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SENSE

THE NEWSLETTER OF THE AMERICAN ACADEMY OF EMERGENCY MEDICINE



PRESIDENT'S MESSAGE: CALL FOR HELP

Howard Blumstein, MD FAAEM

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In this issue of *Common Sense*, you will find an insert asking all members to consider making a donation to the AAEM Foundation. This is a good opportunity for me to review why the Foundation exists and what it has done.

The Foundation was established in 2004, following our involvement in a lawsuit that is referred to as the Mt. Diablo case. In this episode, a large for-profit contract management company lost its contract at a hospital, but most of the physicians planned to continue working at the hospital. The contract management group (CMG) sued the physicians involved. AAEM and the physicians both filed countersuits, which were merged. The primary issue was the use and enforcement of restrictive covenants.

Ultimately, the lawsuit was settled to everybody's satisfaction; a happy outcome and a victory for the Academy. But, it cost a significant amount of money that had not been budgeted for that purpose.

Following that episode, the Foundation was established. Part of its mission statement says that the Foundation's purpose is: "... defending the rights of patients to receive [emergency care]..., and emergency physicians to provide such care." Over time, members have contributed generously to the Foundation.

More recently, the Foundation provided financial support for two lawsuits in Texas. In these cases, emergency physicians were again facing the takeover of their practices by for-profit contract management companies. The details of the lawsuits varied, but they were again based on 1) violations of corporate practice of medicine rules and 2) unfair business practices by the defendants.

Unfortunately, as I write this message, the lawsuits have been dismissed based on technicalities. Our appeals failed. It is important to note that the courts *never heard or considered the actual issues in the case*. That is too bad, because we felt that we had a very strong case. We had hoped that a positive ruling by the court would force these contract management groups to significantly alter their business practices, restoring control of physicians' practices to the physicians. But, we never reached that point. (See the AAEM press release on this issue reprinted on page 7).

Lawsuits are not cheap. The Foundation's reserves have been depleted and need to be restored before we can pursue legal remedies to the ongoing abuses and legal violations being committed by those seeking to profit from our labor.

The AAEM board of directors continues to look for the right opportunity to become involved in a landmark legal case that could radically alter the way business is conducted in emergency medicine and give thousands of our colleagues the opportunity to wrest back control of their medical practices. But, we need to be ready to pounce when the right opportunity arises.

I have asked the board of directors to consider making contributions to the AAEM Foundation and they have responded handsomely. Now, it is time to ask our members for help. Please consider making a contribution to the AAEM Foundation by filling out the insert inside this issue of *Common Sense*. Thank you.



Editor's Letter

David D. Vega, MD FAAEM

Updates on Board Certification Issues

Recently, there has been some very good news on the board certification front. In Oklahoma, the Board of Medical Licensure retracted its proposed amendment that would have allowed physicians to advertise themselves as "board certified" in emergency medicine without an ACGME- or AOA-approved residency in emergency medicine. This was an important victory for board certified emergency physicians and emergency department patients across the country. Along with similar successes in North Carolina and New York, the statement is being made that emergency medicine residency training matters. AAEM actively fought to help achieve these successes and continues to monitor the activities of other state boards for similar proposals.

In Texas, however, the struggle continues. The Texas Medical Board (TMB) is considering changes to an existing rule that would allow physicians to advertise themselves as "board certified" if they are certified by the American Board of Physician Specialties (ABPS). However, the ABPS does not require emergency medicine residency training for certification. The current TMB Rules (available online at <http://www.tmb.state.tx.us/rules/rules/bdrules.php>) state that certifying organizations must require "all physicians who are seeking certification to have satisfactorily completed identifiable and substantial training in the specialty or subspecialty area of medicine in which the physician is seeking certification..." (Texas Administrative Code, Title 22, Part 9 §164.4[b][5]). Organizations that do not require diplomates to have completed a residency in emergency medicine would not seem to qualify as certifying organizations under the current rule. AAEM is opposed to any rule changes that undermine the importance of emergency medicine residency training as the current pathway towards board certification.

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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

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*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.

Georgia Supreme Court Upholds ED Liability Law

Kathleen Ream

Director of Government Affairs

In a split 4-3 ruling on March 15th, the Georgia Supreme Court upheld a controversial provision of the state's tort reform law that makes it extremely difficult for patients to recover damages in cases involving emergency department (ED) care. The ruling affirmed a state trial court decision that upheld the constitutionality of the statute in the context of a malpractice lawsuit (*Gliemmo v. Cousineau*) brought by Carol and Robert Gliemmo against St. Francis Hospital ED physician Mark Cousineau and his employer, Emergency Medical Specialists of Columbus PC.

Carol Gliemmo went to the hospital in 2007 complaining of serious pain behind her eyes and a "snapping in her head." She said she was diagnosed with high blood pressure, and the ED doctor sent her away with a prescription but failed to diagnose a brain hemorrhage that left her paralyzed. The Gliemmos alleged that the doctor was negligent. The defendants sought to have the suit dismissed under the 2005 tort reform law that requires "clear and convincing evidence that the physician or health care provider's action showed gross negligence."

Plaintiffs argued that the law creates what is tantamount to an insurmountable legal threshold for patients injured by malpractice in hospital EDs. But attorneys for hospitals and insurers contended that the statute takes into account what happens in EDs, where doctors are often faced with life-or-death decisions without knowing their patients' medical histories.

In rejecting the Gliemmos' claim, the majority compared the ED law to one already held to be constitutional, the **Hospital Care for Pregnant Women Act**. That law requires certain hospitals to care for pregnant women in labor and prohibits lawsuits except when the person providing treatment "has been grossly negligent." Relying on that precedent, the four justices decided the law that Gliemmos challenged also was not an unconstitutional special law. Writing for the majority, Justice George Carley said the Legislature had a legitimate reason to promote affordable malpractice insurance for hospitals and health care providers and that it is "entirely logical" to assume that ED care is different than care provided in other hospital settings. In dissent, Justice Robert Benham called the ED provision "unreasonable and arbitrary" and said it leaves ED patients with "a lower standard of care and a higher burden of proof."

Separately, the Supreme Court upheld another key provision of Georgia's 2005 **Tort Reform Act** in a case involving a former player for the Atlanta Falcons. This provision encourages settlements in all civil tort lawsuits and penalizes litigants who do not accept good-faith financial offers to close a case. Also, by the end of the month, the state Supreme Court is expected to decide the constitutionality of the cornerstone of Georgia's tort reform law – the \$350,000 cap on jury awards in medical malpractice cases.

Editor's Note: The Georgia Supreme Court has since ruled, in a unanimous decision, that the existing caps on noneconomic damages in medical malpractice actions infringe on the right to a jury trial granted under the Georgia Constitution. The Court's decision is to be applied retroactively to the inception of the caps in 2005. More information about this unfortunate decision is available online at <http://www.medscape.com/viewarticle/718938>. In light of the similar decision in Illinois (see below), a disturbing trend is developing which threatens to set back progress made towards tort reform in several other states.

Illinois Supreme Court Strikes Down Malpractice Caps

In February 2010, the Illinois Supreme Court struck down a five-year-old state law that capped medical malpractice noneconomic damages awards at \$1 million for hospitals and \$500,000 for physicians. The Court ruled that the law violated the separation of powers provision in the state constitution, marking the third time since 1976 that the Illinois high court has struck down malpractice damages caps.

The ruling stems from *Lebron v. Gottlieb Memorial Hospital*, a 2006 lawsuit filed by the family of a girl who suffered severe brain damage during her caesarean birth. The suit, which was a test case for several lawsuits challenging the constitutionality of the 2005 law, partially affirms a 2007 ruling in Cook County Circuit Court. In writing for the majority, Chief Justice Thomas Fitzgerald stated, "The crux of our analysis is whether the statute unduly infringes upon the inherent power of the judiciary. Here, the legislature's attempt to limit...damages in medical malpractice actions runs afoul of the separation of powers clause." The case was sent back to the circuit court for further proceedings.

The state's physician and hospital groups criticized the ruling, characterizing it as rejection of and ignoring the wishes/will of Illinois citizens, while trial lawyers and labor groups saw the ruling as a victory for victims of medical errors. The 2005 law did not cap economic damages or other compensation for victims, such as lost wages, potential future earnings and medical expenses.

U.S. Supreme Court Invites Solicitor General's View on Decision to Extend EMTALA Reach

This case involves claims brought by the estate of a woman whose spouse murdered her after he was discharged from Providence Hospital in Michigan, following a psychotic episode. For the facts in this case, see the *Common Sense* article titled "Estate of Murdered Woman Allowed to Pursue EMTALA Claims," accessed at: <http://www.aaem.org/commonsense/commonsense0709.pdf>.

On January 25, 2010, the U.S. Supreme Court issued an interim order inviting the U.S. solicitor general to file a brief about whether the high court should review the U.S. Court of Appeals for the Sixth Circuit decision in *Moses (Providence Hospital and Medical Centers Inc. v. Moses, U.S., No. 09-438, interim order 1/25/10)*. In particular, the court seeks an opinion as to whether:

- EMTALA's requirement for screening and stabilization should be expanded to apply to hospital inpatients; and
- A CMS regulation clarifying that EMTALA is inapplicable to hospital inpatients is valid and applies retroactively.

The main task of the Office of the Solicitor General is to supervise and conduct government litigation in the U.S. Supreme Court. Nearly all such litigation is channeled through the Office of the Solicitor General. The Solicitor General determines the cases in which Supreme Court review will be sought by the government and the positions the government will take before the high court. Another responsibility of the Office is to review all cases in the lower courts that are decided adversely against the government in order to determine whether they should be appealed and, if so, what position should be taken. Moreover, the Solicitor General determines whether the government will participate as *amicus curiae*, or intervene, in cases in any appellate court.

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At present, only hospitals in the states in the sixth circuit (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.

Procedure Is Power

A U.S. District Court case in California involving an EMTALA liability claim alleging injury caused by inadequate screening was first reported in the August 2008, issue of *Common Sense*. (See "No EMTALA Liability for Inadequacy in Screening Leading to Injury" at <http://www.aaem.org/commonsense/commonsense0708.pdf>.) Plaintiff Donna Hoffman sued defendant Memorial Medical Center (MCC) after an ED physician, Dr. Kent Tonnemacher, failed to diagnose her bacterial infection (*Hoffman v. Tonnemacher*, E.D. Cal., No. 1:04-cv-5714, 4/10/08). Defendant filed a motion for partial summary judgment, which the district court denied. After further discovery, MCC moved again for summary judgment, which the district court granted in part and denied in part. Hoffman's surviving claim alleged that Dr. Tonnemacher's screening examination constituted disparate treatment in violation of EMTALA because it failed to comply with MCC's EMTALA policy.

At trial, MCC moved for judgment as a matter of law at the close of the evidence. The district court denied the motion. The jury deadlocked, and the district court declared a mistrial. Following the mistrial, MCC moved for modification of the pretrial order. The district court modified the order allowing the hospital to add a new expert witness and to file another summary judgment motion. This time the district court granted MCC's summary judgment motion on the ground that Hoffman "could not show a genuine issue of material fact with respect to causation." Hoffman then appealed to the United States Court of Appeals for the Ninth Circuit, challenging the propriety of allowing the successive summary judgment motion.

On January 21, 2010, the Ninth Circuit held that "the district court has discretion to entertain successive motions for summary judgment and that the district court did not abuse its discretion in this instance" (*Hoffman v. Tonnemacher*, 9th Cir., No. 08-16166, 01/21/10). This civil procedure ruling joined the Ninth Circuit with five other circuits, which in prior decisions clarified that consideration of successive summary judgment motions is within the district court's discretion.

The court noted that the "Federal Rule of Civil Procedure 56 does not limit the number of motions that may be filed. Indeed, the version of Rule 56 that was in effect when the district court modified the pretrial order stated that a motion for summary judgment could be filed 'at any time' after certain events." In addition, the Ninth Circuit previously had ruled such motions were permissible on the issue of qualified immunity and noted that summary judgment decisions are subject to reconsideration at any time.

The Ninth Circuit Court found the district court was within its discretion to hear the second motion mainly because activity between the first and second motions provided an expanded factual record. The court wrote: "We review for abuse of discretion a district court's decision to permit a successive summary judgment motion. In this case, the district court did not abuse its discretion by allowing Defendant to file another summary judgment motion after the mistrial. The deposition of an expert witness after the deadline for pretrial summary judgment motions, the testimony at trial, and the addition of a new expert witness after the mistrial expanded the factual record beyond what it had been at the time of the pretrial summary judgment motion."

The entire opinion can be viewed at <http://www.ca9.uscourts.gov/datastore/opinions/2010/01/21/08-16166.pdf>.

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

Editor's Letter - continued from page 2

Meanwhile, on May 1, the Texas Medical Association (TMA) House of Delegates passed a three-part resolution, "That the Texas Medical Association (1) recognize that, and shall ask the Texas Medical Board (TMB) to recognize that, the American Board of Medical Specialties (ABMS), American Osteopathic Association Bureau of Osteopathic Specialists (AOABS), American Board of Oral Maxillofacial Surgery (ABOMS), and non-ABMS/AOABS/ABOMS boards with equivalent standards and training, are the standard in specialty board certification for the specialties they encompass; (2) evaluate TMB rules and practices regarding physicians' ability to advertise that they are "board certified" and report back to the 2011 TMA House of Delegates; and (3) actively oppose all efforts of any alternate certifying organizations in the State of Texas, or before the TMB, to recognize its members as "board certified" without the equivalent certification and training standards." The TMA House of Delegates should be applauded for taking a solid stance on this issue. Physicians living in Texas should contact the Texas Medical Association and encourage them to aggressively pursue the actions in this resolution. Physicians in other states should work with their own state medical associations to pass similar resolutions.

Texas residents may contact the Texas Medical Board (<http://www.tmb.state.tx.us/agency/contact.php>) directly to express

concern over changes to its board certification rules. There are likely to be significant efforts by the ABPS to lobby in favor of these changes. In addition, the ABPS has "a very aggressive and active governmental affairs program for 2010"¹ which underscores the importance of having members in every state keep a careful watch of his or her state medical board's activities for potential decisions that could damage the academic integrity of our specialty.

1. SoRelle, Ruth. "AAPS Ramping Up Campaign for Recognition." *Emergency Medicine News*. Lippincott Williams & Wilkins, March 2010. Accessed March 12, 2010. <http://journals.lww.com/em-news/Fulltext/2010/03000/AAPS_Ramping_Up_Campaign_for_Recognition.1.aspx>.

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 or by calling 800-884-AAEM.

Recognition Given to Foundation Donors

Levels of recognition to those who donate to the AAEM Foundation have been established. The information below includes a list of the different levels of contributions. The Foundation would like to thank the individuals below that contributed from 1/1/2010 to 6/7/2010.

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

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continued on page 7

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American Academy of Emergency Medicine

FOR IMMEDIATE RELEASE
May 3, 2010

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MILWAUKEE— Texas Litigation Involving Team Health and Hermann Hospitals

Texas courts dismissed a case filed by the American Academy of Emergency Medicine (AAEM) and other parties against Team Health, the Hermann Hospital System, and subsidiaries. The decision denied AAEM and its co-plaintiffs a right to argue its claims. Significantly, the decision did not address the facts of the case.

The lawsuit argued that Team Health clearly violated Texas prohibitions against the ownership of a medical practice by a lay corporation. The Texas Medical Association provided an amicus brief in support of AAEM's claims.

The lawsuit made three claims, that (1) Texas law bans the ownership of medical practices by lay corporations, (2) Team Health owns and operates medical practices at Hermann Hospitals, and (3) Team Health has many lay shareholders.

The trial court dismissed the lawsuit without any explanation, and did not allow AAEM and the other plaintiffs a chance to amend our pleadings. The court of appeal affirmed, suggesting the claims should be heard by administrative bodies. The Texas Supreme Court denied a request to hear the case.

Since the court did not hear the facts of this case, the outcome bears no relationship to the validity of the claims, which add up to the assertion that Team Health is practicing medicine in violation of state law. On an ongoing basis, AAEM will decide how to represent the best interest of its members and their patients, as well as the specialty of emergency medicine.

###

The American Academy of Emergency Medicine (AAEM) is the only true specialty society in emergency medicine today. As an organization, AAEM believes achievement of board certification represents the only acceptable method of attaining recognition as a specialist in emergency medicine.

For more information, please visit www.aaem.org

The Organization of Specialists in Emergency Medicine

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Legitimate

Andy Walker, MD FAAEM
AAEM Board of Directors

Legitimate:

(adj. 1. Being in accordance with established or accepted patterns and standards. 2. Based on logical reasoning; reasonable. 3. Authentic; genuine. 4. Being in compliance with the law; lawful.)¹ Is emergency medicine a legitimate specialty? Wasn't that question settled decades ago? Yes and...maybe not. More than twenty years after the American Board of Emergency Medicine (ABEM)² closed the practice track to board certification, several organizations and thousands of people in the United States are still hard at work trying to find a way for physicians trained in other specialties to call themselves board certified in emergency medicine. Although imitation may be the sincerest form of flattery, success in this self-serving quest would threaten the future of emergency medicine as an independent specialty. Before looking at the history and recent activity of this movement, we must consider the history of legitimate board certification.

Justified fears over the state of medical education in the U.S. led to the famous Flexner report³ in 1910, and an overhaul of medical education followed. This had no effect, of course, on physicians already in practice. At the time, any doctor could claim to be a specialist in any field, regardless of actual training. Concern about this state of affairs among ophthalmologists led to the founding of the American Board for Ophthalmic Examinations (later the American Board of Ophthalmology) in 1917. This was the first of several specialty boards to be established over the following years, and in 1935, the American Board of Medical Specialties (ABMS) was created to link the specialty boards and ensure a certain amount of consistency. There are currently 24 primary specialty boards in ABMS, including ABEM. It should be noted that most boards allowed a practice track at the time of their founding, so those physicians who founded their specialties could "grandfather in" to board eligibility without a residency in their fields. The median time to closure of these practice tracks was seven and a half years. ABEM's practice track was open for nine years, its closure in 1988 being announced when ABEM was accepted into ABMS in 1979. Applications via the practice track were accepted until 1990, as long as all requirements had been fulfilled by 1988. In fact, ABEM left its practice track open longer than any specialty founded after 1950. No board has ever reopened a practice track after it was closed.⁴

In 1990, Gregory Daniel and 176 co-plaintiffs filed suit against ABEM and several codefendants, alleging restraint of trade and seeking to have the practice track reopened. In 1991, the Association of Disenfranchised Emergency Physicians (now the Association of Emergency Physicians, or AEP) was founded, mainly by plaintiffs in *Daniel v. ABEM*, with Dr. Daniel serving on its board of directors.^{5,6} After 15 years of court decisions and appeals, the *Daniel* lawsuit was ultimately dismissed in 2005, with legitimate board certification intact and seemingly safe. However, the story did not end with the *Daniel* case.

There are organizations in addition to AEP that would like to find a way for their ABEM-ineligible members to call themselves board certified in emergency medicine. Most importantly, these include the Board of Certification in Emergency Medicine (BCEM) and the Section on Certification and EM Workforce (Certification Section) of the American College of Emergency Physicians (ACEP). BCEM was founded in 1987, the year before the practice track closed in emergency medicine. From that time up until the year 2000,

BCEM was willing to designate a physician as "board certified" in emergency medicine without the completion of any residency.⁷ Even now, it will bestow "board certification" on a physician who has never completed a residency in emergency medicine. BCEM is by far the largest component of the American Board of Physician Specialties (ABPS).⁷ ABPS is the certifying body of the American Association of Physician Specialists (AAPS), and I will refer to both as AAPS hereafter. In fact, at the website of these organizations you can see that AAPS, ABPS and BCEM all have the same address and phone number (www.abpsus.org).

AAPS began as the American Association of Osteopathic Specialists (AAOS) in 1952. At that time, doctors of osteopathic medicine (DOs) were not eligible for certification by ABMS boards, even if they had done an allopathic residency, and boards under the authority of the American Osteopathic Association would not certify DOs who did an allopathic rather than an osteopathic residency. AAOS was created to fill this gap, which fortunately no longer exists since ABMS boards will now certify DOs. The leaders of BCEM, recognizing the opportunity presented by the closure of the ABEM practice track, asked the AAOS to change its membership criteria so that allopathic physicians could join. This was done, and the name was changed from AAOS to AAPS.

ACEP's Certification Section has a long and interesting history, including name changes that occurred as its primary goals shifted. I highly recommend going to ACEP's website (www.acep.org), putting the cursor over "membership," and then clicking on "sections of membership" followed by "certification and em workforce." You can then read the newsletters of the Certification Section, which go back to February 1994. I especially recommend the March 2008 issue (vol.14 #2), which includes a historical timeline containing such interesting facts as:

1993 - A group of ACEP members and other emergency physicians form the Association of Emergency Physicians to represent their interests.

2000 - ACEP Board approves "Recognition of Certifying Bodies in Emergency Medicine" policy, which includes the asterisk statement: "ACEP acknowledges that there exists a non-ABMS and non-AOA certifying body, the Board of Certification in Emergency Medicine (BCEM), that may allow emergency physicians who do not meet existing training standards of ABEM or AOBEM to present themselves for evaluation and testing in the clinical content of emergency medicine and achieve certification based on specified criteria. This ACEP policy is not intended to pass judgment on the work of BCEM."

2001 - ACEP representative quietly presents ACEP's official "Recognition of Certifying Bodies" policy to the Florida Board of Medicine; the Florida BOM subsequently votes to officially recognize the BCEM.

2002 - ACEP Board adopts "ACEP Recognized Certifying Bodies in Emergency Medicine" policy, now with no mention of BCEM. The wording "...is not intended to pass judgment on the work of BCEM" is now gone from official ACEP language.

The decision of the Florida Board of Medicine mentioned in the timeline focused the attention of AAEM on the board certification activities of state medical boards. It was a watershed event in

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American Board of Emergency Medicine

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FOR IMMEDIATE RELEASE
April 1, 2010

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EARL J. REISDORFF, M.D., NAMED NEW EXECUTIVE DIRECTOR AT THE AMERICAN BOARD OF EMERGENCY MEDICINE

(East Lansing, MI) – The Board of Directors of the American Board of Emergency Medicine (ABEM) named Earl J. Reisdorff, M.D., as its new Executive Director effective May 1, 2010. Dr. Reisdorff is currently a practicing emergency physician and Director of Medical Education at Ingham Regional Medical Center in Lansing, Michigan. He is currently an associate professor in Emergency Medicine, and past Program Director of the Michigan State University Emergency Medicine Residency Program.

Dr. Reisdorff has been active with ABEM as an Oral Board Certification Examiner since 1994, an item writer for the qualifying examination from 1999-2009, a Senior Case Reviewer for the oral certification examination, and has participated as a member of the Case Development Panel.

Dr. Reisdorff has served the emergency medicine community through his involvement with related organizations. He served on the Board of Directors of the Michigan College of Emergency Physicians (MCEP) from 1998 to 2003, and served as President of MCEP from 2004 to 2005. In 2003, Dr. Reisdorff was appointed by the Secretary of the U.S. Department of Health and Human Services (DHHS) to the Council on Graduate Medical Education; an advisory group to both DHHS and the Congress on physician workforce and training.

Dr. Reisdorff has authored multiple peer reviewed articles, chapters, and textbooks. He has presented over 300 scientific and didactic presentations, and received several awards for excellence in teaching. He has served as a peer-reviewer for multiple scientific specialty journals.

Dr. Reisdorff lives in Okemos, Michigan with his wife Jane and his daughters Rebecca and Hannah.

###

The American Board of Emergency Medicine is one of the 24 medical specialty boards of the American Board of Medical Specialties. Founded in 1976, ABEM develops and administers the Emergency Medicine certification examination for physicians who have met the ABEM credentialing requirements. ABEM has over 26,000 emergency physicians currently credentialed.

the post-Daniel struggle to preserve the value of legitimate board certification in emergency medicine. Neither the Academy nor its Florida chapter were aware of the AAPS hearing before the Florida medical board, seeking permission for its members to advertise themselves as board certified. The board was told that diplomates of AAPS were required to have residency training. After reviewing transcripts of that meeting, however, I can find no indication that the board was ever told that BCEM made up a majority of AAPS or that BCEM would grant “board certification” in emergency medicine to physicians who had not completed a residency in emergency medicine. ACEP’s Florida chapter did have a representative at the meeting, and when asked for his opinion on the AAPS and BCEM, Dr. Michael Lusko simply reiterated the ACEP policy quoted in the timeline above. This neutral-sounding policy has been described by Dr. Timothy Geno, ACEP member and BCEM diplomate, as “... benign neglect, not supporting BCEM, but not condemning them either.”⁵ Furthermore, two members of the Florida Board of Medicine were members of AAPS. One, Dr. Peter Lamelas, was a diplomate of BCEM as well as a member of ACEP. To his credit, he did disclose this during the meeting.

Once news of this event reached the Academy, AAEM and its Florida chapter, along with the Florida Medical Association, multiple specialty societies and their Florida chapters, and even ACEP and its Florida chapter, argued strongly to have the Board of Medicine reverse its decision, without success. It seems to me, after reading literally hundreds of pages of minutes and supporting documents, that the medical board believed that under Florida law it could only reverse itself if it first found that representatives of AAPS had deliberately misled the board. Ultimately, the Florida Board of Medicine did not think it had been intentionally deceived and did not reverse its decision.

The Academy sharply criticized ACEP for its behavior in this episode⁸, and as mentioned in the timeline above, ACEP has since changed its policy on BCEM. Both FCEP^{9,10} and ACEP have since issued several strong statements against the recognition of BCEM and in support of legitimate board certification requiring residency training in emergency medicine.

As you might expect, there is significant overlap in the memberships of AEP, AAPS and ACEP’s Certification Section, especially at the leadership level. This becomes obvious when, after studying the websites of the three organizations, one then looks at the list of ACEP members who became fellows of the American College of Emergency Physicians from 2007-2009. During this window of opportunity, ACEP dropped board certification in emergency medicine as a requirement for fellowship. This decision was controversial, even though ACEP still has a large number of members who are not eligible to take the ABEM exams. In fact, it appears that less than 60% of ACEP’s membership is board certified by ABEM.¹¹ Consistent with that is the fact that the Certification Section is just behind the Young Physicians Section as the biggest section in ACEP.¹²

After the unfortunate outcome in Florida, the Academy wrote to every state medical board in the country, asking that we be notified if AAPS or BCEM was on the agenda for any upcoming meeting. We sent representatives to several of these meetings and helped defeat attempts by AAPS in several states to have itself designated as equivalent to ABMS. However, late in 2009 Texas and Oklahoma temporarily recognized AAPS, and thus BCEM. In Oklahoma we did not have advance notice to attend the meeting. Under pressure from emergency physicians and the state legislature, though, the Oklahoma medical board has already reversed its decision.

In Texas, the medical board never reviewed the issue at all. AAPS simply wrote the Texas board asking if its members in the state could advertise themselves as board certified, and the executive director of the board answered in the affirmative despite a Texas Medical Board rule indicating that board certification requires “demonstrable satisfactory substantial training in the specialty.”¹³ To any reasonable reader, “satisfactory substantial training in the specialty” means completing a residency in the specialty.

On February 5, 2010, Howard Blumstein, AAEM’s current president, attended a hearing of the Texas Medical Board to present the AAEM position that BCEM did not comply with the rules and regulations of the Texas Medical Board. Several other organizations argued the same position, including Angela Gardner on behalf of ACEP. As a result, the issue was referred to a subcommittee for further study. AAEM has been allowed to provide only written testimony to that subcommittee. We continue to closely monitor the situation in Texas.

Why should this matter to you? First of all, when the public hears “board certified in emergency medicine” it naturally assumes that this means the completion of residency training in emergency medicine. When state medical boards allow physicians who are not residency trained in emergency medicine to advertise themselves as board certified, they are helping to mislead or confuse the public. Second, if emergency medicine is a legitimate specialty, it should abide by the same rules as every other specialty. That means that once the founders of the specialty are allowed to grandfather into eligibility for board certification via a practice track, the completion of residency training in emergency medicine becomes a prerequisite for board certification. If emergency medicine is not a legitimate specialty with its own unique body of knowledge, then we are guilty of misleading the public, and we should abolish the specialty and roll the clock back 40 years. When those practitioners of emergency medicine who are not board certified argue that they should be allowed to call themselves board certified without first completing an emergency medicine residency, they are really arguing that emergency medicine is not a legitimate specialty, should not be held to the same standards as a legitimate specialty, and should never have been given the status of an independent specialty.

What can you do? First, keep an eye on your state medical board. Check its website monthly. Often, the advance public notice of meetings is nothing more than a posting on a website just days before the meeting itself. Study the posted agenda carefully. If the issue of board certification or a mention of AAPS appears, notify the Academy immediately. You and your local colleagues may even need to attend the meeting to point out that AAPS is mainly BCEM, which still does not require residency training in emergency medicine for “board certification” in emergency medicine.

BCEM often argues that there aren’t enough board certified emergency physicians to staff all the emergency departments (EDs) in the country, and there may not be for many years.¹⁴ They then claim that, if only their diplomates were allowed to call themselves board certified, this shortage would disappear. Of course, this is nonsense on several levels. Nobody, including the Academy, has ever claimed that only board certified emergency physicians should be allowed to work in EDs. Credentialing requirements are solely up to a hospital’s medical staff and those who employ the physicians in the ED. Furthermore, if anyone can adequately learn a specialty while unsupervised on the job, why have residencies in any specialty? After all, there is also a shortage of board certified general surgeons. Should we alleviate that shortage by allowing everyone, regardless of training, to call themselves board certified general surgeons?

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Critical Care Subspecialization in Emergency Medicine

Evie Marcolini, MD FAAEM

Michael Winters, MD FAAEM

Acknowledgement to Linda Kesselring

The American Board of Emergency Medicine (ABEM) recently announced an agreement with the American Board of Internal Medicine (ABIM) to co-sponsor internal medicine (IM)/critical care medicine (CCM) certification (www.abem.org/public). This agreement provides emergency medicine (EM) residency graduates access to training in two year critical care fellowships sponsored by internal medicine (IM) programs. As a result, EM graduates will be eligible for certification in IM/CCM. The American Boards of Surgery and Anesthesiology have declined pursuit of a similar agreement and requested there be no grandfathering availability to EM graduates who have completed surgical or anesthesia critical care programs.

This agreement is a landmark step in ABEM's pursuit of critical care board certification. Some in the EM community do not favor the agreement that ABEM has brokered with ABIM, inasmuch as it does not benefit those who have trained in surgical/anesthesia-sponsored fellowships and it makes the surgical/anesthesia critical care fellowships less competitive for future emergency medicine graduates. To understand and fully appreciate the agreement that has been made, it is important to review the parallel development of EM and critical care as board certified specialties. This summary is based on an article by Somand and Zink, published in *Academic Emergency Medicine* in 2005.¹

In 1961, Dr. James Mills, a general practitioner in Arlington, Virginia, opened the first full-time EM practice. By 1968, the American College of Emergency Physicians (ACEP) was formed. At the same time, the concept of a critical care unit (CCU) was coalescing as an evolution from the post-anesthesia care unit. In 1970, the Society for Critical Care Medicine (SCCM) was founded. One of the 29 physicians who founded SCCM was Dr. Peter Safar, an anesthesiologist and leader of the critical care movement, whose definition of critical care was a triad of 1) resuscitation, 2) emergency medical care for critical illness or injury and 3) intensive care. Today the clinical distinctions of care are blurred, because the general lack of ICU beds requires longer stays in the ED for many critically ill patients, requiring emergency physicians to call on their critical care knowledge base and skills frequently.

In 1972, ACEP, SCCM and the University Association for Emergency Medical Services formed the Federation for Emergency and Critical Care Medicine, the purpose of which was to promote EM and CCM within the American Medical Association (AMA). This union helped ACEP win the designation of a provisional section on emergency medicine by the AMA in 1973, but the collaboration prematurely dissolved as EM and CCM each continued to seek primary board recognition. The hosts of the AMA-sponsored Workshop Conference on Education of the Physician in Emergency Medical Care, held in Chicago in 1973, agreed that EM training followed by a critical care fellowship was highly desirable. As a result of discussions at this conference, SCCM accepted two years of EM residency as a prerequisite for admission to a critical care fellowship.

ABEM was formed in 1976. Three years later, it was approved as a conjoint (modified) board of ABMS, making EM the 23rd medical specialty in the United States. This was indeed an accomplishment, but its stature as a conjoint board precluded the board from issuing certificates of special qualifications. At the same time, CCM was also pursuing primary board status. Its first attempt failed, so critical care was designated as a multidisciplinary subspecialty of the existing

primary boards: anesthesia, internal medicine, pediatrics and surgery. The task of reaching consensus among the four primary specialties on training and testing criteria for primary board status proved to be too much. In 1983, ABIM withdrew from the Joint Committee on Critical Care Medicine and submitted a separate application to certify its own subspecialists. The other specialties followed suit, leading to the creation of four subspecialties having certification processes for critical care subspecialty board certification, with no accommodation for ABEM diplomates to sit for critical care board certification.

In 1986, in keeping with the goal of pursuing CCM as a subspecialty of EM and considering the breakup of critical care subspecialty into four different boards, ABEM modified its pursuit and applied for a certificate of added qualification to ABMS. IM and pediatric leaders opposed the certification because they "viewed the critical care issue as a way for EM to get 'the camel's nose under the tent' of inpatient medicine and worried that if EM were granted the ability to train in CCM, inpatient care by emergency physicians could someday follow.¹ ABIM proposed a combined EM/IM training program to provide an avenue for EM physicians to pursue critical care board certification and announced plans to apply for an added certification in "emergency internal medicine." ABEM decided to put the critical care issue on the back burner and pursue primary board certification through ABMS. ABMS had clarified that a conjoint board was allowed to issue certificates of added qualification but not special qualification. In 1987, ABEM gained unanimous approval of its application for primary board status from the ABMS executive committee, but a small majority of the full delegation rejected the application. Not only did ABEM miss its goal of primary board status, but critical care certification remained on hold, and ABEM watched the boards of internal medicine and pediatrics continue to pursue subspecialization in emergency internal medicine and emergency pediatrics.

Realizing a pivotal point for EM, the president of ABEM, Dr. Judith Tintinalli, and its executive director, Dr. Benson Munger, went to the ABIM summer conference. They realized that concessions needed to be made to preserve the ability of ABEM to become a primary specialty, so they assured ABIM that ABEM had no interest in inpatient care, agreed to the principle of combined EM/IM and EM/Pediatrics programs, and withdrew the application for certificates of added qualification in critical care. As a result, ABIM reversed its opposition to primary board status for ABEM, and in 1989 ABEM was approved by ABMS as a primary board, bringing to fruition two decades of effort.

Critical care has been defined as the delivery of medical care to "any patient who is physiologically unstable, requiring constant and minute-to-minute titration of therapy according to the evolution of the disease process."² It has been shown that staffing ICUs with dedicated intensivists saves money, reduces mortality and shortens length of stay. The Leapfrog Group, a voluntary organization that leverages health care purchasing power to influence quality and affordability, has as one of its quality and safety practices staffing of ICUs by intensivists. This group acknowledges that EM physicians who have completed a critical care fellowship meet the definition of intensivist.

Currently, there are 155 EM residencies with 4,981 filled positions. These graduates will compete with 22,829 graduates of 381 IM residencies for 33 IM-sponsored CCM fellowships. Programs that

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train EM graduates in critical care have 20 to 24 slots specifically intended for emergency physicians. In addition, there are six more slots in programs that do not specifically intend emergency physician enrollment. These slots are not all in IM-sponsored critical care programs, so many graduates understand they will not be eligible for board certification. Of the CCM fellowship programs open to emergency physicians in 2008–2009, affiliations were as follows: 8 EM, 23 surgery, 14 medicine and 20 anesthesia.

Two other options are open to emergency physicians who have completed a critical care fellowship. The European Society of Intensive Care Medicine (www.esicm.org) allows American emergency physicians to sit for the European Diploma in Intensive Care Medicine in Europe, and the United Council of Neurologic Subspecialties (www.neurocriticalcare.org) allows fellowship-trained emergency physicians to sit for subspecialty certification in neurocritical care through either a fellowship or practice track. This practice track availability will be offered only through 2012.

Emergency medicine and critical care share a long and dynamic history in patient care as well as the pursuit of ABMS recognition.

Legitimate - continued from page 10

Finally, if you are a member of ACEP, I believe you should ask ACEP to discipline any of its members who are actively working to undermine legitimate board certification in our specialty. Surely all emergency physicians agree on a few issues: tort reform, federal funding for EMTALA-mandated care, fair treatment in the workplace for emergency physicians, and the need to preserve the academic integrity of our specialty. Don't we?

Footnotes and References

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Physicians interested in combining a career in emergency medicine and critical care medicine sit on the cusp of a monumental movement that is gaining interest as well as importance; as the population ages, U.S. legislators struggle to reform health care, and critically ill patients spend longer times in EDs. Emergency physicians interested in critical care medicine now have the opportunity to continue toward a goal that was set when the specialty of EM was founded.

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Acknowledgment

The manuscript was copyedited by Linda J. Kesselring, MS ELS, the technical editor/writer in the Department of Emergency Medicine at the University of Maryland School of Medicine.

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14. Camargo Jr. CC, et al. Assessment of emergency physician workforce needs in the United States, 2005. *Acad Emerg Med* 2008;15:1317-1320. *Dr. Camargo practices emergency medicine at the Massachusetts General Hospital and is board certified in internal medicine. He is not eligible for certification by ABEM.*

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KOS, Greece 10–14 September 2011





Who Am I???

Michael Epter, DO FAAEM
AAEM Board of Directors
Immediate Past President, YPS

Recently, I was asked to provide a short summary of me for this issue of *Common Sense* as part of my election to the AAEM board of directors. I would like to first thank you for your vote and support - it is a privilege to be a part of this group.

I first became involved with the Academy after completing residency at Albert Einstein – Beth Israel Medical Center in New York. While serving as an attending physician at Brookdale Medical Center (Brooklyn, NY), I enrolled the emergency department in the Academy's "911emergency.org" in an effort to promote public access to quality emergency care provided by a specialist in emergency medicine – one of the Academy's founding principles. Through my practice in community emergency departments, I was exposed to the ever evolving challenges that all emergency physicians face in their daily practice – workload, patient satisfaction, overcrowding, board certification, wellness and corporate practice. My career then transitioned to my current practice at the county hospital in downtown Las Vegas where I serve as program director at the University of Nevada.

I would not be where I am in my career if not for AAEM and its membership. AAEM has afforded me opportunities to serve on a local level as president of the state chapter in Nevada, on a national level in each executive board position within the Young Physicians Section (YPS), and within education through my involvement with the education committee, oral board review course and Scientific Assembly. All totaled, I feel that these experiences will allow me to make a meaningful contribution to the board of directors.

Over this next year, I look forward to continuing the mission of the organization, but hope to make a contribution in the area of best practices to ensure career longevity and job satisfaction. As the current demands we face as emergency physicians continue to increase and overextend us, the potential for burnout is significant. In the American Board of Emergency Medicine (ABEM) Longitudinal Study of Emergency Physicians, over one third of respondents reported problems with work related stress and burnout.¹ This is a challenge to our profession that requires a constant "finger on the pulse" and a proactive approach rather than a reactive one.

As mentioned during the candidate forum at Scientific Assembly, I asked you to remember two things in particular: 1) nothing is ever achieved without passion (think back to your days in medical school and residency and your achievement of board certification) and 2) my personal email – mepter@medicine.nevada.edu. If there is something you are passionate about that challenges you as an EP and/or our profession, I want to know so that I can be your voice and "walk the talk."

So, "Who Am I???" I am your colleague and your advocate who will protect and advance your practice rights and professional integrity while ensuring the highest academic standards for all the days that I serve on the board while promoting your career satisfaction and longevity. To that end, accept nothing but the best, as do I, from me and the organization.

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August 26-29, 2010

- AAEM Written Board Review Course
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www.aaem.org

September 22-23, 2010

- AAEM Pearls of Wisdom Oral Board Review Course
Las Vegas, NV
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October 2-3, 2010

- AAEM Pearls of Wisdom Oral Board Review Course
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February 28–March 2, 2011

- 17th Annual Scientific Assembly
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Do you have an upcoming educational conference or activity you would like listed in *Common Sense* and on the AAEM website? Please contact Kate Filipiak to learn more about the AAEM endorsement approval process: kfilipiak@aaem.org.

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

October 26, 2010

- Update on Behavioral Emergencies
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Vietnam Emergency Medicine Symposium

Joseph Lex, MD FAAEM

I was one of more than 60 volunteer faculty, physicians and nurses from the U.S., Canada, Australia, Thailand and The Netherlands, that attended a Symposium in Hue, Vietnam, from March 22-26, 2010. Our purpose was simple – to kick-start the specialty of emergency medicine (EM) in Vietnam by assembling a critical mass of people who were movers and shakers in the specialty, many of whom had already made their contributions to international emergency medicine in various ways.

It all started for me when I gave rounds at SUNY Buffalo in April 2009. After a daylong Amtrak trek from Philadelphia, I gave several talks the next morning, and then spent the afternoon exploring the local sites associated with the assassination of William McKinley. That evening at dinner, I sat across from an EM faculty member named Sam Cloud, MD, who mentioned that he had just returned from a medical mission in the Socialist Republic of Vietnam, where hopes were high that the specialty of emergency medicine would soon be recognized by the Minister of Health.

Sam is part of a group called Good Samaritans Medical & Dental Ministry, a non-government organization (NGO) which had been doing medical mission work in Vietnam for nearly a decade. They felt the time was ripe for the specialty to blossom and mature, but needed help with contacts. Since serving as a medic in Vietnam with the U.S. Army, I have had a special place in my heart for the land and its people, so I offered my assistance of both prior experience in the international arena and in helping put together AAEM Scientific Assemblies over the past decade. Within a few days, I had received an invitation from the mission's director. Vien Doan, MD, a family medicine specialist from southern California, had taken it as his personal mission to establish EM in Vietnam. He had linked up with Carter Hill, MD, an emergency physician in Seattle and the American College of Emergency Physicians' (ACEP) ambassador to Vietnam. Dr. Doan asked me if I could get a handful of faculty to teach some basic emergency medicine approaches to complaints frequently seen in the Vietnam hospitals – chest pain, shortness of breath, seizures, head trauma, long bone trauma, chest trauma, etc. I put out the word through various listservs and contacts and soon had a handful of eager instructors willing to teach in Vietnam on their own dime. We would have 20 hours of didactic talks from nearly 20 experts in emergency medicine.

Now it got even more interesting. "Joe, it looks like there may be as many as 200 people attending the meeting. We need some afternoon workshops. People want to learn ultrasound skills, intubation skills, other resuscitation skills." Again, I sought volunteers, and again, the response was incredibly strong and gratifying. We now had workshops on all of the above, plus orthopedic procedures and pediatric resuscitation. Companies were extraordinarily open to donating ultrasound machines, simulators, airway and central

line devices. And yet even more EM docs were willing to come to teach these skills; before long, the number of volunteer faculty had blossomed to more than 40.

And then in late 2009, the Minister of Health announced that emergency medicine was approved as a specialty, and our group was asked to help Hue College of Medicine and Pharmacy establish the first residency training program and convince the nine other medical schools (and three other major teaching hospitals) that EM would be for the benefit of all concerned. "Joe, we need a Deans' Conference...a session where the deans of all these schools can be made to see the necessity and urgency of emergency medicine training." So I made a few more contacts, and yet even more people volunteered to come. Kris Arnold, MD, leader of ACEP's International Ambassador Program, volunteered to develop the deans' conference. Tammi Thomas, MD, soon joined him. I knew that combined, these

two had as much experience in international emergency medicine as any other ten people. Howard Blumstein, MD FAAEM, then AAEM vice president (now president), eagerly emailed me his acceptance. Bob Suter, DO, past president of both ACEP and IFEM (International Federation for Emergency Medicine) was about to disembark for active duty with the U.S. Army in Iraq, but said he would be there. Terry Mulligan, DO, and chair of ACEP's International Committee was more than willing to come share his experience in helping establish EM in The Netherlands.

The next request wasn't as tricky as anticipated: "Joe,

we need a textbook of emergency medicine for translation into Vietnamese." Peter Cameron, MBBS MD FACEM, of Melbourne, Australia, then vice president (and now president-elect) of IFEM, had just submitted galleys for the 3rd edition of his *Textbook of Emergency Medicine* to his publisher and unhesitatingly said, "Of course you can use my book." Churchill Livingstone had no qualms about allowing a local translation, so then we had our textbook. Peter also gladly volunteered to come and bring several faculty from Monash University with him.

Then, in November, I was attending the Emergency Medicine in the Developing World Conference in Cape Town, South Africa, when I got another missive from Dr. Doan. "Joe, the nurses want a conference too. Can you help?" By coincidence, Bob Suter was attending this meeting with his wife Michelle Suter, RN, a nurse educator at Parkland Memorial Hospital in Dallas, Texas. After surreptitiously asking if she would be accompanying Bob to Vietnam (she said yes), I tagged her with the additional responsibility of assembling a nursing conference – she took it and ran with it, and soon our volunteer faculty list had swelled to more than 60.

Then, the prehospital group wanted to get involved, and yet another meeting was assembled for their edification.



Left to right: James Ramseier, MD (Good Samaritan Medical-Dental Ministry, Las Vegas, NV); Vien Doan, DO (medical director, Good Samaritan Medical-Dental Ministry, Riverside, California); Kris Arnold, MD (chair, ACEP Ambassador Program, Boston, MA); Howard Blumstein, MD FAAEM (president AAEM, Winston-Salem, NC); Terry Mulligan, DO (chair, ACEP Section for International Emergency Medicine, Utrecht, Netherlands); Joe Lex, MD FAAEM (symposium chair, Philadelphia, PA); Bob Suter, DO (past president, American College of Emergency Physicians; past president, International Federation for Emergency Medicine; Dallas, Texas).

continued on page 17

So, what started as a symposium to teach practicing emergency physicians about emergency medicine had now enlarged to four separate meetings: a deans' conference to help with the nuts and bolts of establishing emergency medicine training programs, a physicians' meeting, a nurses' meeting, and a meeting of prehospital specialists.

Finally, we sought educational materials for the medical school libraries and attendees, and the response was overwhelming. Rick Nunez, MD FAAEM, of EMedHome.com (<http://www.emedhome.com/>), graciously granted a free subscription to his website for every attendee. After establishing that each medical school and teaching hospital in the country has rudimentary but adequate electronic tools, I started recruiting material. Mel Herbert, MD FAAEM, gave free access to Emergency Medicine Reviews and Perspectives (EMRAP) to each site; Diku Mandavia, MD, of CMEDownload.com (<http://cmedownload.com>), gave free access to his site; Rick Bukata, MD, gave free access to Emergency Medical Abstracts; Mr. Bob Sweeney, CEO of Challenger, Inc., gave free subscriptions for all Challenger, Inc., programs; and Mr. Lon Osmond of Audio-Digest Emergency Medicine contributed three years of back issues to each site. My own site, Free Emergency Medicine Talks (<http://www.freeemergencytalks.net/>), is available to anyone who wants to access and download mp3s of talks from around the world. Within a few days, we had arranged access to thousands of hours of material, worth tens of thousands of dollars, and no one hesitated in the least.

On Monday morning, March 22, 2010, it all came together: Peter Cameron, MBBS MD FACEM, IFEM president-elect, gave opening remarks about the importance and necessity of emergency medicine as a global specialty; Howard Blumstein, MD FAAEM, AAEM president, talked about his reasons for wanting to see emergency medicine as a worldwide specialty; Bob Suter, DO, past president of both ACEP and ICEP, gave the keynote address, emphasizing that emergency medicine was "the people's specialty." The Deputy Chief of Mission from the U.S. Embassy and the vice minister of the Vietnamese Ministry of Health also gave remarks during the opening ceremony.

I want to emphasize that my role in this was merely one of a facilitator. The groundwork laid through many years of hard work by the Good Samaritan Medical & Dental Ministry was what made this meeting a huge success. To support future faculty who are expected to spend time in the old imperial capital city of Hue, the ministry is purchasing a multi-story, fully equipped, air-conditioned house within easy walking distance of both Hue College of Medicine and Pharmacy and Bach Mai Hospital. If you are interested in contributing your time to this project, contact Carter Hill at CarterHill@Comcast.net.

It was a huge privilege and honor for me to get involved in this program. My involvement was serendipitous, and I was overjoyed to know enough people to make this happen. It's further proof of something I already knew – that the thousands of people from around the world who love emergency medicine are all part of the same global family. I cannot thank them enough for having made this meeting a success beyond our wildest dreams.

...and the people of Vietnam will now have emergency specialists to care for them in their hours of need.

On short notice, I was asked to give closing remarks on the last day of the ceremony. I sketched some notes on a sheet of paper. An approximation of this talk is included below:

The 2010 Emergency Medicine Symposium Closing Remarks

Joe Lex, MD FAACP FAAEM – Symposium Chair

Emergency medicine is the specialty of "now"...and not just because it is the newest specialty in the house of medicine. It's the specialty of "now" because whatever we do must be done now. While the concept of emergency medicine has existed as long as one human being cared for another, it was a long time in being recognized as its own distinct entity, with a specific anatomy and physiology.

As Dr. Suter so accurately noted in his keynote address a few days ago, emergency medicine is the people's specialty. It developed because the people wanted medical care when they wanted it, and the founders of the specialty responded. In doing so, they not only changed medicine, but they changed the people's expectation of what medicine should and could be, and then there was no turning back. And nurses were very much a part of that process; they demanded qualified physicians to care for their patients in the emergency department.

You heard Dr. Blumstein give his "selfish" reason for wanting emergency medicine in Vietnam. When his two children travel the world and explore its wonders, he wants them to have access to the same high quality emergency care they would receive in the United States, Canada and the many other areas where emergency medicine has grown and matured.

Dr. Blumstein is not alone. At this meeting, you have heard and seen more than 60 emergency physicians and nurses from around the world - United States, Canada, The Netherlands, Australia, Thailand - who feel this way. They know the power of emergency medicine to save and change lives, and they know that the power gets stronger first and foremost through sharing. That is why they came on their own time to help you, taking away nothing but memories and the knowledge that emergency medicine is one step closer to being a worldwide specialty.

Ask any one of them, and they will tell you that practicing emergency medicine is the best job in the world. I hope these teachers have opened your eyes to the possibilities of emergency medicine. I hope they have opened your heart to the necessity of emergency medicine. And I hope they have opened your mind to the power of emergency medicine to change people's lives for the better.

The journey to emergency medicine is long and difficult, but you have taken the first steps. With the commitment to a training program at Hue College of Medicine and Pharmacy, they are strong steps. With contributions of a textbook from Dr. Cameron, free subscriptions to EMedHome from Dr. Nunez, and free access to invaluable educational materials from Emergency Medicine Reviews and Perspectives (thank you Dr. Herbert), CME Download (thank you Dr. Mandavia), Challenger Inc. (thank you Mr. Sweeney), Emergency Medical Abstracts (thank you Dr. Bukata), and Audio-Digest Emergency Medicine (thank you Mr. Osmond), you have been given a wealth of information to use to improve the care of your patients. By using free downloads from FreeEmergencyTalks.net, you can educate yourself whenever you like.

I too have a selfish reason: in 1968 as a medic with the 25th Infantry Division, I practiced emergency medicine in Vietnam. It is one of the great joys of my life to return 42 years later and help you on your journey to establishing emergency medicine as a specialty.

You have complex times facing you, but the conclusion is inevitable. You will change the way medicine is practiced, and you will change expectations for what medicine can be for the people of Vietnam. Welcome to the best job in the world - emergency medicine.

Don't Just Pack Your Luggage When You Travel to an International Emergency Medicine Conference!

Gary Gaddis, MD FAAEM

One of the things for which our American Academy of Emergency Medicine (AAEM) is well-known is its involvement in international emergency medicine. I am one of a growing number of AAEM members who have had the opportunity to be an invited speaker at scientific meetings in countries that are not as resource-rich as the United States.

I recently gave three talks at the 2010 Winter Symposium of Emergency Medicine and Intensive Care in Karpacz, Poland. This meeting occurred March 2-6, 2010. The meeting chair was a leader many of us know, Professor Juliusz Jakubaszko, MD, of the Wroclaw Medical University and the Polish Society for Emergency Medicine (Polskie Towarzystwo Medycyny Ratunkowej). Because of his leadership, Poland has had an officially recognized specialty of emergency medicine for over 10 years. He is a man whom I greatly respect.

As Dr. Jakubaszko and I were emailing back-and-forth finalizing details of my talks in February, he made a request I had never received as a speaker. He asked that I bring along a few textbooks that could be placed into emergency departments in Poland. Poland is still emerging from its time under Soviet domination, and although it is by no means the world's poorest country, Poland is not as wealthy as some of its neighbors.

I surveyed my old texts and found, among other things, several recent versions of the Tintinalli study guide. I also came across a two-volume, always-up-to-date book about radiographs commonly obtained by emergency physicians and a copy of *Just the Facts*, the abridged version of the study guide assembled under the leadership of O. John Ma and David Cline.

When it came time to travel, the airline check-in personnel "looked the other way" when my bag checked in at 51.5 lb after I told the clerk the reason my suitcase was so heavy was to take textbooks to a resource-poor country. Between my checked and carry-on bags, I had over 45 pounds of books with me.

These books arrived in Poland without accruing any extra shipping charges. The books I brought now reside in emergency departments in Gdansk and Wroclaw where they will be used frequently as reference materials, rather than gathering dust on my shelves! (Irony: Judy Tintinalli is of Polish ancestry!).

Books are not the only valuable resource we accumulate without thought of what to do with them. I hate wasting soap and shampoo, and I take home what I have been given and what I don't use after hotel stays. I had acquired a sizable stash of hotel shampoo, conditioner, soap, body wash and sewing kits. I had been planning to give them to our hospital's social workers for distribution to the homeless at Christmas.

Recently, however, two of our nurses went to Haiti for post-earthquake relief. They planned ahead well, and I was told the small soaps and shampoos I had been saving would be valuable to them. After they returned, they told me these personal care products were at least as useful and valuable as the no-longer-used three person tent I gave these nurses.

So the bottom line is to ask, whenever you or a co-worker travels internationally for any reason, if any of the things that are sitting unused in your office or home may be useful at the travel destination. The particular beauty of taking recent (past 20 years), well-written and well-edited emergency medicine books with you as luggage on your international travels is that their content is probably still relevant and pretty accurate; having them is certainly better than having none, as is the case in many emergency departments of resource-poor nations. Further, no added charge needs to accrue in their shipping!

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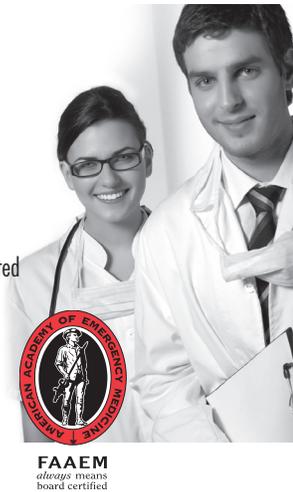
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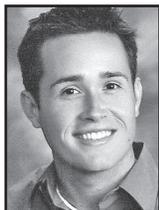
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RESIDENT PRESIDENT'S MESSAGE

Health Care Reform and Its Surprising Impact on Student Loans

Michael Ybarra, MD
AAEM/RSA President

Health care reform legislation is now law, and we are left to wonder what the impact will be over the coming decades. Emergency medicine and every facet of the health care system will feel the ripple effects. Interestingly, there are changes that were rolled in to the health care legislation that are beyond the scope of medicine but will still have an impact on resident quality of life and pocketbooks.

The official bill that passed the House of Representatives and the Senate is called the Patient Protection and Affordable Care Act. This bill originated in a Senate committee in 2009 and was passed by the upper chamber of The Congress in a dramatic and rare Christmas Eve vote. The house had passed a separate health care bill called the Affordable Health Care for America Act in November of 2009.¹ Democrats had originally planned to merge the two bills in conference committee, sending a new bill back for a vote in both chambers of Congress. With the election of Republican Scott Brown as the new Senator from Massachusetts, the Senate Democrats lost their 60-vote supermajority that they required to prevent a Republican filibuster. As a result of this seismic shift in Congress, the House Speaker, Nancy Pelosi, made a calculated decision to pass the Senate bill as is, but make amendments through a separate reconciliation process.

As we all know by now, the House passed the Senate bill (the Patient Protection and Affordable Care Act) and went on to pass a reconciliation bill entitled the Health Care and Education Reconciliation Act of 2010. This reconciliation bill had a rider attached which is very similar to a House bill called the Student Aid and Fiscal Responsibility Act of 2009 (also known as SAFRA). This bill was passed by the House of Representatives in 2009 by a vote of 253-171, but had not been passed by the Senate until it was considered in the health care reconciliation bill.²

The cornerstone of the SAFRA change is an end to private companies providing federally guaranteed loans. Most of the changes are for undergraduate loans, but SAFRA will inevitably impact medical student lending. Starting almost immediately, students and universities will borrow directly from the U.S. Department of Education as opposed to companies like Sallie Mae.³ Eliminating this program is estimated to save the government \$61 billion (because it will no longer be paying private lenders to administer federally backed student loans).

Almost half of that savings will be given back to the Pell Grant program which provides money to individuals from low income families. It raises the annual Pell Grant to \$5,500 (from \$4,050 currently) and ties yearly increases to changes in the consumer price index. Pell Grants do not require repayment but are only eligible to undergraduates less than 24 years old. Additionally, the bill makes changes to repayment plans for federally backed student loans. Recent college graduates with student loan debt have payments

that are currently capped at 15% of discretionary income. SAFRA lowers the cap to 10%.⁴

These changes are significant and will have an impact on the year-to-year borrowing of medical students. It will be helpful for those with significant undergraduate debt and for future physicians currently in college who will benefit from expanded Pell Grant funding. By borrowing directly from the U.S. Department of Education as opposed to private lenders, the servicer of federally backed loans (such as Pell Grants, Perkins and Stafford loans) will, as of July 1st, be the Federal Government, and not private for-profit corporations such as Sallie Mae. Though not explicitly part of the bill, it is possible that this significant change away from federally subsidized private lending may allow medical students and residents access to lower interest rates and fees.

Despite the progress achieved in recent months toward an improved landscape for student lending, more can, and should, be done. Many argue for easier deferment for residents, as monthly salaries for physicians in training is sometimes equal to the monthly payment on their loans. Additionally, interest rates on Federal Stafford loans are much higher than current market rates for a comparable 15 year home mortgage.

One of the most anxiety-provoking aspects of our training is the cloud of debt that looms over us. AAEM/RSA will continue to advocate both locally and nationally to improve access to low interest loans with easier deferment and repayment options while still brainstorming creative ways to lessen student debt. We share this challenge with all trainees in every field of medicine.

It has been a pleasure to serve as president of AAEM/RSA over the past year. I consider myself incredibly lucky to have had this opportunity to work on such important issues, meet some of the best and brightest young minds in the country, and fight for what is right in emergency medicine. Together, we have seen AAEM/RSA grow larger and stronger. As the new leadership team rises to the occasion of a new academic year, we have an executive committee with years of experience in the organization and an at-large board of fresh and energetic residents. I look forward to many more years of advocating and educating on all that is important to residents and emergency physicians.

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Resident Journal Review: May-June 2010

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

This is a continuing column providing synopses of high-impact journal articles pertinent to EM residents. It is not meant to be an extensive review of the articles, nor is it wholly comprehensive of all the literature published. Rather, it is a short list of potentially useful literature important to the busy EM resident. Residents should read the articles themselves to draw their own conclusions. These papers were selected after a review of twenty-two of the most pertinent journals for emergency medicine. This edition will include articles published over a two month period, between January and February of 2010.

A prospective case series of pediatric procedural sedation and analgesia in the emergency department using single-syringe ketamine-propofol combination (ketofol). Andolfatto G, Willman E. *Acad Emerg Med.* Feb;17(2):194-201.

The use of propofol for procedural sedation has become more popular in recent years. The rapid onset and short recovery time makes this sedative hypnotic an appealing option in the busy emergency department. Procedural sedation in the pediatrics population is often accomplished with IV or IM ketamine. This medication is associated with nausea, bronchorrhea and an adverse emergence phenomenon. Ketofol is used as a single-syringe with a 1:1 mixture of 10mg/ml ketamine and 10mg/ml propofol. The use of ketofol has been shown to be effective in providing adequate sedation while using lower doses of each drug. The lower dose helps to reduce the adverse effects typically seen with the individual drugs. Clinical studies on ketofol have mainly involved adults. The authors of this article sought to evaluate the effectiveness of ketofol in pediatric patients in a large prospective observational study conducted over three and a half years in a trauma-receiving community teaching hospital.

This was a single center study of patients under the age of 21 years, who underwent procedural sedation in the emergency department. The only exclusion criterion was known allergy to either medication. The sedative agents used were up to the discretion of the ED physician. Outcome measures included percentage of successful sedation, physician and nursing satisfaction scores, recovery time and total sedation time.

Of the 298 patients for which complete data was obtained, 219 patients (73%) received ketofol, 57% of whom were under 13 years old, and 20% were less than eight years. All patients who received ketofol had successful sedation. This was defined as a completed procedure without the need of adjuvant medications. The median dose of ketofol used was 0.8mg/kg, with 96% of patients using <1.5mg/kg and 68% of patients using <1mg/kg. Median recovery time for ketofol was 14 minutes, with 90% of patients recovering within 20 minutes. Median total sedation time was 18 minutes. Median physician and nursing satisfaction scores, based on a scale of 1(low) - 10(high), were 10 and 10.

Limitations to this study include the lack of patient randomization, potential selection bias, lack of a standardized dosing protocol, and a lack of a control group for comparison. Adverse effects included emergence reactions (two patients), temporary apnea (two patients), laryngospasm (one patient), and need for airway intervention (three patients). No patients required endotracheal intubation or admission to the hospital. Despite these issues, this is the largest observation study to date on the use of ketofol in pediatric patients, and it provides compelling evidence that ketofol can be used safely and

effectively for procedural sedation in this group. Due to the limited numbers of patients under age two, no conclusions about the use of ketofol in this age group can be made.

Sensitivity of bedside ultrasound and supine anteroposterior chest radiographs for the identification of pneumothorax after blunt trauma. Wilkerson RG, Stone MB. *Acad Emerg Med.* Jan;17(1):11-17.

Supine chest radiographs are the routine study in the evaluation of thoracic injury for blunt chest and severe trauma. In many cases, supine positioning is a necessary requisite for spinal immobilization. However, supine chest radiographs have been reported to have poor sensitivity for the detection of pneumothorax. Chest ultrasonography is an emerging modality for the evaluation of pneumothoraces. This study sought to compare the sensitivity of chest ultrasonography to supine radiographs for the detection of pneumothorax in blunt trauma.

The authors of this review conducted a structured search of the literature, including a search of bibliographies to identify additional articles. Prospective, observational studies of adult patients in whom pneumothorax was suspected after blunt trauma were included. Pneumothorax detection was compared between chest radiographs and ED physician-performed chest ultrasonography. The criterion "gold" standard was either computed tomography (CT) of the chest demonstrating a pneumothorax or the presence of a "rush of air" on chest tube insertion in patients unstable for CT. Four studies met inclusion criteria, comprising 606 patients. The sensitivity and specificity of ultrasound ranged from 86-98% and 97-100%, respectively, as compared to a sensitivity of 28-75% and specificity of 100% for chest radiographs.

In this review, chest ultrasonography demonstrated a superior sensitivity and similar specificity for the detection of pneumothorax after blunt trauma when compared to a standard supine chest radiograph. However, several important limitations must be considered. First, the ED physicians performing the chest ultrasounds were generally experienced ultrasonographers, potentially limiting the applicability of the results to the general ED physician. Second, clinical outcomes were not examined. Thus, the resultant benefit of increased sensitivity can only be assumed. Other limitations included a nonrandom study design and a relatively small sample size. Despite these limitations, the review demonstrates the higher sensitivity of ultrasound compared to a supine chest radiograph. While chest radiographs will remain a mainstay in the evaluation of blunt trauma due to the additional clinical information provided, chest ultrasonography is emerging as a more sensitive alternative to aid in the diagnosis of pneumothoraces.

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Resident Journal Review - continued from page 22

Diagnostic accuracy of noncontrast computed tomography for appendicitis in adults: a systematic review. Hlibczuk V, Dattaro JA, Jin Z. *Ann Emerg Med.* Jan;55(1): 51-59.

Acute appendicitis is a diagnosis that is frequently considered in the emergency department in patients presenting with right lower quadrant abdominal pain. Classic symptoms and signs are frequently absent. The use of computed tomography (CT) to aid in the diagnosis of acute appendicitis has decreased negative laparotomy rates significantly. There is still debate on whether or not intravenous contrast is necessary to make the diagnosis. The authors of this study performed a systematic review to evaluate the accuracy of non-contrast CT scan for acute appendicitis.

This review included studies of adult patients with suspected acute appendicitis that used a multi-slice helical scanner and had a pathologic diagnosis or patient follow-up at a minimum of two weeks. Exclusion criteria included articles that involved mixed adult and pediatric populations. Seven studies were included with a combined total of 1,060 patients. The prevalence of acute appendicitis in these studies ranged from 20.1 to 84.5%, with a median of 39.3%. The pooled estimates of sensitivity and specificity were 92.7% and 96.1%, respectively.

There were a number of limitations in this review. The number of CTs that were inconclusive in each study was omitted from the final analysis. In one study, acute appendicitis was ultimately diagnosed in 41% of the patients with a non-conclusive CT. It is unknown how this would have affected the results. Also, despite follow up, the number of false negative scans is not truly known as patients may have had subclinical disease. In addition, the prevalence of appendicitis in some of the studies, as high as 84.5%, likely reflected some selection bias by the enrolling physicians. The use of oral and rectal contrast was also not fully disclosed.

Non-contrast CT of the abdomen has good sensitivity and specificity for acute appendicitis, but it also has a false negative rate of 7.3%. With this in mind, non-contrast CT is a viable option in the ED setting, but those patients with a strong suspicion for appendicitis might need an admission for serial examinations or an additional study to confirm the diagnosis. The lack of contrast can also affect the ability to diagnosis an alternative condition as the cause of the patient's pain. Overall, the option of doing a CT without contrast can help decrease the time to diagnosis in the majority of patients with appendicitis and help improve patient flow through the ED.

Does the early administration of beta-blockers improve the in-hospital mortality rate of patients admitted with acute coronary syndrome? Brandler E, Paladino L, Sinert R. *Acad Emerg Med.* Jan 2010;17(1):1-10.

For decades, beta-blocker therapy has been a mainstay in the treatment of acute coronary syndrome (ACS). Beta-blockers decrease the workload of the heart by reducing chronotropy and inotropy, lowering the oxygen demands of the ischemic myocardium. Early studies from the 1960s showed mortality benefits when beta-blockers were given in the early and chronic setting, leading to its frequent use in the ED. More recent studies, however, have gone against this old paradigm, and beta-blockers may in fact cause harm

due to the risk of reduced cardiac output and cardiogenic shock. The authors of this study sought to determine if in-hospital mortality improved when beta-blockers were given early in suspected acute coronary syndrome.

This systematic review included studies of adult patients who presented within 24 hours of chest pain onset and who were given beta-blocker therapy within eight hours of presentation. Studies of patients with chronic stable angina were excluded. There were no exclusions based on the type of beta-blocker therapy or other therapies given to the patient (i.e. thrombolysis, angioplasty). The primary outcome measure was in-hospital mortality. Eighteen articles from 1965 to 2005 were included that showed a pooled relative risk ratio of 0.9 (CI 0.9-1.01), demonstrating that there is no benefit of early administration of beta-blockers on in-hospital mortality.

Limitations to the review included the large heterogeneity of the trials in regards to sample sizes, type and dosing of beta-blockers, placebo use and adjuvant therapies. The largest study included was the 2005 COMMIT trial (n=45,852), which showed no benefit and an increased incidence of cardiogenic shock with early beta-blocker administration. By comparison, the next largest studies were the ISIS-1 study of 1986 (n=15,997) and the MIAMI trial of 1985 (n=5,779). If the COMMIT trial was excluded from the analysis, the pooled relative risk ratio would be 0.86 (CI 0.7-0.96), weakly favoring early beta-blocker therapy. In addition to the differences of sample sizes, there were large differences in the control mortality rates amongst the studies. For all trials prior to 1984, the control mortality rates were all >12%. After 1984, the highest control mortality rate was 7.8%, while most others ranged from 1.2 to 5.7%. This was likely due to the adjuvant therapies such as thrombolysis and percutaneous interventions that were not available prior to that time. The data from older studies may show larger benefits of beta-blockers on survival because more current therapies were not available, which may have skewed the overall results.

Based on this review and largely due to the findings of the COMMIT trial, there is no evidence that beta-blocker therapy started in the ED decreases the in-hospital mortality of ACS patients and, in fact, may actually increase mortality rates.

Nasogastric aspiration and lavage in emergency department patients with hemochezia or melena without hematemesis. Palamidessi N, Sinert R, Falzon L, Zehtabchi S. *Acad Emerg Med.* Feb 2010;17(2):126-132.

Nasogastric aspiration and lavage are common practices in the management of melena and hemochezia. The benefits of these procedures have recently been questioned. Proponents argue nasogastric tube (NGT) aspiration helps localize bleeding (upper versus lower) thereby guiding subsequent endoscopic management, while clearance or lack of clearance of the aspirate assists in determining the urgency of endoscopy. Opponents argue that nasogastric aspiration results rarely change management yet subject patient to the risks of complications and the discomfort of NGT placement (noted by patients to be among the most painful procedures performed in the ED). The authors of this study sought

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to examine if nasogastric aspiration and lavage differentiates upper and lower gastrointestinal (GI) bleeding in patients with melena or hematochezia without hematemesis.

In this systematic review, a structured search of the literature was performed including a review of bibliographies of relevant articles. Adult patients presenting with melena and hematochezia without hematemesis were included. Patients with hematemesis were excluded (presumed to have upper GI bleeding). Esophagogastroduodenoscopy (EGD) was used as the reference standard. In total, three studies met inclusion criteria, comprising 533 patients. Primary endpoints included sensitivity and specificity of finding an upper GI bleed as the source of the melena or hematochezia.

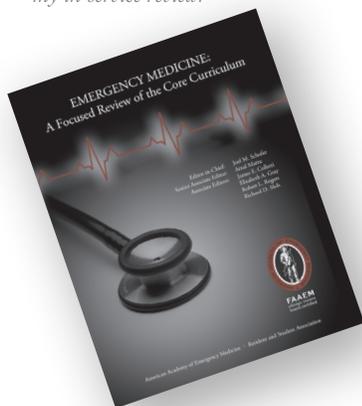
The sensitivity and specificity varied among the studies, from 42-84% and 54-91%, respectively. The positive predictive value and negative predictive value ranged from 41-93% and 61-78%, respectively. The positive likelihood and negative likelihood ratios varied from 1.44-4.74 and 0.2-0.65, respectively. Several important limitations to these results were noted. All the studies included were retrospective and carry the biases inherent to these types of analyses. There was significant heterogeneity among the definitions of positive NG

aspirate results as well as the reference standard (various criteria for a positive EGD or positive diagnosis for upper GI bleed). One study only included patients with GI bleed after having myocardial infarction, thereby introducing bias into the study population and limiting the universal application of its results.

These important limitations prevent definitive recommendations for the use of nasogastric aspiration for hematochezia or melena. However, all the included studies showed poor sensitivity for nasogastric aspiration or lavage questioning its role as a useful test to rule out upper GI bleed. Specificity was also low. The authors note that a positive result may still provide useful information if the consulting gastroenterologist would consider emergent (versus delayed) endoscopy based on these findings. However, such a decision would likely be based on a multitude of additional factors, such as hemodynamic stability and hematocrit, time of day, and availability of support staff. This review suggests that the common practice of nasogastric aspiration or lavage in the setting of hematochezia or melena has limited value. However, more rigorous studies are needed for definitive conclusions.

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MEDICAL STUDENT COUNCIL PRESIDENT'S MESSAGE

Akiva Kahn, outgoing AAEM/RSA Medical Student Council President
Brett Rosen, incoming AAEM/RSA Medical Student Council President



This year has been one of tremendous growth both for me and for the AAEM/RSA Medical Student Council! I am so grateful that I had the opportunity to be a part of the council this year. None of this would have been possible without the help of the incredible leadership of Dr. Michael Ybarra and the board members of AAEM/RSA.

Some of the exciting highlights over the past year:

- Vice president Deena Ibrahim completely updated EM Select, our interactive website for learning about and applying to residency programs.
- With the help of Dr. Jeff Pinnow and the rest of the AAEM/RSA Education Committee, the 3rd annual Midwest Medical Student Symposium was held at Loyola University Chicago Stritch School of Medicine and was a huge success.
- The student track held during AAEM's 16th Annual Scientific Assembly in Las Vegas was extended from a half day to a full day and was the site of the first annual EMIG leadership luncheon sponsored by Western University of Health Sciences and the University of California Irvine.
- Introduced an international ex officio position on both the AAEM/RSA board of directors and medical student council which increased our exposure and international membership.
- Lastly, this year marks the creation of EMIG Select, a program designed to acknowledge medical schools that have over 20 AAEM/RSA student members. Congratulations to:
Chicago Medical School at Rosalind Franklin University of Medicine and Science
David Geffen School of Medicine at UCLA
Drexel University College of Medicine
Georgetown University School of Medicine
Keck School of Medicine of the University of Southern California
Lake Erie College of Osteopathic Medicine
Loma Linda University School of Medicine
Loyola University of Chicago Stritch School of Medicine
Meharry Medical College School of Medicine
Midwestern University/Arizona College of Osteopathic Medicine
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University of California, San Diego, School of Medicine
University of Illinois at Chicago College of Medicine
University of Maryland School of Medicine
Western University of Health Sciences – College of Osteopathic Medicine of the Pacific

During the year, AAEM/RSA and the medical student council have become strong advocates and have increased valuable resources for Emergency Medicine Interest Groups (EMIGs)! I hope that the council continues to distinguish itself from other national student organizations by serving as a resource for individuals either starting a new EMIG or improving the existing one at their school.

I want to thank everyone for the support I have received over this past year – the AAEM/RSA board of directors and medical student council and the AAEM/RSA staff (Janet Wilson and Jody Bath). I hope I get to work with you again in the future! I am excited for all that we have accomplished and am looking forward to the momentum our newly elected board and council will bring in the upcoming year. With that, I turn over the reins to the new council and turn over the rest of this article to the new AAEM/RSA medical student council president, Brett Rosen!

AAEM/RSA Medical Student Council

President: Brett Rosen - Drexel University College of Medicine
Vice President: Meaghan Mercer - Western University

Regional Representatives

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Taylor Burkholder - Tulane University
Tom O'Grady - Chicago College of Osteopathic Medicine

Northeast:

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West:

David Markel - University of Washington School of Medicine
Tiffany Nelson - University of Texas Medical Branch

International Ex Officio:

Joshua Ramjist - St George's University School of Medicine

From the 2010-2011 AAEM/RSA medical student council president, Brett Rosen:

Thank you, Akiva. I would first like to congratulate the members of the 2010-2011 AAEM/RSA medical student council on their election. I look forward to working with all of them over the next year. As the incoming president, I am also looking forward to continuing our outreach to medical students and increasing our student membership through active involvement of our EMIG site coordinators and regional representatives. I hope to increase the number of schools in EMIG Select and expand the educational opportunities available to student members through our regional symposia and growing online resources. I will make updates on our progress throughout the year with regular articles and anticipate an exciting year of growth and development for everyone involved with the AAEM/RSA medical student council.

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2010-2011

AAEM/RSA Membership Applications

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AAEM/RSA is going green! Beginning July 2010, the Journal of Emergency Medicine (JEM), the official journal of the American Academy of Emergency Medicine, will be provided in electronic format only. If you prefer to receive JEM in both paper and electronic format, a subscription upgrade is available for an additional \$20 per year. If you are a current member and would like to upgrade your JEM subscription now, please [click here](#).

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If you are a graduating resident or medical student and your email address will be changing, we recommend you use an email address outside of your institution once you've logged into the RSA member's only section. You may update your email address on file at any time. This will ensure your member benefits will continue without interruption. Please include any changes to

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West:

David Markel – University of Washington School of Medicine

Tiffany Nelson – University of Texas Medical Branch

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In the coming weeks, we will be sending out a call for volunteers for AAEM/RSA committee members and AAEM/RSA representatives to AAEM committees.



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