussion. Later that night, the AAEM Resident & Student Association (AAEM/RSA) and YPS hosted their annual joint social gathering at Shadow Bar in Caesars Palace. This event was a perfect opportunity for networking and socializing with young emergency physicians from around the country. This continues to be one of my favorite events at each Scientific Assembly.

As a review, YPS serves as a linkage between the young physician members and the greater Academy. We want to foster this connection of members as they transition from resident members of AAEM/RSA

and into their first 4-5 years of post-graduate clinical practice. We have developed a number of benefits that can assist our members including CV and cover letter review services, a mentoring service, as well as the YPS edition of the *Rules of the Road for Young Emergency Physicians* publication. We have also done a great deal to update our website [www.ypsaaem.org](http://www.ypsaaem.org) during the last year. We also have a Facebook fan page that was created within the last few months, and we encourage all YPS members to join this fan page (see the Facebook link on our home page) and receive timely updates and news from YPS through this online platform.

If you are a YPS member who would like your CV and cover letter reviewed, you can go to the link on our website to submit your files. We provide a review service for free to YPS members. If you are a resident (AAEM/RSA) member of AAEM, you can receive the same review services at the cost of \$25. This will be considered a deposit to fulfill your first year YPS dues upon graduation. This makes the service essentially free to residents in their last year of training.

A few months ago, we conducted a survey of YPS members to get feedback and determine how we may serve you best. We appreciate all members who provided responses to the survey. The feedback and information provided through this survey will help guide the YPS board to provide desired benefits and encourage growth of our membership.

My goal as YPS president during this coming year is to have more frequent communication with our members to let you know what YPS is doing, as well as to encourage more feedback from our members. This will make us a more interactive and responsive section of AAEM. Stay tuned for future YPS articles in *Common Sense* from our YPS board. I also encourage any YPS member who would like to write an article for *Common Sense* to submit one to [info@ypsaaem.org](mailto:info@ypsaaem.org).

Finally, YPS plans to create a number of YPS committees this year including 1) membership, 2) governmental affairs/advocacy, 3) editorial/communications, and 4) education. I would encourage you to contact us at [info@ypsaaem.org](mailto:info@ypsaaem.org) if you are interested in becoming actively involved on a committee.

If you have any suggestions as to how YPS can better serve you, please let us know.

#### An International Medical Experience - continued from page 6

After my experience in Honduras, I returned to the busy high-tech emergency department with a tiny twinkle in my eye, remembering the real joys of medicine. When I can, I spend that extra moment talking to the patients and families about things that are "off the computer template."

Before I left for my international experience, I thought I was being the altruistic American doctor and would be helping the poor of

Honduras. That did happen, but what I really returned with was a re-framing of my place in the global house of medicine. After we turn off all the computers and scanners, it is about the communication that occurs between you and the patient. That is what the patient really wants. If you wonder about what you are doing at work, consider an international experience. You might return with a sparkle in your eye and a skip in your step.



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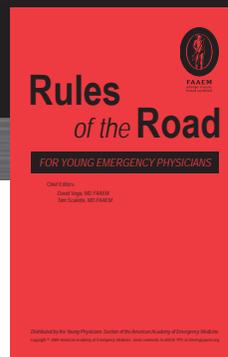


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# AAEM Young Physicians Section

## The CT Scan

Marc D. Haber, MD FAAEM

Past President, Young Physicians Section

Assistant Professor of Emergency Medicine

Tufts University School of Medicine/Baystate Medical Center

The Computerized Tomography (CT) Scan, perhaps like nothing else in our emergency departments, has significantly changed how we practice medicine. I personally trained immediately prior to the advent of widespread multi-slice detector use. Physicians who recently graduated, especially those in affluent or highly funded facilities, may have never had the pleasure of needing to place your potential C-Spine injured patient into a prone position in order to adequately obtain facial bones images. Furthermore, any patient with a respiratory rate greater than apneic always seemed to have significant "respiration artifact" limiting the results. The modern CT scan, including CT angiography, provides fast and amazing resolution of patients' underlying anatomy and pathologies.

The CT scan certainly has revolutionized the way we care for many patients. For example, lower risk abdominal pain patients with a negative scan are often sent home with routine follow-up. It is cost effective in many circumstances and well-studied.<sup>1</sup> Due to these factors, the CT scan is now a widespread and often used tool in the emergency physician's arsenal. While many clinical decision rules exist, there is always the physician gestalt "out" which allows physicians to lean towards scanning. Often appropriate, but perhaps just as often, the test is ordered due to some combination of self-doubt, consultant desire and/or concern that the patient desires a CT scan.

X-rays have great value outside of the abdomen. But when looking at the abdomen, seldom is the abdominal X-ray diagnostic, more often only suggestive. The MRI has its utility in ruling out appendicitis in the pregnant patient with abdominal pain, but is difficult to obtain in community hospitals.<sup>2</sup> Abdominal sonography is more useful than CT scanning in the diagnosis of uncomplicated cholecystitis, but when the clinical presentation is confusing either by history or physical exam, CT imaging may retrospectively be more valuable.<sup>3</sup> For all the promise of ED-based focused ultrasonography, the CT scan remains king of emergency abdominal imaging.

Yet CT scans have known risks - risks in which we are well-versed. Occasionally, we directly witness contrast allergy, aspiration of oral contrast, and the traumatic and avoidable "Code Blue" in the scanner. Sometimes we see contrast induced nephropathy (CIN), but that typically is a ward-based diagnosis. The majority of outpatients with CIN likely go unnoticed and self-resolve. What we never see, or so we thought, was the occurrence of malignancy attributable to CT imaging. We all know of the ionizing radiation risks of most forms of radiographic imaging, but the impact of our imaging studies has just recently been quantified. And the results are frightening.

In a recent *Archives of Internal Medicine* study, 57 million at-risk Americans already on the case<sup>4</sup> are estimated to have been scanned in 2007.<sup>5</sup> Twenty percent were 34 years of age or younger. 60% of those scanned were female. 29,000 cancers are estimated to have developed out of those studies. CT angiograms of the chest, abdomen and "whole body" have the highest risk of cancer per scan, but due to its large number scanned, 48% of CT related cancers are attributable to abdominal and pelvic imaging.

According to the U.S. Department of Health and Human Services, there were 119 million visits to our emergency departments in 2006. Of these visits, abdominal pain, followed by chest pain, is the most common chief complaint of those between 18 and 44 years of age. These two complaints reverse places for those 45 years and older.<sup>6</sup> It goes without saying that the decision to utilize a CT scan in the work-up of an individual with abdominal or chest pain rests in the hands of the ordering physician. That said, often, our hands are pushed, if not forced outright. How many of us have surgical departments whose surgeons will only see the patient "after the CT scan?" How many have been pressured to see more patients per hour or "move the meat" often leading to us putting the CT scan much earlier in the work-up? Who hasn't started providing a patient oral contrast immediately after the physical exam "just in case?" The CT scan may defer a patient's disposition to either later in the shift or to the radiologist, the consultant, a post sign-out colleague. In doing so, our shifts might become slightly less burdensome, help avoid confrontation, or reduce the anxieties and risks of making a wrong diagnosis. Yet this concept certainly was not taught in our emergency training programs; at least not overtly.

Additionally, the CT scan has gotten so fast that it often takes more time for the technologist to enter patient information into the computer than it does to actually perform the scan. Anecdotally, we have all seen patients who ought to be in either the OR or ICU brought to the scanner for a "quick" scan prior to reaching their appropriate destination. Furthermore, cost-controlling measures may push us towards the scan as well. Health insurance companies may prefer to pay for a CT scan rather than a short hospital admission for serial abdominal exams. They may, for example, nudge hospitals, and therefore providers, towards CT guided disposition by increasing reimbursements for imaging and reducing payments for observational inpatient care and revisits. Furthermore, patients, who also are just as busy with life, might prefer the quicker route to an answer. Overall, the CT scan has the potential to make everyone's lives easier. By the CT scan's ability to hasten a disposition, physicians can see more patients, earn more RVUs, and avoid consultant confrontations, and the patient can wait less time on an uncomfortable gurney for a potential diagnosis.

It follows, if abdominal and chest pain are the two most common chief complaints of an ever-increasing volume of ED patients, and the CT scan may make our lives easier during a shift, then more and more patients will be receiving a CT scan, perhaps unnecessarily. Perhaps the Press-Ganey's will rise, as the patient started the contrast at triage and happily departs quicker. Perhaps our reimbursement rates will rise, because our work RVUs have likewise risen. Perhaps we leave the shift with slightly more certainty of a patient that we treated in the ED. But perhaps we took the easy way out. Perhaps we inadvertently took the less ethical option. Perhaps we exposed our patients to unnecessary and harmful ionizing radiation. Perhaps we added to the 29,000 patients who developed iatrogenic cancer.

*continued on page 18*

# AAEM Young Physicians Section

*The CT Scan - continued from page 17*

Relatively speaking, it is true that 29,000 patients is a small number. And it is also true that many, if not most, of these patients were scanned for valid reasons. But population statistics are cold. They do not reflect the personal realities. They ignore the human factor. The individual who develops cancer likely does not care that they hit the cancer lottery. Why should we accept even one case of unnecessary iatrogenic cancer? Perhaps from a cost-analysis basis we should perform more scans. Yet, were it our spouse or child who developed cancer from a questionably needed CT scan, we would most certainly think differently. If neither the cold numbers nor the abstract personal rationale for re-evaluating our practice patterns sways us, then perhaps an even more personal argument will work. If we don't think about these things and act accordingly, again, our hands will likely be forced, as the tort lawyers are already on the case.<sup>7</sup> It is only a matter of time before an emergency physician is named in a lawsuit as an agent that caused cancer in one of these unfortunate patients.

As we move further and further into amazing technological advances, we need to continually check back with our own responsibilities to our patients and ourselves. Does this patient truly need a CT scan? Is there not, even if it requires more work, a different or better alternative? Do the risks of the CT scan truly outweigh the benefits in this particular patient? Did I explain the risks and benefits of the CT scan to the patient? Maybe as a specialty, we should take over and master the concept of the right lower quadrant ultrasound. No doubt there are questions to be asked and improvements to be made.

We are extraordinarily busy on the job. We have countless things to do and only a short amount of time in which to do it. Choosing an option that might require more energy and time may not be our first choice. The CT scan is often a correct and necessary test, but it cannot be always. Sometimes not doing a test is also the right action.

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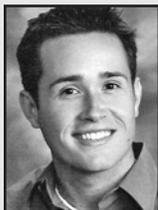
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## RESIDENT PRESIDENT'S MESSAGE

### Health Care in America: Prescribing Power

Michael Ybarra, MD  
AAEM/RSA President

Prescription drugs have taken somewhat of a back seat in the year-long debate over health care reform. Despite significant attention in the decade prior (with the introduction of Medicare Part D), prescription drugs have not been as central to the debate over reform, which instead has focused more on health insurance, access to care and cost.

This is due in part to the fact that the pharmaceutical industry is on board with the president's reforms. That is not to say that pharma will not be significantly impacted by the 2010 bill. They have agreed to contribute \$85 billion in the form of industry fees and lower prices on drugs for government subsidized programs. By most expert assessments, the pharmaceutical industry is considered a big winner in the new legislation. Despite the hefty bill they agreed to pay, the money is a down-payment to the government in exchange for millions of newly insured consumers.

America and Americans spend roughly \$220 billion annually on prescription drugs. According to the Kaiser Family Foundation, this makes up only about 10% of total health care costs (compared to 31% for hospital reimbursement and 21% for physician services).<sup>1</sup> However, prescription drug costs represent the fastest growing component of overall health care costs (spending has increased at double digit rates since 1990 when costs totaled roughly \$40 billion).<sup>2</sup>

The landscape of prescription drug costs and payments changed significantly in 2003 with the passage of the Medicare Prescription Drug, Improvement, and Modernization Act which went in to effect in 2006. Signed in to law by a republican president, it was then the largest expansion of government in decades. The plan helped reign in the out of pocket costs assumed by many seniors, but was, and still is, controversial because of provisions that prevent the government from negotiating the cost of drugs with pharmaceutical companies and the so-called "donut hole."<sup>3</sup> The "donut hole" is a gap in coverage where the senior must pay all out of pocket expenses if their costs go above a certain level up until a point that coverage kicks in again. President Obama has vowed to end the "donut hole,"<sup>3</sup> and the health reform bill of 2010 incrementally fulfills that pledge.

Despite its shortcomings, Medicare Part D was a major shift in prescription drug cost and payment trends and has delighted the AARP and many seniors. Prior to 2006, private insurance paid for roughly half of all prescription drugs, and individuals paid approximately 25% of the costs. Since the implementation of Medicare Part D, the government has kicked in 40% of total costs lowering the burden on private insurance and individuals.

In 1990, individuals paid for over half of all costs of prescription drugs. Over the last twenty years, that share has steadily declined.<sup>1</sup>

The question central to this issue is why prescription drugs cost so much. Advocates of the pharmaceutical industry frequently cite the high cost of research and development. While the cost of producing the actual pills patients purchase may be pennies apiece, the cost to develop that first pill is in the million to billion dollar range. And, while the United States accounts for about 5% of the total world population, it accounts for 36% of total pharmaceutical research and development.<sup>4</sup> Further, expensive drugs sold on the market pay for failed products and future endeavors. Only 11% of drugs actually make it to the market.<sup>5</sup>

Industry advocates also cite a number of sources who argue expensive prescription drugs actually save the country money in the long run. For example, medication compliance may save a patient with heart failure from a costly hospitalization. One study noted that, in particular, medications for AIDS, cancer, coronary artery disease, Alzheimer's disease and psychiatric disorders can prevent the expense of frequent hospitalization.<sup>4</sup>

These arguments from pro-pharma groups are countered by equally compelling arguments from a number of watch-dog groups who cite data that suggest the cost of prescription drugs is a serious issue in the U.S. Drugs are significantly more expensive in the United States compared to virtually every other country in the world, and the U.S. Customs Department estimates that 10 million people bring medications across the border from Canada in order to save money.<sup>6</sup> Over the last decade, online purchase of foreign manufactured drugs has become a burgeoning industry that is poorly regulated.

An interesting statistic frequently cited is the fact that more money is spent on advertising than research and development (R&D). A study of the U.S. Pharmaceutical Industry from 2004 found that 25% of all expenses were on advertising and promotions versus 13.4% on R&D.<sup>7</sup> The Center for Public Integrity reported that the industry also spent \$850 million from 1998 to 2006 on lobbying of elected officials, making the pharmaceutical industry among the most well-funded lobby.<sup>8</sup>

Agree or disagree with pharma, the industry is a large and ever-growing part of the U.S. health system. They play an important role in our every day practice and will certainly be shaped by the changes that are now forthcoming.

*continued on page 21*



## RESIDENT EDITOR'S LETTER

# An Argument in Favor of Mandatory Medical School Rotations in EM

Ryan Shanahan, MD  
AAEM/RSA Resident Editor



Recently, the University of Minnesota backtracked from a long standing tradition and made their emergency medicine rotation optional for medical students. This change was made to save costs for the University, as mandatory rotations are expensive to run. Emergency medicine is a newer field in the house of medicine, and mandatory rotations in medical school are the exception and not the

rule, but as one of the early pioneers in the field, it is disappointing that the University of Minnesota made this change.

Before emergency medicine existed, people with acute cholecystitis, dissecting aneurysm, ectopic pregnancy and meningitis presented to the hospital or clinic and were seen by internal medicine, ob/gyn and surgery residents. Often, these encounters were unsupervised, and the dangers to patient care that such situations presented lead to the development of our specialty. Just because this care was dangerous does not mean that it was not educationally useful, however. This was how physicians in training learned the spectrum of disease presentation and the initial approach to diagnostics when starting a work-up de novo.

With the establishment of emergency medicine residency programs, this vital educational opportunity was changed. It is true that, to this day, a diverse array of other specialties recognize the benefits of seeing patients in the emergency department and send their

residents to learn from our faculty and department. Others, however, have completely abdicated the role of primary diagnostician of acute disease and see patients only when the disease process has been determined to lie within their increasingly narrow specialty. It is for this reason that emergency medicine exposure in medical school is such a vital component of the making of the modern physician.

In medical school, students typically deal only with the management of already diagnosed disease. That management can be incredibly complex, but it is almost never related to the initial diagnosis. It is often only in the emergency department that undifferentiated abdominal pain turns into the post-op day two laparoscopic cholecystectomy patient a surgery clerk is rounding on. Emergency medicine is the ideal capstone to a medical education as it allows a young clinician to synthesize all these things that they have learned in the course of three or more years and finally apply those skills to the diagnosis and acute management of disease.

Most medical students will go into a field other than emergency medicine. Those who are interested will always have the elective option open to them. It is true that a mandatory rotation would likely sway some who otherwise would have headed in another direction. The real loss, however, will be to all those interns and residents who have never had the chance to primarily diagnose across the wide spectrum of pathologic disease. They will always be scared when someone inevitably asks, "Is there a doctor in the house?"

*Resident President's Message - continued from page 20*

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## Resident Journal Review: March-April 2010

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

*This is a continuing column providing synopses of high-impact journal articles pertinent to EM residents. It is not meant to be an extensive review of the articles, nor is it wholly comprehensive of all the literature published. Rather, it is a short list of potentially useful literature important to the busy EM resident. Residents should read the articles themselves to draw their own conclusions. These papers were selected after a review of 22 of the most pertinent journals for emergency medicine. This edition will include articles published over a two month period, between November and December of 2009.*

### **Systematic review: sodium bicarbonate treatment regimens for the prevention of contrast-induced nephropathy. Zoungas S, Ninomiya T, Huxley R, et al. Ann Intern Med. Nov 3 2009;151(9):631-638.**

Contrast-induced nephropathy (CIN) is one of the leading causes of hospital-acquired acute kidney injury. In the emergency department (ED), contrast computer tomography (CT) scans have been employed with dramatically increasing frequency, raising concern that an increasing number of patients will face this potential adverse outcome. Various interventions have been proposed to mitigate this risk. Recently, several systematic reviews, meta-analyses and studies have examined the effect of sodium bicarbonate infusion on CIN with varied results. This review represents the latest of these studies in which the authors sought to perform an exhaustive review of this issue.

The authors conducted a structured search of the literature, along with a manual search of reference lists to identify additional literature. QUORUM guidelines were followed, and studies were assessed using JADAD scores. The search yielded 1,231 articles, of which 23 were included (randomized controlled trials (RCTs) with sodium bicarbonate in one of treatment groups), encompassing 3,563 patients and 396 CIN events. CIN was defined as a 25% increase in baseline serum creatinine measured two to five after administration. Intervention groups varied and included various combinations of sodium bicarbonate, sodium chloride and N-acetylcysteine.

Overall, the summary estimate for relative risk of CIN with use of sodium bicarbonate was 0.62 (95% CI, 0.45-0.86). However, when stratified according to published and unpublished articles, formal statistical testing revealed publication bias, with unpublished studies showing no benefit. Greater estimates of effect were noted in studies that were published before 2008, had fewer participants, fewer events, were of low JADAD quality, and measured CIN within 48 hours of event. Sodium bicarbonate use had no effect on requirement of dialysis, heart failure and mortality. The use of N-acetylcysteine showed no effect.

The summary estimate in this review showed a small benefit for the use of sodium bicarbonate. However, as the authors pointed out, that benefit is brought into question given the publication bias noted. The result was also questioned since the studies were of poor quality, small size, and heterogeneous, especially those showing benefit. Most included studies that included coronary angiography, which uses higher volumes of contrast than CT, rendering conclusions even less relevant for the emergency medicine physician. Thus, no conclusion could be drawn and routine implementation of sodium bicarbonate to prevent CIN is still of uncertain benefit. Larger RCTs with improved quality, including ED relevant uses of contrast, are required.

### **Acute detection of ST-elevation myocardial infarction missed on standard 12-Lead ECG with a novel 80-lead real-time digital body surface map: primary results from the multicenter OCCULT MI trial. Hoekstra JW, O'Neill BJ, Pride YB, et al. Ann Emerg Med. Dec 2009;54(6):779-788 e771.**

Acute myocardial infarction (MI) is an essential differential diagnosis that the emergency medicine provider (EP) must rule out for a wide range of presenting symptoms. Twelve lead electrocardiography (ECG) is arguably the most important diagnostic tool used in the diagnosis of this ubiquitous condition. However, 12 lead ECG is not sensitive for the diagnosis when ST elevation is not present or for right-sided, inferior and posterior wall MI. A novel diagnostic tool, the 80-lead digital body surface map, worn as a vest, has been developed to overcome these challenges and improve the diagnosis of acute MI. The purpose of this study was to characterize the prevalence, management patterns and outcomes of patients having acute coronary syndromes who are identified as having an ST elevation myocardial infarction (STEMI) by 80 lead ECG compared to traditional methods of diagnosis and management.

In this multi-center prospective cohort study, patients with chest pain and high-risk features, such as ECG abnormalities, three or more cardiac risk factors, or known CAD, were included. Of the 1,830 patients enrolled, 91 were diagnosed with 12 lead ECG as a STEMI, 132 were diagnosed with non STEMI (NSTEMI), and the remaining 1,607 were diagnosed with unstable angina, acute coronary syndrome (ACS) or other. Of the patients without a STEMI on 12 lead ECG, 25 additional patients were found to have a STEMI by 80 lead ECG. These patients were treated with a more conservative approach (delayed and conservative coronary catheterization), more consistent with patients with NSTEMI. When compared to 12 lead STEMI patients, 80 lead-only STEMI patients had similar rates of 30 day mortality, recurrent MI, rehospitalization and similar angiographic features. However, 80 lead-only STEMI patients also had similar rates of these outcomes as compared to patients with NSTEMI. Among all patients without a diagnosis of 12 lead STEMI, an 80 lead ECG STEMI was associated with a higher rate of death (OR 11.2 95% CI 1.8 to 67).

Many limitations of this study prevent widespread support for routine use of 80 lead ECG. First, the sample size of 80 lead ECG STEMI patients was small, and the study was not adequately powered to find statistically significant difference in clinical outcomes. Due to time constraints, 68 of the 91 patients with 12 lead STEMI did not undergo an 80 lead ECG, thereby limiting ability to calculate sensitivity and specificity against the standard. Also, cost-benefit analysis was not performed to compare the benefit of finding 25 additional STEMIs with an 80 lead ECG analysis to the significant costs (\$160/disposable suit) of using this tool on each of the 1,830 patients.

*continued on page 24*

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Resident Journal Review - continued from page 22

Since this study was not adequately powered, differences in clinical outcomes were not significant. The question remains if patients found to have a STEMI on 80 lead ECG that is not found on 12 lead ECG would benefit from a time sensitive management approach, similar to 12 lead STEMI patients. Alternatively, is this simply a more expensive diagnostic study (with results that may be obtained using cardiac biomarkers) for a less time-sensitive condition? While EPs should be aware of this potentially useful diagnostic test, more studies are needed prior to widespread use.

**Percentage of US emergency department patients seen within the recommended triage time: 1997 to 2006. Horwitz LI, Bradley EH. Arch Intern Med. Nov 9 2009;169(20):1857-1865.**

The state of emergency care in the U.S. has been described by the Institute of Medicine (IOM) and others as a "growing national crisis." Increasing numbers of patients seeking care, reduced ED (and hospital) beds, increasing age of patients seeking care, and the resultant effects on patient care, outcomes, and costs are all part of this crisis. The authors of this study examined the trends of one such outcome - the percentage of patients seen within recommended triage times.

Of about 865 million ED visits during the period of 1997 to 2006, a random, stratified sampling of 151,999 visits were extracted from the National Hospital and Ambulatory and Medical Care Survey (NHAMCS), after omitting those with incomplete data. Patient encounters were examined to determine the percentage of patients seen within recommended triage times (time of arrival to time to physician), as it relates to triage category and other independent variables including payer type and ethnicity. Triage categories, according to the NHAMCS data set, were defined as emergent (should be seen within 15 minutes), urgent (15-60 minutes), semi-urgent (1-2 hours), and non-urgent (2-24 hours).

Median wait time for all patients increased 4.6% per year, from 22 minutes to 33 minutes. The percentage of patients seen within the recommended timeframe declined from 80% in 1997 to 75.9% in 2006. The percentage of emergent patients seen within 0-15 minutes declined from 59.2% to 48.0%. For urgent patients, it declined from 84.0% to 76.3%, and for semi-urgent patients from 90.6% to 84.7%. All non-urgent patients were seen within recommended times. Patients who had higher acuity of illness, were ultimately admitted, were Hispanic or black, seen by trainees, or visited urban hospitals were less likely to be seen within the recommended timeframe. No significant interaction was found for payment type.

Alarming, those with the highest acuity had the highest rate of decline in percentage seen within the recommended timeframe. Similar declines were seen among all triage groups. In total, one in four patients was not seen within a recommended timeframe. EPs, communities and politicians must be aware of this important trend in the state of emergency care that may ultimately result in significant impacts on patient care, outcomes and costs. Further resources, policies and interventions are urgently needed to address these trends.

**Initiation of inappropriate antimicrobial therapy results in a fivefold reduction of survival in human septic shock. Kumar A, Ellis P, Arabi Y. Chest. Nov 2009; 136(5):1237-1248.**

Septic shock is a leading cause of mortality in the ICU and a condition in which the patient's ED care can make a difference. Initiation of inappropriate antibiotics early in a patient's care can delay the time to effective therapy and worsen morbidity and mortality. The authors of this study sought to examine the effects of inappropriate initial antimicrobial therapy on patient survival.

This was a multicenter, retrospective review of 5,715 patients from 22 institutions from Canada, the U.S. and Saudi Arabia. Inclusion criteria included patients with a diagnosis of septic shock and age  $\geq 18$  years. Septic shock was defined as a documented or suspected infection, persistent hypotension requiring pressors, and two or more SIRS criteria. "Appropriate antibiotic" was defined as effective therapy based on subsequent cultures or, in cases in which the patient had no positive cultures, based on antimicrobial recommendations by the "Clinical Approach to Initial Choice of Antimicrobial Therapy" in the *Sanford Guide to Antimicrobial Therapy 2004 (34th ed.)*. The primary outcome measure was survival to hospital discharge.

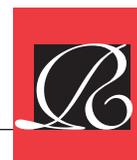
Of the 5,725 patients, 82.2% had documented infection by cultures. Appropriate antimicrobial therapy was initiated in 80.1% of these patients. Overall survival to hospital discharge for all patients was 43.7%. Patients with appropriate initial antibiotics had a survival rate of 52%, and those who had inappropriate initial antibiotics had a survival rate of 10.3% (OR 9.45, 95% CI 7.74 to 11.54). Interestingly, those with the highest appropriate antibiotics rates included skin & soft-tissue infections (86.9%) and UTIs (84.8%), and those with the lowest were catheter-associated infections (69.8%) and primary blood infections (68.6%). The greatest benefit from appropriate initial antibiotics was in patients who had septic shock due to *Candida albicans*; survival was 24.6% with appropriate initial therapy compared to 4.6% without.

This study brings attention to the importance of antibiotic choice when treating patients with septic shock in the ED. A weakness of this study is that it is observational. Research involving therapeutics is better served with prospective studies. In observational studies, there are many unmeasured elements that can affect the results. This study does not indicate how long inappropriate antibiotics were administered or how long appropriate therapy was delayed, if started at all. Despite this study's limitations, it reiterates the point that initial antibiotic selection in the ED can have significant effects on patient care and should not be made lightly.

**Resuscitation on television: realistic or ridiculous? A quantitative observational analysis of the portrayal of cardiopulmonary resuscitation in television medical drama. Harris D, Willoughby H. Resuscitation. Nov 2009;80(11):1275-1279.**

Patient and family preferences for cardiopulmonary resuscitation (CPR) are related to the perceived likelihood of recovery. Previous studies have demonstrated that patients have unrealistic expectations of CPR outcomes and survival to discharge: in some cases overestimating survival to discharge by greater than

continued on page 25



Resident Journal Review - continued from page 24

200%. Television media may play a central role in creating these expectations. The authors of this study sought to compare patient characteristics and outcomes in medical television drama with published resuscitation statistics.

Eighty-eight new episodes of two U.S. based dramas, "Grey's Anatomy" and "ER," and two BBC aired dramas, "Casualty" and "Holby City," aired between July 2008 to April 2009, were reviewed. Age, sex, medical history, cause of arrest, initial rhythm, immediate survival, and survival to discharge were recorded when available.

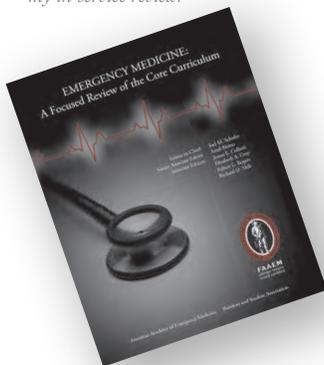
In 88 episodes, there were 76 cardio-respiratory arrests and 70 resuscitation attempts. Immediate survival was 46%, which compared well to published immediate survival rates of 40-47%. Survival to discharge from hospital and long-term outcomes were rarely shown, making data on these measures unattainable. The average age of patients resuscitated was 36 years compared to a true average age of 65-75 years. Furthermore, there was no age-related difference in resuscitation outcomes noted on television drama. The cause of arrest was major trauma in about a third of patients on television drama in contrast to hospital data that indicate less than 5% of arrests are secondary to major trauma and 85% are

attributable to underlying cardiac or respiratory disease. Accuracy of resuscitation was difficult to determine due to brief depictions of resuscitation.

While immediate survival after resuscitation on television mirrored published reports of actual survival, rarely did television drama provide any portrayal of intermediate to long-term outcomes. Furthermore, most outcomes revealed either full recovery or death, without portraying realistic long-term sequelae. The patient profile also differed significantly, favoring the young and healthy who had experienced major trauma, instead of the older and moribund, experiencing chronic cardiorespiratory diseases. The actual age-related declines in resuscitation success were notably omitted. Clearly, this was a small, limited, study of a select sample of television drama. In addition, the impact on viewer perceptions was not directly measured. Noting these limitations, the influence of television is not trivial, and the data provides important clues to the attitudes of patients and families toward resuscitation. This data can assist EPs in discussions with patients and family involved in situations of resuscitation, end-of-life and death.

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## MEDICAL STUDENT COUNCIL PRESIDENT'S MESSAGE

### “It Takes a Village...”

Jamie “Akiva” Kahn  
President, AAEM/RSA Medical Student Council



...to raise a doctor. Hillary Clinton says to raise a child, but I believe the sentiment is the same when it comes to cultivating physicians. I recently went on stage at my medical school during Match Day to read my results and had planned to thank my family and friends for all their support. But in the excitement of the moment I simply squealed, “Emergency Medicine, Jefferson!!”

As we all know, the road to becoming a physician is not always perfectly smooth and has many challenges along the way. Not only must we excel in our studies, but we must also attempt to hold our personal lives together through family struggles, relationship troubles and even health issues.

Medical school is an interesting paradox - a plethora of emotions.

We are told at the beginning that it would be challenging and that we would make sacrifices. I think each person who first hears that hopes they are the exception, but eventually the ‘burden’ of medical school hits each one of us. We recognize that we are the “lowest on the totem poll,” but hope that our role allows us to empathize more with our patients. We know our residents can smell fear and overcompensate in confidence and effort to earn their respect, their lessons and their evaluations. It’s not only hard on us, but the people who we turn to help get us through.

Before the bustle that always happens at the end of the year, consider taking a moment to thank the people in your lives who helped you get to where you are: the family you call and vent to, the friends you spend less time with in order to study more, the residents and mentors who push and teach you, and the peers who support and celebrate with you. Thank you.

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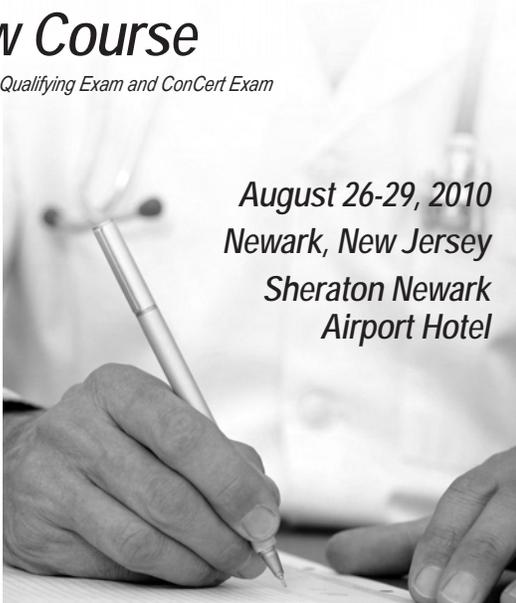
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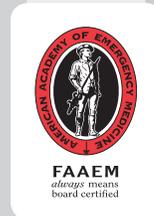
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