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SENSE

THE NEWSLETTER OF THE AMERICAN ACADEMY OF EMERGENCY MEDICINE



PRESIDENT'S MESSAGE

Howard Blumstein, MD FAAEM

Dear Colleague

I recently received a message from a fellow emergency physician. The following is my response. The only edit I made was to remove his name. Enjoy.

I received your email, which was sent to the AAEM home office in response to an email sent out to folks who had not renewed their memberships. Yours seems to be the sort of tragic story we hear all too much from emergency physicians all over the country.

My job is pretty frustrating. We get calls for help on a regular basis from docs who, like you, get screwed somehow. What's frustrating is that most of the time there is little we can do to help out. Most of the time these doctors have gotten themselves into a situation in which they have signed contracts that give them no recourse.

We have offered support where we can. We suggest that the doctor (or doctors) appeal to the medical staff of the hospital, we sometimes write a letter to the hospital administration suggesting that their new contracts are not legal or are otherwise disadvantageous, we suggest that the doctor(s) contact their state chapter of the AMA. But realistically I have not seen that help.

We have, on rare occasions, gotten involved with lawsuits in which illegal contracts were challenged in court. We have had some success, but the most recent efforts fell victim to an incompetent judge.

You are not the first emergency doc to be disappointed by what they felt to be a tepid response to a call for help. But the fact is that when contracts give the employer the right to hurt you, they are nearly impossible to reverse and it is futile to try.

In truth, the best way to deal with the sort of situations you were in is to avoid them in the first place. That is why we place so much emphasis on trying to educate residents and members about the traps that exist in our specialty. I am on the road at least once a month to speak at residency programs about these issues. If you had a fair contract to start with, you wouldn't have gotten into the trouble that

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you experienced. Yet I am willing to bet that if you received any education about contracts and job hunting, it did not address the issues that allowed your situation.

I can assure you that I am not "on the take" as you say. I work at a university hospital (Wake Forest), I get paid by the university and made less than \$5000 doing legal consulting last year, all for the defense. I get no money from contract groups and my university and my department make absolutely no money off of me except for my clinical activities. I get no time off for AAEM related activities and I get no bonus or additional financial consideration for being president, although it does reflect very well upon my department. About the only benefit I can see is that I have accumulated over 150,000 frequent flier miles related to AAEM activities.

I suggest that you contrast this with ACEP, where the President gets a handsome stipend for his/her activities.

I wish we had the resources to do more. Some members have contributed handsomely to the AAEM Foundation, which gives us a war chest that allows us to take action when the opportunity arises. But, unlike other organizations, we refuse to take donations from unscrupulous (and sometimes illegal) entities. That cuts off a big potential source of cash.

All this said, I am very sorry that AAEM was not able to meet your expectations when you were in trouble. You are not the first. I hope that physicians these days are more savvy and less likely to get into these bad legal situations. I know that our efforts already make it harder for unscrupulous and crooked business people and emergency docs to take advantage of our colleagues. I hope our continued efforts will continue to bear fruit. Only with the continued support of emergency physicians like you will we have the resources and clout to move forward.

Thanks for your consideration.

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EDITOR'S LETTER

Supporting the Next Generation

David D. Vega, MD FAAEM

Once again, we are at that time of year when a fresh batch of residency-trained physicians have been added to the roles of attending emergency physicians. I offer my congratulations to those who have entered this next phase in their careers. Those of us who have already gone through the transition from a relatively protected position as a resident in training to an independently-practicing physician can remember how one's self-confidence, built up through rigorous residency training, is tempered with a healthy fear of not having an attending physician "watching your back." It can be a great feeling to finally be free of this supervised status while at the same time there is at least a little anxiety about what those first few shifts "alone" will bring.

As AAEM moves forward with its mission and goals, we especially need to focus on the younger generation of physicians that represent the future of our specialty. They bring with them enthusiasm and hope for the future, along with new and fresh perspectives that can help drive progress. However, the early years of practice often bring struggles such as job changes and moves, changes in career tracks, new financial situations, and difficulties finding the right balance in life. This can be a significant impediment to young physicians having the ability or desire to participate with organizations like AAEM. The unfortunate reality is that we prepare residents well for the rigors of clinical medicine, but leave them much less prepared for the political, administrative and other non-clinical concerns that face them when their training is done.

Every one of us must continue to look for ways to reach out to successive generations of physicians and educate them about the issues for which AAEM fights. We should offer mentorship and guidance in achieving personal and career goals. Whenever possible, this should start at the level of residents, and even medical students. We should encourage membership and active involvement with AAEM. The Young Physicians Section (YPS) is a great

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AAEM Mission Statement

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

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

Membership Information

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

*Associate Member: \$250

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

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

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

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

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

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

*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.

5th Circuit Appeals Court Embraces Hospital's Summary Judgment Motion

Kathleen Ream, Director of Government Affairs

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

As reported in the January/February 2010 issue of *Common Sense*, in June 2009 the U.S. District Court for the Southern District of Texas granted a hospital's motion for summary judgment, finding that the hospital did not violate EMTALA in handling a boy treated and later transferred by the hospital's emergency department. The plaintiffs, Wendy and Dominic Guzman, who sued Memorial Hermann Southeast Hospital (Memorial) on behalf of their son Tristan, appealed the 2009 federal district court ruling. On February 1, 2011, the 5th Circuit Court of Appeals affirmed the lower court decision, holding that Memorial had fulfilled its obligation under EMTALA to screen Tristan for an emergency medical condition (Guzman v. Memorial Hermann Hospital System, 5th Cir., No. 09-20780, unpublished opinion 2/1/11).

The Facts

In February 2006, seven-year old Tristan was taken to the ED at Memorial, where Guzman reported that her son had vomited during the night and had been running a fever. The triage nurse recorded the child's temperature as 98.1 degrees, his blood pressure as 110/67, and his heart rate as 145. Under Memorial's policy, all pediatric patients with a heart rate above 140 are categorized as "Emergent Level 2" and must be seen by a physician. In accordance with this policy, the nurse took the child to an examination room to be seen by Dr. Haynes. Haynes first took Tristan's medical history and examined him. Believing that Tristan likely had a virus, Haynes ordered several laboratory tests, including a manual white blood cell differential test.

Knowing that Tristan's heart rate had decreased, that he was receiving fluids and everything he needed, and that the Guzmans were interested in going home, absent knowing the white blood cell differential test results, Haynes diagnosed a urinary tract infection. Haynes made the decision to discharge and Tristan was released from the hospital. Upon discharge, Haynes told the Guzmans that their son's condition should begin to improve within 24 hours but to return to the ED if it did not. The Guzmans brought Tristan back to Memorial's ED the following morning. Tristan was complaining of fever, abdominal and chest pain, was vomiting, and had diarrhea. His condition worsened. By late in the afternoon, Tristan was transported to Memorial Hermann Children's Hospital, where he was hospitalized in the intensive care unit. Tristan remained at Memorial Hermann Children's Hospital for several weeks. Diagnosed with septic shock, which caused organ injury, Tristan still requires follow-up medical care and therapy.

The Guzmans sued Memorial alleging that Memorial Hermann committed EMTALA violations. In June 2009, the U.S. District Court for the Southern District of Texas iterated that "negligence in the screening process or providing a faulty screening or making a misdiagnosis, as opposed to refusing to screen or providing disparate screening, does not violate EMTALA . . ." Finding that "Guzman's allegations and the summary judgment evidence . . . do not as a matter of law support a claim under EMTALA that the screening examination was not appropriate," summary judgment was granted on Guzman's EMTALA screening claim. Also on the Guzman claim of a failure to stabilize an emergency medical condition, the court wrote that "[w]hether a patient is in fact suffering from an emergency medical condition is 'irrelevant for purposes of [EMTALA] . . . The statutory language makes clear that 'what

matters is the hospital's determination of the patient's medical status. The standard is a subjective one.'" Determining that there was no dispute as to the hospital's actual lack of knowledge of an emergency medical condition and that Guzman did not present any evidence of a difference of opinion within the hospital staff as to Tristan's condition, the district court granted Memorial's motion for partial summary judgment on the Guzman EMTALA failure to stabilize claim (Guzman v. Memorial Hermann Hospital System, S.D. Tex., No. 4:07-cv-3973, 6/16/09).

Fifth Circuit Court Ruling

On appeal from the U.S. District Court for the Southern District of Texas, the Fifth Circuit Court of Appeals determined that the Guzman complaint was unsuccessful in raising a genuine issue of material fact as to whether the hospital failed to follow its guidelines for screening Tristan when he arrived at Memorial's ED. The court rejected Guzman's complaint that Memorial's failure to follow its own screening guidelines constituted a violation of EMTALA, stating that the hospital's "Triage Guidelines" specify only the steps to follow during triage, not after the physician's examination.

Plaintiff did not present evidence that Memorial's policy required that a physician could not discharge patients until after all test results were read. The court also determined that a physician's testimony that "he normally reviewed all available results did not establish a standard of care for the entire hospital." Finding no evidence to support that an EMTALA violation had occurred, the appeals court affirmed the district court's grant of summary judgment on behalf of the hospital.

Hospital Found Liable for EMTALA Violation, but Relief on EMTALA Claim Denied

On March 25, 2011, the U.S. District Court for the District of Maine denied a hospital post-verdict motions – for a new trial or for judgment as a matter of law – where the hospital had been found liable on an EMTALA failure-to-stabilize claim. The initial complaint was brought by a woman who presented to a hospital ED with contractions, but was discharged only to later deliver her dead fetus at home. While the federal court decision left intact a \$50,000 compensatory damages award and a \$150,000 punitive damages award, the court denied the woman's post-trial motion for equitable relief, determining that it lacked authority under EMTALA to grant any general relief requiring the hospital to change its policies regarding women having contractions and whose discharge would pose a threat of harm to them or their fetus (Morin v. Eastern Maine Medical Center, D. Me., No. 1:09-cv-258, 3/25/11).

The Facts

On July 1, 2007, Lorraine Morin, who was sixteen weeks pregnant, was experiencing pain and suprapubic cramps ten minutes apart. Having been advised by her obstetrician/gynecologist to go to the hospital if she had any problems – given that her pregnancy was high-risk due to a history of cervical cancer, a miscarriage, a previous caesarian section, and pregnancy-induced hypertension – Morin and her boyfriend traveled from Millinocket, ME, to Bangor, arriving at 4:37 a.m. at the ED at Eastern Maine Medical Center (EMMC). Relating her symptoms and medical history to the triage nurse,

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she was brought to an examining room, where she saw another nurse and repeated her symptoms and history, although there is no notation in the record of Morin describing that she had a high-risk pregnancy.

Several hours later after returning home, Morin locked her boyfriend out of the bathroom and delivered the dead fetus at around 9 p.m. on the bathroom floor. Through the night Morin was bleeding. The next morning, she called her obstetrician, who immediately admitted her into EMMC for surgery to stop her bleeding and to remove the remaining placenta. Morin subsequently sued the hospital in U.S. District Court, claiming that doctors violated EMTALA when they discharged a patient in an emergency medical condition.

In July 2010, the U.S. District Court ruled that EMTALA is not inapplicable merely because fetal demise has been confirmed and the mother is not, therefore, in active labor. Rather, the question is whether the patient has an emergency medical condition that places her in a medically unstable condition, posing a threat to her health or safety if she is discharged without necessary stabilizing treatment. In this case the patient had a medical condition requiring stabilization, that is, delivery of her fetus before being allowed to leave the hospital. To support this finding, the court accepted an experienced labor and delivery nurse's testimony as an expert witness on the possible complications this patient was facing when she was discharged [*Morin v. Eastern Maine Med. Ctr.*, ___ F. Supp. 2d ___, 2010 WL 3000286 (D. Me., July 28, 2010)].

On October 20, 2010, a jury issued a verdict finding that EMMC had violated EMTALA and that its EMTALA violation had directly caused Morin to suffer personal harm. The jury awarded compensatory damages of \$50,000.00. In addition, the jury found that Ms. Morin had proven her claim for punitive damages against EMMC by clear and convincing evidence and awarded \$150,000.00 in punitive damages. The Court reduced the verdict to Judgment. Morin then moved for an order granting equitable relief against the EMMC, "seeking a court order directing the Defendant to change its policies for women facing contractions whose discharge poses a threat of harm to themselves or their unborn children."

On November 16, 2010, EMMC renewed its motion for judgment as a matter of law and for a new trial, claiming that EMTALA distinguishes between viable and non-viable pregnancies, that the court erred in allowing a nurse to testify as an expert, and that the trial evidence did not sustain the verdict.

The Ruling

Plaintiff's order for equitable relief –

The court concluded it had no basis to order EMMC to "change its policies for women facing contractions whose discharge poses a threat of harm to themselves or their unborn children." First, the court found that while EMTALA's language limits equitable relief to remedy the personal harm the plaintiff herself sustained as a consequence of a violation, it was questionable whether the court is statutorily authorized to order generalized relief to individuals who are not parties to the laws. Even if EMTALA authorizes generalized equitable relief, the court wrote that "Morin's request fails as a matter of proof. She did not begin to provide the Court with an evidentiary basis to impose such a sweeping judicial directive against EMMCs medical policies . . . [I]t is not sensible for a judge

to arrogate for himself the authority of highly trained and licensed physicians to act in the best medical interest of their patients. If there is a case where a court should intervene in such an invasion fashion into the practice of medicine, this is not it." The court denied plaintiff's claim for equitable relief.

Defendant's motion for new trial or for judgment as a matter of law – The court rejected EMMC's challenge of the award by first ruling that there was substantial evidence to support the jury's verdict: "EMMC has taken the untenable position that EMTALA entitles it to treat pregnant women carrying dead fetuses with less care than it treats women carrying viable fetuses. The Court extensively addressed EMMC's argument in its July 28, 2010, Order on EMMC's motion for summary judgment, and it adopts that opinion in response to EMMC's reiterated position . . . From the Court's perspective, EMMC's position is legally wrong and morally questionable . . . EMMC's contention is not justified by the language of the statute or its implementing regulations and has disturbing policy implications. There is simply no suggestion that Congress ever intended such a harsh and callous result for women who, like Ms. Morin, are carrying a non-viable fetus."

The federal court also dismissed the hospital's claim that the court had erred in allowing the testimony of an on-duty nurse by rejecting "EMMC's blanket contention that nurses are not experts." Finding that the nurse's testimony was properly focused, the court likewise ruled that its jury instructions appropriately stated the law: "It was a jury question whether Nurse O'Brien was less or more persuasive than the EMMC's three physician experts. During final instructions, the Court gave the jury the standard instruction regarding expert testimony, informing them that they were entitled to judge expert testimony 'like any other testimony', that they could 'accept it or reject it', and could give it as much weight as [they] think it deserves considering the witness's education and experience, the reasons given for the opinion, and all the other evidence in the case . . . Nurses are nursing experts, not physician experts, but this limitation goes to weight, not admissibility."

Furthermore, owing to the distance between the ED in Bangor and Morin's residence in Millinocket, the court acknowledged that the physician's decision to discharge the patient effectively consigned her to miscarry at home. "Simple math compels the conclusion that if she miscarried within two hours of discharge, there was not enough time to return to Millinocket and get back to the EMMC . . . The jury was fully capable of applying the time frames of the doctors' testimony to the time-distance from EMMC to Ms. Morin's home in Millinocket and back to EMMC . . . It was also capable of finding that EMMC had discharged Ms. Morin while she was still having contractions, before she had delivered the fetus, and with a risk to her health and safety."

Rejecting EMMC's contention that the trial evidence was inadequate to sustain the verdict, the federal court determined that both damage awards were supported by the jury's conclusion that Morin was subjected to both physical and emotional injury, and that the hospital acted maliciously in how it treated Morin. The court denied defendant's motion for judgment as a matter of law and motion for new trial, and ordered that a final judgment consistent with the verdict be issued in favor of plaintiff.

American Academy of Emergency Medicine 2012 Elections and Awards — Nomination Deadline: November 10, 2011

AAEM encourages candidates for election to the board of directors who have a previous record of service and commitment to the Academy.

The president, vice president, secretary-treasurer and three at-large positions on the AAEM board of directors are open as well as the Young Physicians Section (YPS) director position. Any Academy member may nominate a full voting or YPS member (for the YPS director position only) for the board. Self-nominations are allowed and encouraged. You must be a YPS member to be eligible to run for the YPS director position.

Elections for these positions will be held at AAEM's 18th Annual Scientific Assembly, February 8-10, 2012, in San Diego, CA. Although balloting arrangements will be made for those unable to attend the Assembly, all members will be encouraged to hold their votes until the time of the meeting.

The Scientific Assembly will feature a Candidates Forum, in which members will be able to directly question the candidates before casting their ballots. Winners will be announced during the conference, and those elected will begin their terms at the conclusion of the Assembly.

In order to nominate yourself or another full voting member for a board position, please complete the nomination form and attestation statement found at <http://www.aaem.org/elections/2012nominationform.pdf> and send the information listed below to the AAEM office before midnight CST, on November 10, 2011. Any YPS member can be nominated and elected to the YPS director position. The nomination form and required information is the same as that for a board position.

1. Name of nominee. Each nominee may have only three individuals as nominators/endorsers.
2. Name of nominee's medical school and year graduated.
3. Board certification status of nominee, including board and year completed.
4. Number of ED clinical hours worked each week by the nominee.
5. A candidate statement (written by the nominee, 500 word max.) listing recent AAEM contributions, accomplishments, activities or any other information detailing why the nominee should be elected to the board. A photo for publication may accompany the statement if the nominee wishes.
6. Any emergency medicine related business activity in which the nominee has a financial interest.
7. A current CV for the nominee.
8. AAEM Attestation Statement filled out by the nominee.
9. Conflict of Interest Form must be completed by the nominee prior to the nomination deadline.

The candidate statements from all those running for the board will be featured in an upcoming issue of *Common Sense* and will be sent to each full voting and YPS member along with the ballot.

These nomination and election procedures are what set AAEM apart from other professional medical associations. We believe the democratic principles that guide them are one of AAEM's greatest strengths and are an integral part of what makes us the organization of specialists in emergency medicine. In AAEM, any individual, full voting or YPS member can be nominated and elected to the AAEM board of directors.

Award Nominations Sought for AAEM Awards

AAEM is pleased to announce it is currently accepting nominations for its annual awards. Individuals can be nominated for the following awards:

David K. Wagner Award

As an organization, AAEM recognizes Dr. Wagner's contributions to the specialty by offering an award named in his honor to individuals who have had a meaningful impact on the field of emergency medicine and who have contributed significantly to the promotion of AAEM's goals and objectives. Dr. Wagner himself was given the first such award in 1995.

Young Educator Award

Nominees must be out of residency less than five years and must be AAEM members. This award recognizes an individual who has made an outstanding contribution to AAEM through work on educational programs.

Resident of the Year Award

Nominees for this award must be AAEM resident members and must be enrolled in an EM residency training program. This award recognizes a resident member who has made an outstanding contribution to AAEM.

James Keaney Award

Nominees for this award must have 10 or more years of experience in EM clinical practice and must be AAEM members. Named after the founder of AAEM, this award recognizes an individual who has made an outstanding contribution to our organization.

Peter Rosen Award

Nominees for this award must have 10 or more years of experience in an EM academic leadership position and must be AAEM members. This award recognizes an individual who has made an outstanding contribution to AAEM in the area of academic leadership.

Joe Lex Educator of the Year Award

This award recognizes an individual who has made an outstanding contribution to AAEM through work on educational programs. Nominees must be AAEM members who have been out of their residency for more than five years.

Nominations will be accepted for all awards until midnight CST, November 10, 2011. The AAEM executive committee will review the nominees and select recipients for all awards. Award presentations will be made to the recipients at the 18th Annual Scientific Assembly to be held February 8-10, 2012, in San Diego, CA.

All nominations for the awards listed above should be submitted in writing and should include:

1. Name of the nominee.
2. Name of the person submitting the nomination.
3. Reasons why the person submitting the nomination believes the nominee should receive the award.

Master of the American Academy of Emergency Medicine (MAAEM)

Active members of AAEM may also recommend nominees to the AAEM executive committee for the Master of the American Academy of Emergency Medicine (MAAEM). This recognition of senior AAEM fellows shall be extended to those who demonstrated a long career of extraordinary (1) service to AAEM, (2) service as an exemplary clinician and/or teacher of emergency medicine, (3) service to emergency medicine in the area of research and/or published works, (4) service as a leader in the hospital, the community, or

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organized medicine, (5) service in the areas of health policy and advocacy, (6) volunteerism, and (7) other activities or high honors that distinguished the physician as preeminent in the field of emergency medicine.

Nominees are expected to meet most, but not necessarily all of the above criteria. However, with very rare exceptions, nominees must meet the first criterion, extraordinary service to AAEM. Individuals shall not self-nominate. Current members of the board of directors may not receive a nomination, but will become eligible for a nomination two years after completion of their service as members of the board. Those nominees who receive approval from the board of directors shall receive their awards at the next Scientific Assembly. AAEM authorizes Masters to use the title MAEM for as

long as their AAEM membership remains current.

The nominator should submit the following to the AAEM executive committee:

1. Letters of reference for the nominee from three other members in addition to the nominator (Total of 4 letters).
2. Provide the nominee's current curriculum vitae

Completed nominations, including all letters of reference and the CV, will receive consideration by the executive committee for submission to the board of directors.

Please submit all nominations to:

AAEM, 555 East Wells Street, Suite 1100, Milwaukee, WI 53202
800-884-2236, Fax: 414-276-3349, info@aaem.org

New AAEM Board of Director Member: Robert E. Suter, DO MHA FAAEM

First, let me say "thank you" to all of the AAEM members who elected me to the board of directors. By way of re-introduction, my name is Bob Suter, and while my career has included EMS, military practice, small group practice and regional democratic group practice, for the past four years I have been a professor and director of practice management, health policy and international emergency medicine at the University of Texas-Southwestern (UTSW).

I grew up and worked in EMS in the St. Louis area when it was a CMG stronghold and a backwaters for EM residency trained physicians. After graduating from Washington University in St. Louis, I received DO and MHA degrees from Des Moines University. I did my residency training in emergency medicine at Brooke Army-Wilford Hall USAF Medical Centers in San Antonio, TX, and achieved board certification by the American Board of Emergency Medicine (ABEM) and the American Osteopathic Board of Emergency Medicine (AOBEM), followed by service as an oral examiner for ABEM.

Ever since my EMS days, I have tried to offer myself in service to emergency medicine on a state, national and international level. During my Army residency, I was ordered to run for president of EMRA, triggering subsequent participation in numerous state and national committees. In the 1990s, I served on the boards of several EMS organizations and was the co-chair of the federal project "EMS Agenda for the Future." During this time, I also served as a member of the ACEP council, supporting Bob McNamara's run for the ACEP

board of directors in 1993. In 1999, I was elected to the ACEP board. I was chosen for ACEP president in 2004-05, and served on the board of the International Federation for Emergency Medicine (IFEM), including IFEM president in 2006.

In addition to UTSW, I also hold appointments as a professor at the Medical College of Georgia, Des Moines University and the Uniformed Services University of the Health Sciences as a Colonel in the U.S. Army Reserve and have deployed in support of operations in Southwest Asia.

I am a big believer in physician empowerment, ownership and workplace fairness in emergency medicine, as well as in the necessity of firmly establishing the primacy of residency training and board certification in emergency medicine for those entering our field. At the same time, I feel that our advocacy efforts should be aimed at our real, external threats, rather than spending lots of resources on those within whom perhaps are not as strident in their beliefs, but who essentially agree with us nonetheless. Along with my years of networking, experience and knowledge of emergency medicine issues, it is this perspective, which I feel is common among AAEM members, that I hope to offer to the board during my term.

Again, thank you for your trust and the opportunity to represent you on the AAEM board. Please feel free to contact me at resuter@gmail.com at any time if I can be of service to you or your concerns.

New AAEM Board of Director Member: Leslie Zun, MD FAAEM

Serving on the board of directors for the American Academy of Emergency Medicine provides me the opportunity to contribute to the advancement of the field. I thank you wholeheartedly for your support.

A few years ago, we met at a dingy hotel in Las Vegas to form AAEM. Since this rather inauspicious beginning, AAEM has made significant advances in emergency medicine. However, there are still many objectives to be accomplished over the next few years. One of the most important of these is to ensure that every patient in the emergency room is seen by an emergency physician working in an equitable practice environment. By and large, hospital administrators and trustees lack the fundamental understanding of the virtues promoted by AAEM. As a hospital administrator, I saw a major emphasis being placed on the bottom line and unscrupulous marketing practices all too often trumping the need to do the right thing. Many of the other hospital administrators I met failed to understand the advantages of board certification in emergency medicine and the importance of independent, democratic groups.

One of the best means to influence the staffing of emergency departments in this country involves approaching the hospital administrators and trustees who determine the staffing of their emergency departments. AAEM has attempted to influence the decision-making process but has made only limited progress thus

far. At the February 2011 meeting, the AAEM board of directors agreed that educating hospital administrators and trustees was an important goal. The best method of educating this group is through face-to-face interactions, rather than through mailings or the distribution of fliers.

First, we need to educate hospital decision makers, and then, we need to influence their choice for the provision of emergency care in their hospitals. Meetings of administrators provide excellent settings for explaining the virtues of AAEM, board certification and independent democratic groups. This month, we will be exhibiting at a meeting of the American Hospital Association, the premier association of hospital administrators.

I plan to continue to propose and support initiatives that promote the advancement of emergency medicine. Educating administrators is only one of many goals we need to accomplish this year. Understanding and securing our role in accountable care organizations (ACOs) is another objective that is of prime and urgent importance. We need to be at the forefront of these discussions as ACO rules and regulations are developed.

These are only a few of the many important objectives we must accomplish in the near term. If you have any comments or suggestions, please feel free to contact me at zunl@sinai.org.

AAEM Takes Its Message to Hospital Administrators

William Durkin, MD MBA FAAEM, AAEM Vice President
Leslie Zun, MD MBA FAAEM, AAEM Board Member

The American Academy of Emergency Medicine exhibited at the American Hospital Association's (AHA) Leadership Summit in July. Drs. Les Zun and Bill Durkin staffed the booth to expound to hospital administrators the virtues of independent democratic groups in hospital emergency departments. We also informed this group about the values of AAEM.

Prior to the meeting, with the assistance of the Practice Management Committee, promotional materials and a consulting service were created. The practice management committee developed the message for the hospital administrators and assisted in the marketing plan. The materials included a pre-meeting postcard to visit our booth, two pull up signs and a brochure.

The meeting was attended by hospital CEOs, board members and hospital managers. The booth had over 70 visitors during the day and a half exhibiting time. We not only had the opportunity to promote independent, democratic groups but also had a chance to better understand these administrators' priorities in staffing their emergency departments. We plan to follow up with everyone who came by our booth.

Several administrators were interested in learning more about the Academy. Interestingly, one administrator who uses a CMG stopped by to get information on how his daughter, currently an EM resident, could join the Academy. He, like a few others who were using the CMGs, was not very forthcoming as to why he chooses to use a CMG to staff his ED. Another administrator was having difficulty staffing one of their emergency departments and is considering using our consultation service.

AAEM was one of two specialty organizations at the exhibit hall, the other being the American College of Surgeons (ACS). We did get our message out regarding the advantage of independent democratic groups staffing an ED and increased the visibility of the Academy to hospital decision-makers. There were a few contract management companies exhibiting at the meeting, some with huge expense accounts and booths to go along with it.

University of Maryland School of Medicine Creates New Vice Chair for Department of Emergency Medicine

Dr. Amal Mattu Appointed to New Position

Baltimore, MD -April 26, 2011—Dean of the University of Maryland School of Medicine, E. Albert Reece, M.D., Ph.D., M.B.A., and Brian J. Browne M.D., professor and chair of the Department of Emergency Medicine, announced today the appointment of Amal Mattu, M.D., professor of emergency medicine, as the new vice chair of the Department of Emergency Medicine.

In this newly created position, Dr. Mattu will focus on faculty development as well as the expansion of the department's educational programs on all levels. He will also help to extend its international program. The Department of Emergency Medicine has a distinguished history as one of the pioneering emergency departments in the country. "We are leading the nation in a wide range of emergency care, including cardiopulmonary and brain resuscitation, clinical toxicology, pre-hospital care, emergency medical services, and disaster preparedness," says Dr. Reece, who is also vice president for medical affairs, University of Maryland, and the John Z. and Akiko K. Bowers Distinguished Professor and dean.

Dr. Browne explains, "Our decision to create the position of vice chair of the Department of Emergency Medicine is based on the increasingly complex and comprehensive nature of our educational programs for students, residents, and fellows. I have appointed Dr.

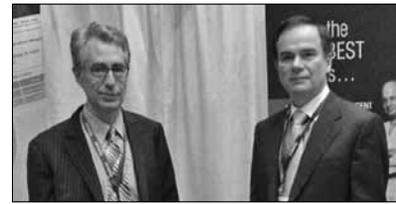
In addition to providing us with a better understanding of ED staffing preferences,

exhibiting at this conference also gave us the chance to find out how AAEM is viewed by hospital administrators. Some administrators stated they had an independent EM group but did not know if it was a democratic or an autocratic one. About 40% said that their EPs were hospital employees or employed by the hospital's medical group. Some administrators approached us thinking that we were a staffing organization. Since this was our first exposure to the AHA meeting, we realized that we need to do a better job of advertising exactly who we are and what we are promoting. Not surprisingly, administrators at the conference noted that their main priorities are increasing quality and decreasing costs.

There is value to promoting ourselves to hospital administrators through the American Hospital Association and other hospital and administrative organizations. We need to increase the visibility of the Academy to these decision-makers. It will take some time to develop our name, our message and become a service to this group. We need to pursue other opportunities to get in front of this group of hospital administrators and similar groups such as the American College of Healthcare Executives.

We also learned that we need to continue to refine our message to hospital administrators so that they see independent democratic groups as "value-added." A white paper demonstrating that we can help decrease admissions, integrate patients within the community, and provide observation care to decrease admissions might be one means to accomplish this task.

Overall, we thought that this was a positive exercise for the Academy. It was a valuable opportunity to get in front of hospital administrators from all over the country. We need to continue to expose the virtues of independent democratic groups and AAEM to this essential audience.



Mattu because he is one of the most qualified and successful emergency medical educators in the country." Since joining the emergency medicine faculty at the University of Maryland in 1996, Dr. Mattu has received more than a dozen teaching awards, including three national awards from the American College of Emergency Physicians and three others from the American Academy of Emergency Medicine. In 2000, he was named Founder's Day Teacher of the Year for the University of Maryland at Baltimore campus.

Although Dr. Mattu is officially stepping down from his previous role as director of the residency program, he has a new global and supervisory role, focusing on all aspects of education for the department. He says, "I will continue to oversee the education of the residents and perhaps spend a bit more time with students, too. However, a major interest of mine will be faculty development. I started a faculty development fellowship several years ago, and I want to spend more time on that." In addition, he hopes to create a risk management curriculum for the Department of Emergency Medicine. Dr. Browne states, "Dr. Mattu's leadership and vision will be integral to maintaining the momentum and quality of our educational programs."

Make a Decision

Adam Sharp, MD

As emergency physicians, we make difficult clinical decisions regularly. We have continuing medical education, residency training, clinical trials, and our own experience to help guide our decisions. Use of these tools leads to confidence and satisfaction with our work. However, the emergency department presents many societal problems for which we have not been prepared. I feel helpless looking into the tearful eyes of a single mother who cannot afford her medicines. Arranging a follow-up visit for the patient needing a primary care physician to manage a blood pressure of 198/112 often ends in frustration. Navigating a system with a shortage of specialists can be debilitating. These dilemmas can lead to disappointment and cynicism because of our lack of preparation and involvement in our health care system.

Last year, I had the opportunity to spend a month with an Indiana State Senator and learn about the process of legislation. Let me clarify; I have no interest in politics and have no specific political affiliation. However, I wanted to see why these politicians were not more active in removing the barriers to health care my patients encounter on a daily basis. Why are physicians the only ones that care about helping patients? What I discovered was astonishing.

At the State House, I met a dermatologist, Senator Gary Dillon. We spoke just prior to his last session as a retiring Senator. He was reflective of his political career and his dissatisfaction with the lack of involvement by physicians and the medical community in improving health care through legislation. His comments were consistent with the 2004 *JAMA* article, "Is There a Doctor in the House?...Or the Senate?" (CK Kraus, TA Suarez. *JAMA* 2004;292(17):2125-29), which illustrated the declining involvement of physicians in the political process. We have declined from the 10.7% of physician signers of the Declaration of Independence to only 1.1% of physician government officials between 1960 and 2004. Keep in mind the small role the government played in health care for our founding fathers, compared to the major role it plays in our current system. Physicians with the desire to improve care for patients are a scarce resource for policy makers and have an opportunity to make a significant impact.

Most of the problems we face in our respective departments cannot be fixed while we are working a shift. We can barely keep up with the patient load requiring immediate physician attention. However, we are uniquely positioned to use our stories and experience to improve the system. My charge is to get involved. We are emergency physicians, and we make difficult decisions with limited information all the time. Once you have made up your mind, here are a few recommendations to get started:

- **First, pick the problem that bothers you the most.** When you pick an issue you are passionate about, you will be able to persevere past road blocks, but most importantly, you will be the beneficiary of your own work. Or, pick a simple problem you can resolve easily. This will give immediate results and help establish an environment of change leading to the resolution of more complex problems.
- **Second, go to the person or entity that can fix the problem.** This may be your ED director, department chair, hospital CEO, elected official, national society, etc. This is never a comfortable meeting, but it gets you involved with others who can be allies in finding solutions. Just getting to know the players in the game of health policy can be challenging. You can start with your state

senator or representative; they may be surprised a physician is approaching them with a problem and potential solution. They are accustomed to getting complaints about pot holes or trash removal. You will be a refreshing change and may build a relationship that can improve future policy decisions.

- **Third, don't ask for money.** You may need money, but how you ask for it is vital to your success. Everybody wants money. As an advocate, we want to speak for a cause. We should support our cause with numbers and evidence, but even more effective will be the stories of our patients. Don't just give policy makers a fact sheet with the number of patients killed by DUI's. Tell them the heart wrenching story about the young family you had to inform that their husband/father had been killed by a drunk driver on the way home from work. This is something people can remember. If you are not convinced, read "The Power of Stories over Statistics" by Thomas B. Newman (*BMJ* 2003;327:1424-27). It's not the numbers that will get us the change we are looking for; it is the passion invoked by stories that support the numbers.

Now is the time to make a difference. Change is coming to our health care system. We can either complain about it or be a part of the process to make it better. As emergency physicians, we know we are the safety net for the various system failures. How we fill in the holes may vary based on our location and unique circumstances, but without exception, we should be a part of the solution.

Editor's Note: Dr. Sharp is one of five emergency physicians selected for the prestigious Robert Wood Johnson Foundation Clinical Scholars Fellowship. In July, he will join 27 other young physicians who will learn to conduct innovative research and work with communities, organizations, practitioners and policy-makers on issues important to the health of all Americans.

Congratulations to

Manish Garg, MD FAAEM, on receiving the

2011 Russell and Pearl Moses Memorial Endowed

Medical Award for Outstanding Teaching at

Temple University Hospital.

Dr. Garg was chosen for this award by students and

housestaff at Temple University School of Medicine

and Temple University Hospital. Dr. Garg is a

board certified emergency physician and has been a

member of AAEM since 2006.

View from the Fishbowl

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

One of the members of the AAEM board of directors received the following email from a recent residency graduate. Identifying information has been removed:

Hey Dr. XXXX,

I hope all has been well in XXXX. My wife and I moved to XXXX, and things are going great (we have a 7 month old who is wonderful, also). I know senior residents are looking for jobs, and since I have worked for [a national contract management group] and now a democratic group, I just wanted to let you know you can refer them to me so I can let them know first hand what it is like working for each.

On top of what you and AAEM have been fighting for, the biggest thing for me is that hospitals [staffed by this contract management group] don't really let you practice EM the way it should be. None of the other departments respect the ED at all (how can they when no one sits on committees?) and problems in the ED don't get resolved. It is so difficult to admit problem patients because no one else wants to share any responsibility and the administration could not care less because we are just contractors. To be honest, it is even difficult to get a primary doctor to admit 80 year-old cardiac patients with chest pain unless they have positive enzymes or EKG changes.

Working in XXXX for my democratic group has been wonderful...I work a lot harder, but it is much more satisfying because the hard work is for patients and not haggling with consultants. Anyway, I thought you might like an update.

Please send my best to the others at XXXX.

Thanks!
XXXX, MD

I've been heavily involved in AAEM for years. During that time, I've been exposed to a number of opinions about contract management groups (CMGs) owned by lay people in violation of Corporate Practice of Medicine statutes. As a military physician, though, I've been relatively sheltered from their dominance of the EM marketplace. Recently I have emerged from my safe haven, and I can say that CMGs and their influence are everywhere.

When I finished my ultrasound fellowship and relocated to Virginia, I inquired about local moonlighting jobs. The most lucrative position was in an ED staffed by a national CMG. As a board member of AAEM, I cannot work for a national CMG. Well, I guess I technically "can," but that would be hypocrisy at its finest, so I guess I am "morally" prevented from working for a CMG. My conscience prevented me from taking advantage of this opportunity to maintain my skills and pocket a little extra cash.

I recently decided to get out of the Navy, and during my search for employment, I was looking for an academic position somewhere

where I could play golf year round. I found two residency programs with positions I'd be interested in and climates that would benefit my golf game, but both were affiliated with national CMGs. Once again opportunities I was interested in were "off limits" because of their CMG affiliation.

After I found and accepted a civilian position, my wife and I started to look at places we could live. One area we are considering is a small town in the mountains of California. My wife is a pediatrician, and the town only has one other pediatrician who is approaching retirement age, so that would be a nice opportunity. In addition, they are planning on building a new hospital. Working part-time in their soon-to-be brand new emergency department (ED) could be a nice opportunity in the future...but it is staffed, once again, by a national CMG.

I've come to learn that not all national CMGs are the same. Some are owned by lay persons, "regular people" (not physicians), and Corporate Practice of Medicine laws prohibit "regular people" from opening up or owning a medical practice. There are some owned and operated by physicians that I could probably work for while serving on the AAEM board without feeling pangs of guilt. The email from the resident above, though, should remind everyone that the principles upon which AAEM was founded and the things we strive for are still relevant today, perhaps even more so, because, as I've come to learn, CMGs are everywhere.

(Contact Dr. Schofer with any comments at jschofer@gmail.com.)

*The views expressed in this article are those of the author(s) and do not necessarily reflect the official policy or position of the Department of the Navy, Department of Defense or the United States Government.

I am a military service member. This work was prepared as part of my official duties. Title 17 U.S.C. 105 provides that 'Copyright protection under this title is not available for any work of the United States Government.' Title 17 U.S.C. 101 defines a United States Government work as a work prepared by a military service member or employee of the United States Government as part of that person's official duties.

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Levels of recognition to those who donate to the AAEM Foundation have been established. The information below includes a list of the different levels of contributions. The Foundation would like to thank the individuals below that contributed from 1/1/11 to 7/19/11.

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

AAEM–Sponsored Conferences

August 24-25, 2011

AAEM Oral Board Review Course
Las Vegas, NV
www.aaem.org

August 25-28, 2011

AAEM Written Board Review Course
Newark, NJ
www.aaem.org

August 26-28, 2011

Florida Chapter of AAEM (FLAAEM)
Scientific Assembly
Miami Beach, FL
<http://www.flaaem.org/>

September 10-14, 2011

The Sixth Mediterranean Emergency
Medicine Congress (MEMC VI)
Kos, Greece
<http://www.emcongress.org/2011/>

September 17-18, 2011

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

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

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

AAEM–Recommended Conferences

September 8-9, 2011

Practical Emergency Airway Management
Baltimore, MD
<http://jeffline.jefferson.edu/jeffcme/airway/>

September 23-25, 2011

The Difficult Airway Course-Emergency™
Seattle, WA
www.theairwaysite.com

September 26-28, 2011

2nd Up To Date Emergency Medicine
Practice Conference
Riyadh, Saudi Arabia
www.kfmcmed.com/uemp

October 6-7, 2011

Practical Emergency Airway Management
Baltimore, MD
<http://jeffline.jefferson.edu/jeffcme/airway/>

October 28-30, 2011

The Difficult Airway Course-Emergency™
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November 3-4, 2011

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November 5-10, 2011

Emergency and Disaster Preparedness
Course in Israel
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www.apfmed.org

November 13-16, 2011

Heart Course: Cardiac Emergency and
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December 2-4, 2011

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Editor's Letter - continued from page 2

place to encourage younger member involvement. Perhaps you, your group or your department can sponsor part of the already low cost of AAEM membership (and YPS membership is just \$25 more). Early involvement with AAEM and education from you can help counter some of the flood of messages and misinformation that come from corporate management groups and other organizations that do not have the interests of board certified emergency physicians and their patients in mind. Early involvement with AAEM can also engender loyalty to the organization and our specialty that will pay continuing dividends for many years.

We all owe a great debt to those who have founded and led the Academy to where it is today. AAEM also enjoys dedicated ranks of members and leaders who give tirelessly to the organization and who deserve the thanks of everyone in our specialty. But every one of us must continue to look to the future and cultivate growth of the organization by supporting each new generation of physicians through education, inspiration, mentoring and encouragement.

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AAEM Young Physicians Section

OUTGOING YPS PRESIDENT'S MESSAGE YPS: the year in review

Brian Potts, MD MBA FAAEM



It has been my honor to serve as the YPS president for the last year. The job is easy when you are surrounded by such a great group of active and energetic board members.

Mike Pulia and Elizabeth Hall served admirably in their roles as Vice President and Secretary-Treasurer, respectively. The section is fortunate to have their guidance as leaders for the coming year. Jeff Pinnow kept our members informed throughout the year with his bimonthly communications regarding YPS events, website updates, and upcoming plans for 2011 Scientific Assembly. Alicia Pilarski coordinated our membership strategy and welcomed new and renewing members to the section. She worked closely with AAEM/RSA knowing our section's future membership will come from graduating resident members. Jennifer Kanapicki did an amazing job throughout the year spearheading our plans for the educational RSA/YPS track and YPS sponsorship for "Open Mic" at Scientific Assembly in Orlando. Having just returned from Orlando, I can definitely say that it was our most successful educational

track ever. The six lecturers were top notch, and we had our best attendance turnout for the track. Warren Wiechmann coordinated our government affairs work with the main AAEM board and kept us informed regarding board certification issues and other developments at the state and national level. David Vega, our section's founder, has served as YPS Director, the liaison between the main AAEM board and our section, for the last two years. I also want to thank my predecessor, Michael Epter, who laid the foundation two years ago for much of what we accomplished during my tenure in 2010 – 2011. Last, it has been a pleasure to work with our AAEM office staff, Ginger Czajkowski and Janet Wilson, who do so much of the work for our section and make things happen. Our section is extremely lucky to have these dedicated staff members at our side.

Our section continues to get better year after year. The "Rules of the Road for Young Emergency Physicians" is a must read for any recent graduate or a person considering a job change. We are striving to create more benefits for our members and we hope that every young physician's involvement with YPS will help foster a connection to AAEM throughout their careers.

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AAEM Young Physicians Section

YPS INCOMING PRESIDENT'S MESSAGE: Defining Value: Our Promise to You

Michael S. Pulia, MD FAAEM
YPS President



AAEM just wrapped up another successful Scientific Assembly (SA) in Orlando and by all accounts it was a tremendous success. This free member benefit continues to set the standard for value and quality educational offerings in EM. During SA, it was with sincere pride that I presided over the first meeting of your 2011-2012 Young Physicians Section (YPS) board of directors.

Taking the reins from Dr. Brian Potts is a tremendous honor as his leadership and contributions over the past several years were integral to the success of YPS. In addition, the incoming board is comprised of talented individuals with proven success in AAEM leadership roles. They are a diverse group from a wide variety of practice settings around the country. With two new board members bringing new ideas and energy, our first meeting was dynamic and productive.

The overall theme for the upcoming year will be value. It is our mission to continue developing the benefits that provide true value for our members. Your new board fully intends to strengthen existing offerings and use an upcoming membership survey to obtain feedback and new ideas. The future direction of this section is truly in your hands.

The SA educational track co-developed by the Resident & Student Association (RSA) and YPS is a shining example of how we use member feedback to guide our efforts. Pulling topics directly from a previous member survey, Dr. Kanapicki and the Education Committee were able to invite nationally recognized speakers to present the following topics: integration of EKG and ultrasound into your practice, patient satisfaction, CV workshop, finding your niche and how to navigate the resident to faculty transition. This type of

educational offering is geared to our members who are navigating the often challenging early years following residency.

The goal of YPS is to connect young physicians, in the 7 years post-residency, with the larger AAEM community. In addition to the annual educational event at SA, the benefits we offer to achieve this mission include the CV and cover letter review service, mentoring program, networking events, and *Rules of the Road for Young Emergency Physicians* publication. In addition, we provide opportunities for YPS members to publish articles in *Common Sense*. Anyone interested in becoming an author should email us at info@ypsaaem.org for more details. In the past few years, we have also made efforts to improve our interaction with members through an updated website www.ypsaaem.org and our Facebook fan page. We hope each of you will follow the link on the website to join the fan page and post comments to start a dialogue with other section members and the board.

For members looking to take advantage of the free CV review or mentor programs, follow the links on the homepage. For resident members (AAEM/RSA), this service is available for \$25 during your final year of training. If you join AAEM after graduation, this cost will then be applied as your first year YPS dues, making it essentially free.

For those of you looking to take a more active role in the YPS, I highly recommend joining one of the committees (membership, governmental affairs/advocacy, editorial/communications and education). A link to the descriptions of each committee and the application pages can be found on the YPS website.

Based on the strength of our board and growing membership, this promises to be another exciting year for YPS. I sincerely hope you each take an active role in guiding our efforts on your behalf. Thank you for providing us the opportunity to serve and represent you.

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RESIDENT PRESIDENT'S MESSAGE

Ryan Shanahan, MD
AAEM/RSA President



As I progress further into my training, I realize more and more that emergency medicine is a very unique field. Where other specialties have defined themselves in regards to body systems and ever increasing subsets of body systems, emergency medicine has defined itself as a specialty of a temporal period in the duration of an illness. We are trained to be acute care physicians. I knew this going into the field, but

as I progress through it, I am recognizing more and more that it creates some unique challenges.

First among these is that emergency medicine physicians work in a fishbowl. More specifically, we are judged as a selected catch from a wide ocean caught and examined in a fishbowl. On off service rotations, I see the occasional well-placed disdain and distrust of emergency medicine physicians. We are judged based on the least competent of our peers. When someone comes to clinic with a completely inappropriate splint, it is never Doctor X from ABEM General who applied it; instead, it is the completely generic "emergency room" (ER), and it is insulting.

It seems unfair, but we are still judged in the whole. In surgery, if a physician consistently has good outcomes, they are labeled as a good surgeon and known as such. The same with internists and any other physician who has long-term care of patients. The emergency medicine care provided, however, usually does not leave with a name indelibly attached to it – the physician and care provided is not good or bad; it is the specialty that is judged. This reason, more than any other, is why it is so important to enforce rigorous standards for the qualification and identification as an emergency medicine specialist. The weakest among us bring us all down, not just themselves.

The second thing came to me in a random encounter 100 feet from my house. I recognized the name on the side of a contractor's truck and the person standing beside it as the brother of someone I had coded and pronounced a few weeks prior. I went over to say hello and again give my condolences for his loss. In the process, I found out all sorts of things about a person I never knew in life. I also accepted his heartfelt thanks for our efforts that day to revive his brother. While our temporal specialty has traded away long-term relationships with patients, we have not lost the ability to make a long-term impact.

When emergency medicine specialists are appreciated, it is often completely anonymously. Even when your patients remember your name, they often never tell you again how much of an impact your care made on their life years later. I am guilty of this myself. One of the most important factors driving me into a career in medicine, and emergency medicine in particular, was a personal history of asthma. It is only through my hospital records that I even know the name of the physician in the ER at Keller Hospital in West Point, NY, on a cold December night in 1988. In an asthma attack that cumulated in pushing intravenous isoproterenol, I endured the scariest night in my then 5 year-old life. Though he has never heard from me since Dr. (then Major) Noce is the most important reason I am alive today and in medicine as a career; for that I would like to say thank you. There are undoubtedly hundreds of people out there that would be able to say the same to each and every person reading this article.

This will be my last column as AAEM/RSA president. Teresa M. Ross, MD of Georgetown University will take over next year along with the rest of the newly elected board of directors. I look forward to a wonderful year working with her as immediate past president. I want to thank the Academy for giving me this chance to see the larger moving picture this early in my career and will always value this year as a blessed experience.

**AAEM/RSA is Proud to Announce the New 2011-2012 Board of Directors and Council:*

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RESIDENT EDITOR'S LETTER

The Perils of Algorithmic Medicine

Leana S. Wen, MD MSc

AAEM/RSA Board Member



I have a confession to make: I am guilty of practicing algorithmic medicine.

I make this confession with much angst and embarrassment. In my daily practice, I actively rail against making diagnoses by using mindless, algorithmic pathways. My September/October *Common Sense* column was about how EPs need to return to the art of medicine that prioritizes individual narratives.

Yet, this is a true story of what happened last week. It was 5:00pm, and I just started my evening shift. The ED was in black “crisis” mode. The waiting room had been converted into patient bays, and there were patients out in the hallways stretching to the main lobby of the hospital.

I rolled up my sleeves and went to work. First, I met Mr. A, a middle-aged man with atypical chest pain for a day. Never had heart problems before, but his father had an MI at age 50. Normal vitals and EKG. Check! Here was an easy dispo for low-risk chest pain. I sent off for cardiac enzymes and put Mr. A in our observation unit for a second set and stress in the morning.

Next patient. Mr. B, a man in his seventies being treated for lung cancer who came in with fever and a productive cough. He was tachycardic, looked weak, and his lungs sounded junky. Again, easy dispo. Labs, X-ray, antibiotics for pneumonia and oncology admission.

And the next. For kicks, let’s call her Mrs. M, a well-appearing woman in her sixties transferred from an OSH to get an MRI for a one-hour episode of aphasia eight hours ago. When I saw her, she talked fluently and had no neuro deficits. Once again, I knew what to do. I ordered an MRI, called neurology, and put her into the observation unit to await the scan and neuro consult.

My shift started just 15 minutes ago, and I had dispos on three patients! But something was wrong with this picture. While a lot of attendings would have applauded my actions as “efficient” and “having solid plans,” my very astute attending that day frowned. “You’re seeing patients fast and that’s good,” she said, “But think about what they have. Don’t let your practice become algorithmic.”

She was right. In my misguided attempt at becoming faster to help with ED flow, I was evaluating my patients based on how quickly I could send them somewhere else, instead of stopping to figure out what they actually came in with. My reaction to each patient was reflexive, almost as if I were doing a multiple-choice board exam. Atypical chest pain? To observation Mr. A goes. But had I even heard him talk about how the pain got worse after eating, how it came and went, how it traveled to his right side and back? Fever and productive cough? Must be pneumonia. Or maybe not. After Mr. B undressed, I went back and saw that he had raging erythema covering one of his legs. He’d been telling me about scratching his legs but I hadn’t listened—and I could have missed diagnosing and treating a bad cellulitis.

And Mrs. M. When I went back to ask her what exactly happened, she said that she and her husband were driving on the road when

she forgot the names of two streets she had lived on when she was young. She thought they were on the tip of her tongue but she couldn’t quite remember them. She panicked, and her husband drove her to the OSH. An hour later, she finally recalled the names of the streets. Never during this time did she have slurred or unclear speech. This was the “aphasia” that the OSH had sent her in for, that was not actually aphasia and definitely not a TIA! But the joke was on me—I hadn’t done my own evaluation and had asked for a consult and ordered a scan that Mrs. M didn’t need at all.

By its high-stress, high-intensity nature, EM is a challenging and demanding profession. We have to make quick decisions with limited information while seeing many complex patients at once. Being efficient is important, and we often feel the temptation to take shortcuts on the history and physical and call a consultant to figure things out instead of working things out for ourselves. But this practice of reflexive, algorithmic medicine doesn’t lead to better outcomes and, I would argue, isn’t any faster than thoughtful, common sense medicine. Having a guy get ruled out for ACS while he has biliary colic doesn’t help anyone. Missing a raging cellulitis in an immunocompromised patient could lead to bad outcomes. And scanning a woman who doesn’t have TIA based on history is a waste of time and resources.

So how can we avoid the tempting low-hanging fruit of algorithmic medicine? One tip is to always think about your patient’s diagnosis. “Chest pain” and “abdominal pain” are symptoms, not diagnoses. Ask yourself each time what the patient has. Most of the time, there is a diagnosis. Some of the time, you may not know the exact diagnosis after your evaluation, but at least thinking about the diagnosis—and not just what the patient DOESN’T have—forces you to break out of comfortable algorithmic pathways before ordering tests and thinking about dispos.

Something else that’s helpful is to explain your thought process to the patient. Patients like it when you talk to them about what tests you are ordering and why and what diagnoses you are considering and why. If you find yourself unable to justify these tests to your patients, you might want to consider why you want them in the first place—perhaps you’ve unwittingly entered an algorithmic practice and are reflexively (rather than thoughtfully) putting in orders.

Another tip is to try to figure out what the patient has before calling a consultant. EM is the modern home of diagnosis; it’s exciting to take the first crack at a diagnosis and to send a patient to the floor with a diagnosis in hand! To that end, make sure to follow-up on your patients. You will learn an awful lot and be satisfied—and humbled—by your diagnostic acumen.

As we residents advance another year, it’s a good time to remind ourselves of the perils of algorithmic medicine. Not only does it dehumanize our patients, algorithmic practice leads to unnecessary tests and missed diagnoses, not to mention dissatisfaction—by both the patient and the practitioner. Let’s try our best to uphold the excellent standard of care that we are so proud of in our field and practice the type of medicine that our patients deserve.

I welcome comments to my articles. Please email: wen.leana@gmail.com.



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Resident Journal Review: Summer 2011

Karin Chase, MD; Alena Lira, MD; Christopher Doty, MD FAAEM; and Michael C. Bond, MD FAAEM

This is a continuing column providing a review of journal articles pertinent to emergency medicine (EM) residents. It is not meant to be an extensive review of the articles, nor is it wholly comprehensive of all the literature published. Rather, it is a short list of potentially useful literature that the busy EM resident may have missed. Residents should read the articles themselves to draw their own conclusions. This edition will include articles published in January and February 2011.

Ketamine With and Without Midazolam for Emergency Department Sedation in Adults: A Randomized Controlled Trial. Sener S, Eken C, Shultz CH, Serinken M, Ozsarac M. *Ann Emerg Med.* 2011;57:109-14.

The risk of recovery agitation still makes many clinicians hesitant to use ketamine for procedural sedation in adults. The authors of this randomized controlled trial investigated whether co-administration of midazolam with ketamine decreases the incidence of this unpleasant adverse effect.

This was a prospective, double blind, placebo controlled, randomized trial of healthy adult patients between the ages 18 and 50 receiving procedural sedation, conducted in a single emergency department (ED). Patients were assigned to receive one of four treatments: 1.5mg/kg intravenous (IV) ketamine with either 0.03mg/kg of IV midazolam or placebo, or 4mg/kg of intramuscular (IM) ketamine with either 0.03mg/kg of IV midazolam or placebo. To maintain complete blinding of patients and providers, each patient received three pre-prepared administrations – two IV administrations (midazolam or placebo, and ketamine or placebo), and one IM administration (ketamine or placebo). Investigators recorded the incidence of recovery agitation and other adverse effects, sedation time and characteristics, as well as scoring of the patients' level of satisfaction.

The study enrolled 182 patients, of which 151 had complete data available for analysis. The main outcome, recovery agitation, was decreased in both midazolam groups compared to placebo. There was an absolute reduction in recovery agitation of 17%, and number needed to treat to prevent one case of recovery agitation was 6. Other adverse effects were unchanged between the midazolam and placebo groups, or between the IV and IM ketamine groups. When rating their satisfaction, patients preferred co-administration of ketamine and midazolam to ketamine and placebo.

In this well designed study the incidence of recovery agitation was decreased with statistical significance. Few studies have reported a number needed to treat as low as this one. More importantly, these results convey a true clinical significance. Not only was there a statistically significant decrease in observed agitation, but also subjective reports of the patients support the observed data. This study is limited by a relatively narrow age range of otherwise healthy patients, and administration to older patients with more extensive pathologies should be used with caution. However, this study clearly refutes the validity of physicians' reluctance to use ketamine on the basis of the fear of recovery agitation. Co-administration of midazolam with ketamine during procedural sedation clearly decreases ketamine induced recovery agitation, and does so safely without increasing the incidence of other adverse effects. Clinicians should make the decision to use this method of procedural sedation

based on its indications and contraindications, and not based on a concern for recovery agitation.

Computed Tomography Alone May Clear the Cervical Spine in Obtunded Blunt Trauma Patients: A Prospective Evaluation of a Revised Protocol. Como JJ, Leukhardt WH, Anderson JD, et al. *Journal of Trauma.* 2011;70:345-51.

The management of the cervical spine (c-spine) in obtunded trauma patients who have a negative c-spine computed tomography (CT) has been a subject of debate. Is it safe to discontinue the patient's cervical collar based on a negative CT alone or should further testing with magnetic resonance imagery (MRI) be done to clear the c-spine? This question has yet to be answered definitively, and the evidence continues to be split. In this study the authors evaluated the safety of clearing the cervical spine based on a negative CT alone.

The authors conducted a two-year prospective study in a single Level I trauma facility of all obtunded blunt trauma patients. In order to be included, the patients needed to have gross movements of all extremities, a CT of the cervical spine, and if negative, the cervical collar removed. Patients with injuries on CT were not included and neither were patients with obvious neurological deficits possibly related to spinal cord injury. Follow up was obtained when patients awoke and could reliably participate in their examination. No further testing was done if patients had no pain, no tenderness, and full range of motion of their neck, whereas patients who remained symptomatic in their awake state underwent an MRI. In those who remained obtunded and those who died, further follow up regarding spinal injury was obtained via phone call to their family, long term care facility, or from autopsy reports.

This study included 197 patients who had their c-collars removed based on negative CT and met the above criteria. Of those 122 (64.5%) had no evidence of spinal injury on an awake reexamination, 5 (2.5%) underwent an MRI based on persistent pain, 25 (12.7%) died (two thirds of those had autopsy reports available), 23 (12%) were followed up by phone, and 22 (11.2%) were lost to follow up. None of the patients who had follow-up data available (83.2%) had evidence of a spinal injury. In one patient, the autopsy reported a ligamentous injury, which was classified as a stable injury by a reviewing neurosurgeon.

The authors concluded that a negative C-spine CT in an obtunded blunt trauma patient is sufficient to clear the cervical spine. They intelligently asked the question of what is the clinical significance of MRI findings in patients with a negative CT and a positive MRI. In support of their conclusion they cited multiple studies in which an MRI did or did not identify additional injuries, some resulting in operative repair, and some resulting in prolonged collar use. They

continued on page 20



argued that in any of these patients, even if intervention was done, it was not required, as none of those injuries were classified as unstable.

As much as all ED physicians would like a definitive answer to the question of where CT is good enough for clearance of the c-spine, this study does not provide it due to its large limitations. For one, the study was underpowered to detect unstable cervical injuries in neurologically intact patients with negative CT findings (best estimated incidence is 2.5%). To detect these injuries a much larger study population would be required. Furthermore, there is incomplete follow up data, with 16.8% patients being lost to follow up. A well-powered study or a comprehensive meta-analysis of all the current literature is still needed to definitively answer the question of whether CT is enough to clear the cervical spine.

Treatment of Acute Otitis Media in Children under 2 Years of Age. Hoberman A, Paradise JL, Rokette HE, et al. *NEJM*. 2011;364:105-15.

The recommendations for treatment of acute otitis media (AOM) in children have been changing. The most recent guidelines published by American Academy of Pediatrics and American Academy of Family Physicians in May 2004 recommended watchful waiting as an alternative to antimicrobial treatment for non-severe illness and uncertain diagnosis in children between 2 months and 12 years of age. This recommendation is based on the high level of spontaneous resolution of illness. However, it is not clear in which patients antibiotic treatment may be a preferred management. The authors of this study investigated the effects of antibiotic treatment on the course of illness.

In this randomized placebo controlled trial, 291 children between 6 and 23 months of age who had a clinical diagnosis of AOM and symptoms less than 48 hours were randomized to receive treatment with either amoxicillin-clavulanate [daily dose 90mg/kg] (144 children) or placebo (147 children). The diagnosis of AOM was based on the symptoms reported by parents and recorded on a 14 point AOM severity of symptoms (AOM SOS) scale as a score of at least 3, and otoscopic findings of a middle ear effusion or bulging of the tympanic membrane. The primary outcomes of the study were time to resolution of symptoms and clinical failure, which was defined as lack of substantial symptomatic improvement by day 4 or 5, or failure to achieve complete or near complete resolution of symptoms (AOM SOS score of 0-1), and otoscopic signs by days 10 - 12. Other outcome measures such as overall effectiveness and antibiotic adverse effects were recorded. Follow up data from days 10-12 was available for 285 children (142 in treatment group and 143 in the placebo group).

Resolution of symptoms occurred faster in the group that received antibiotic treatment. By day 2, 35% in the treatment group experienced initial resolution of symptoms (first AOM SOS score of 0-1), compared to 28% in the placebo group. By days 4 and 7 these numbers rose to 61% versus 54%, and 80% versus 74%, respectively. Complete resolution of symptoms (defined as two consecutive readings of AOM SOS score of 0-1) occurred in 20% by day 2, 41% by day 4 and 67% by day 7 of the amoxicillin-clavulanate treated children, compared to 14%, 36%, and 53% of the placebo treated children. These differences, though consistent, were not statistically significant. Treatment failure, on the other hand, was

significantly lower in the children treated with antibiotics. It occurred in 4% of the treatment group and 23% of the placebo group by day 4 or 5 ($p<0.001$), and in 16% versus 51% respectively by day 10-12 ($p<0.001$). One child initially treated with placebo progressed to mastoiditis and several children developed perforation of the tympanic membrane (1 antibiotic treated and 7 placebo treated). The incidence of diarrhea and diaper dermatitis was higher in the antibiotic treated group as compared to placebo group (25% versus 15%, and 51% versus 35%, respectively).

This study challenges the current recommendations for treatment of AOM by concluding that antimicrobial treatment in the studied age group is associated with better short term outcomes - mild but consistent symptomatic improvement and a significant decrease in treatment failure. It is important to note that these findings are irrespective of the severity of the initial presentation, since according to the current recommendations patients with less severe illness may not receive antibiotic treatment initially. The strength of this study lies in its precise definitions and rigorous detailed analysis. However, one has to realize that the conclusion is entirely dependent on the definition of treatment failure. The role of otoscopic findings in the definition of treatment failure can be controversial since the true meaning of otoscopic findings in asymptomatic children remains unclear. In treating entities as common as AOM, weighing the benefits of antibiotic treatment against the risks of adverse events and the development of antimicrobial resistance must be taken into consideration. Despite its limitations, this study provides strong evidence for the use of antibiotics in the studied age group, but a better understanding of the clinical implication of otoscopic findings in the absence of symptoms is needed.

The Effects of Intravenous Calcium in Patients with Digoxin Toxicity. Levine M, Nikkanen H, Pallin DJ. *The Journal of Emergency Medicine*. 2011;40:41-6.

The traditional teaching is that intravenous calcium is contraindicated in digoxin toxicity because, in theory, it can induce a cardiac muscle tetany known as "stone heart". The authors of this article have chosen to investigate this theoretical phenomenon to see if it occurs in practice by analyzing data from hospitalized patients with digoxin toxicity that were treated with intravenous calcium.

The study was a retrospective chart review of all adult patients in a single Boston medical center who were diagnosed with digoxin toxicity between January 1989 and May 2005. A hospital database was queried for patients with a digoxin level >2 , and who carried a diagnosis of digoxin toxicity. Review of the patients chart was conducted to look for any evidence of a cardiac arrhythmia that occurred as a result of calcium administration. The primary outcome was the occurrence of a clinically significant cardiac arrhythmia within one hour of calcium administration, and the mortality rate in those who did and did not receive calcium. A total of 159 patients with digoxin toxicity were entered into the study. Twenty-three patients received calcium for treatment of hyperkalemia while digoxin toxic. Of these patients, none experienced a significant arrhythmia within 1 hour of administration. No arrhythmias were noted even within 4 hours of administration. Overall mortality in all the patients was 20%, and the mortality rate did not vary between the calcium treated and untreated (22% versus 20%, respectively). All deaths occurred when patients were no longer considered to be digoxin toxic. The

continued on page 21



Resident Journal Review - continued from page 20

only association with increased mortality was an elevated potassium level, and this risk was increased proportionately to the level of hyperkalemia.

The authors concluded that there is no evidence of “stone heart” or any clinically significant arrhythmias in digoxin toxic patients treated with IV calcium. They identified 5 case reports in the literature since 1933 that reported a bad outcome shortly after the administration of calcium. However, the authors argue that in these cases there is no proven association between the death and calcium. They also point out that in animal studies where arrhythmias were induced, the calcium level was extremely high and no inference can be drawn regarding the causal relationship between calcium at the levels at which it is clinically used and death.

The authors are very forthcoming with the study’s limitations, such as the retrospective chart review study design, and the fact that all but one patient included had chronic toxicity and not acute digoxin toxicity. Nothing can be concluded about acute digoxin toxicity from this study. Another limitation is that the search process only included patients with digoxin levels greater than 2, and it is possible that this search did not yield all patients with digoxin toxicity. It is important to note that this study did not demonstrate any benefit of using calcium to treat hyperkalemia in digoxin overdose. Clearly, the authors of this study do not advocate the use of calcium in patients with acute or chronic digitalis toxicity; however, this study is a good example of questioning a current dogma, which may prove to be a myth.

Risk of Vascular Events in Emergency Department Patients Discharged Home With Diagnosis of Dizziness or Vertigo. Kim AS, Fullerton HJ, Johnston SC. *Annals of Emergency Medicine*. 2011; 57:34-41.

Patients presenting to the ED with symptoms of dizziness or vertigo are often discharged home without the identification of a specific diagnosis that their symptoms could be attributed to. Given the potential for missing a serious underlying cause (e.g.: posterior fossa stroke or cardiac arrhythmia) discharging these patients represents a risk for an adverse outcome after discharge. Just how large a risk is not known. The objective of this study was to measure the incidence of adverse vascular events in these patients after discharge.

The authors conducted a retrospective cohort study linking hospital records from 337 California EDs and mortality records. The study included 31,159 California residents age 18 years or older who were discharged from an ED with a primary diagnosis of dizziness (24,229; 77.8%) or vertigo (6,930; 22.2%) during a six month period. Patients who had a specific diagnosis of stroke or cardiovascular events during the ED visit or patients who were not discharged home directly from the ED were not included. Comprehensive hospital and mortality records were reviewed for a period of 180 days after the initial ED visit. The records were evaluated for the incidence of all-cause mortality, cerebrovascular events (death or hospitalization due to ischemic or hemorrhagic stroke), and cardiovascular events (death or hospitalization due to acute myocardial infarction, unstable angina, or ventricular arrhythmia). Using Nelson-Aalen survival analysis, the cumulative incidence of these events was calculated. During the 180 day period, 274 patients died and 332 were hospitalized with a major vascular event. The cumulative incidence of all major vascular events was 0.93%, of which 0.32% were cerebrovascular events, and 0.63% were cardiovascular events (14

patients were hospitalized for both). For cerebrovascular events, the incidence rate was highest during the first month, whereas the incidence rate of cardiovascular events showed a relatively stable pattern over the whole follow-up period.

From this data it can be extrapolated that 1 in 108 patients discharged home with a diagnosis of undifferentiated dizziness or vertigo will go on to have a major vascular event within 180 days. One in 159 patients will suffer a stroke in this period, and 1 in 313 patients will suffer a major cardiovascular event. For the ED physician, mortality over a shorter period such as one month would be a better indicator of the need for further intervention. Stroke, which occurred with highest incidence in the first month after discharge, can occur in 1 in 555 patients.

Utilizing hospital records instead of direct patient encounters is subject to limitations such as incomplete data reporting and loss to follow up. However, despite the study design which lends itself to multiple limitations and criticism, the information extrapolated from this study has important implications for the ED physician. Mainly, patients discharged from the ED with a diagnosis of dizziness and vertigo in the absence of a clear specific underlying cause have an overall low incidence of major vascular events in the immediate period after discharge. Even though the risk of strokes in these patients is somewhat increased in the first month after discharge, suggesting that some are presenting with pathologies that are missed on the initial ED visit, the overall low incidence supports the notion that discharge and timely follow-up is an appropriate disposition for these patients.

Resident Journal Review articles are now being translated to Spanish and Italian! To see the full translated Resident Journal Review article, please go to <http://www.aaem.org/international/>.

Program Director of the Year Award Nominations Sought Deadline: November 10, 2011

AAEM/RSA is pleased to announce it is currently accepting nominations for its annual EM Program Director of the Year Award.

Nominees for this award must have been involved in running a program as an assistant, associate or lead program director for five or more years. Nominees must be AAEM members and can only be nominated by AAEM resident members. This award recognizes an EM program director who has made an outstanding contribution to the field of emergency medicine and AAEM. The winner of this award will be chosen by the AAEM Resident and Student Association (AAEM/RSA).

Nominations will be accepted for this award until November 10, 2011, at midnight CST. All nominations should be submitted in writing and should include:

1. Name of the nominee.
2. Name of the person submitting the nomination.
3. Reasons why the person submitting the nomination believes the nominee should receive the award.

The award presentation will be made to the recipient at the 18th Annual Scientific Assembly to be held in San Diego, CA, February 8-10, 2012. Please submit all nominations to: info@aaemrsa.org.



MEDICAL STUDENT COUNCIL PRESIDENT'S MESSAGE Its Been a Great Year!

Brett Rosen, MD
Outgoing AAEM/RSA Medical Student Council President
Meaghan Mercer
Incoming AAEM/RSA Medical Student Council President



In my final column for this academic year, I would like to thank all of you, the membership, for your support and enthusiasm for AAEM, AAEM/RSA, and what we represent for emergency medicine. I would especially like to congratulate all of the outgoing medical students on their graduation and wish them the best of luck in their emergency medicine residencies. I ask that you continue

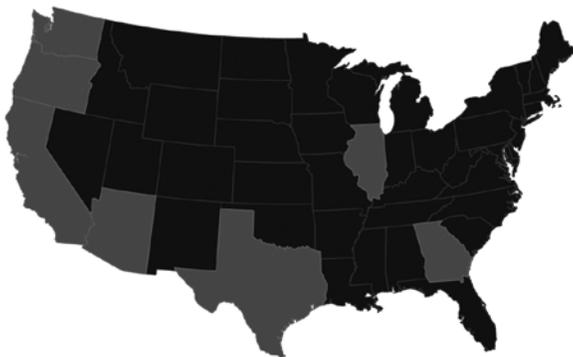
to support AAEM/RSA as a resident member and encourage your programs to support your membership if they do not already!

I also would like to thank the AAEM/RSA medical student council for all of their hard work over the year in disseminating information to the EMIGs and for their efforts in recruiting new members. A big thanks goes out to Joshua Ramjist who increased our international membership tremendously during his time on the council and Meaghan Mercer for updating EM Select.

Over the past year, we helped support the first Capital Area Symposium in Washington, DC, and, again, were pleased to support the Western Regional Symposium held at UC Irvine. In addition, we put on the Student Track at this year's AAEM Scientific Assembly in Orlando, FL. I was thrilled to see such a great attendance from all of you at these events!

Thank you again for all of your support this year. It has been an honor and a pleasure to serve you on the council, and I look forward to continuing to work with a great group to revise the *Rules of the Road for Medical Students* book. At this point, I would like to congratulate the new AAEM/RSA medical student council and turn this article over to the new medical student council president, Meaghan Mercer.

I would like to commend Brett Rosen for his commitment to the AAEM/RSA medical student council over the last year and thank him for the outstanding job that he did. As the incoming president, I am very excited to work with such an exceptional group of individuals who compose the AAEM/RSA medical student council. Over the last three years, I have seen what this student council is capable of and look forward to improving upon the groundwork that has been laid before me. Over the next year, I plan to enhance the communication between AAEM/RSA and medical students, because I believe that it is key to our growth. I also look forward to increasing our membership through strong connections with our regional representatives and the local EMIG site coordinators. I will provide many updates throughout the year; please do not hesitate to contact me, or one of the other AAEM/RSA medical student council members, with any questions or concerns.



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