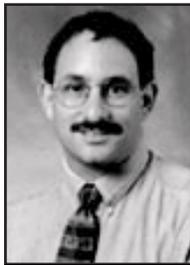




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SENSE

THE NEWSLETTER OF THE AMERICAN ACADEMY OF EMERGENCY MEDICINE



PRESIDENT'S MESSAGE

Board of Directors Develops New Vision Statement

Howard Blumstein, MD FAAEM

Vision is a long-term view, sometimes describing how the organization would like the world in which it operates to be. At least, that is what Wikipedia says. For the Academy, the Vision Statement is an important document describing the ideal practice environment for emergency medicine. The statement describes a setting in which patients benefit from access to properly board certified emergency physicians. It envisions a future in which those doctors are free to make decisions based solely on the patient's medical needs and in which those doctors control their own practices.

Is this idealistic? Sure. But a vision statement is supposed to be idealistic. It is supposed to define the perfect future

for our specialty. It is not the roadmap to our goal; it is the goal.

At its most recent meeting, the board of directors reviewed the AAEM Vision Statement. It was tightened up and revised in order to put more focus on our core issues. It is now cleaner and easier to read. Personally, I have trouble imagining an emergency doctor reading this document and taking issue with any of its tenets.

I encourage all members to review the Vision Statement. Share it with colleagues. Use it to help them learn what the Academy is about. The statement can be a starting point of a discussion of why AAEM's core issues should be important to all emergency doctors.

INSIDE THIS ISSUE

- 1 President's Message
- 3 Washington Watch
- 6 AAEM Activities
- 8 Foundation Donations
- 13 AAEM Sponsored & Recommended Conferences
- 15 Young Physicians Section
- 17 AAEM/RSA Activities
- 23 Job Bank

Vision Statement of AAEM

A physician's primary duty is to the patient. The integrity of this doctor-patient relationship requires that emergency physicians control their own practices free of outside interference.

We aspire to a future in which all patients have access to board certified emergency physicians.

THE PRINCIPLES

1. The ideal practice situation in emergency medicine affords each physician an equitable ownership stake in the practice. Such ownership entails responsibility to the practice beyond clinical services.
2. Emergency physicians should have control over their professional fees and should not engage in fee-splitting.
3. The role of emergency medicine management companies should be to help physicians manage their practice. The practice should be owned by and controlled by its physicians and not by a management company.
4. Medical societies should actively encourage the creation and enforcement of statutes prohibiting the corporate practice of medicine.
5. Medical societies should not accept financial support from entities that do not adhere to the above principles.
6. Emergency medicine specialty societies should work towards the goal of establishing a workforce sufficient to ensure that all emergency departments in the United States and its territories are staffed by emergency physicians certified by either the American Board of Emergency Medicine or the American Board of Osteopathic Emergency Medicine.

7/12/10



Editor's Letter

David D. Vega, MD FAAEM

Spread the Word

"I just want to take care of patients," a resident recently told me during a conversation about his plans after residency. "I really am not interested in doing anything else," he continued, indicating that he had no interest in becoming involved with organized medicine or any of the non-clinical aspects of emergency medicine. This kind of sentiment is not uncommon among emergency physicians. Yet physician involvement in administrative and political activities at the local, state and national levels is essential to protecting our ability to care for patients safely and effectively.

Most readers of this newsletter already realize the importance of active involvement with medical organizations like AAEM. However, we need to actively recruit our colleagues to action as well. Mounting pressures on emergency physicians' time and financial resources continue to take their toll on the membership roles of many organizations. While AAEM continues to see very good growth in its numbers, we need to ensure that this trend continues. We must fight the spread of apathy that can be such an effective tool for those who would violate the rights of physicians or threaten our ability to safely care for patients.

As members of AAEM, we need to help our non-member colleagues realize the important role the Academy plays in supporting the individual emergency medicine specialist. Head to the AAEM website (www.aaem.org) and learn more about the history of the Academy and the many activities of the organization. Then start talking to your colleagues about joining AAEM!



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AAEM Mission Statement

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

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

Membership Information

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

*Associate Member: \$250

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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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AHRQ Studies Detail ED Use for Mental Health & Substance Abuse Disorders

Kathleen Ream
Director of Government Affairs

According to a News and Numbers report from the Agency for Healthcare Research and Quality (AHRQ), nearly 12 million visits made to US hospital EDs in 2007 involved people with a mental disorder, substance abuse problem or both. This accounts for one in eight of the 95 million visits to EDs by adults that year. Of these visits, about two-thirds involved patients with a mental disorder, one quarter involved patients with a substance abuse problem, and the rest involved patients with both a mental disorder and substance abuse.

AHRQ's analysis found that depression and other mood disorders accounted for 43 percent of the visits, anxiety disorders for 26 percent, and alcohol-related problems for 23 percent. In addition, 41 percent of the mental disorder and/or substance abuse-related visits resulted in hospitalization – two and a half times more than ED visits not involving those issues. Finally, concerning payer source, 21 percent were uninsured, Medicare covered 30 percent, 26 percent were privately insured, and Medicaid covered 20 percent.

AHRQ based the report on data found in its statistical brief entitled Mental Health and Substance Abuse-Related Emergency Department Visits among Adults, 2007. For a copy of the brief, go to <http://www.hcup-us.ahrq.gov/reports/statsbriefs/sb92.pdf>.

In addition, the Substance Abuse and Mental Health Services Administration (SAMHSA) released a new series of studies analyzing drug-related ED visits during 2008. The studies reveal that a substantial percentage of those ED visits involved suicide attempts – especially among the young. More than one in every 12 (8.8 percent) of the drug-related ED visits by an adolescent was for an attempted suicide. For cases involving young adults – those age 18 to 25 – the attempted suicide rate was 6.6 percent, and for cases involving adults – those age 25 and older – the rate was 4.4 percent. Females constituted the vast majority of the adolescents' suicide attempts (72.3 percent); and, although at a significantly lower level, females also constituted a majority of the young adults' suicide attempts (57.6 percent) as well as a majority of the attempts of those over age 25 (57.7 percent).

Prescription drugs were involved in more than nine out of ten of these drug-related suicide attempts, but the substances used differed considerably by age and gender groups. For example, acetaminophen was the most commonly used substance involved in ED visits by female adolescents attempting suicide (28.5 percent), while anti-anxiety drugs were the most commonly used substances in cases involving females age 25 or older (49.4 percent). Similarly, adolescent males admitted for drug-related suicide attempts were more than three times as likely to have used anti-psychotic drugs as their female counterparts (14.3 percent versus 4.3 percent).

The level of follow-up care also differed significantly, and often the differences were associated with the type of substance used and the age of those attempting suicide. More than 90.2 percent of adolescents who visited EDs for attempting suicide with antidepressants received follow-up care, but only 52.4 percent of the adolescent cases involving ibuprofen received therapy. As for the alcohol-related cases, 83.1 percent of those involving adolescents received follow-up care, but only 59.4 percent of those age 25 or older received treatment.

The new SAMHSA series comprises three studies entitled: Emergency Department Visits for Drug-Related Suicide Attempts by Adolescents: 2008; Emergency Department Visits for Drug-Related Suicide Attempts by Young Adults Aged 18 to 24: 2008; and Emergency Department Visits for Drug-Related Suicide Attempts by Adults Aged 25 or Older: 2008. For copies of the studies, call 1-877-726-4727 or visit <http://www.samhsa.gov/>.

EMTALA Does Not Preempt Tort Award Caps Against Public Hospital

On April 8, 2010, the U.S. District Court for the District of Nevada found that the Nevada Revised Statutes (NRS) 41A.035 limiting medical malpractice damages did not apply to EMTALA disparate screening claims brought by a patient who miscarried her baby after waiting several hours for medical treatment in a hospital emergency department. The court also ruled that the NRS 41.035 limiting tort awards against state entities did apply to the patient's EMTALA claims against a public medical center (*Abney v. University Medical Center of Southern Nevada*, D. Nev., No. 2:09-cv-2418, 4/8/10).

The Facts

On November 30, 2009, Roshunda Abney arrived at the University Medical Center of Southern Nevada's (UMC) Quick Care facility, describing her symptoms as "severe abdominal pain lasting for two days and vaginal bleeding." After an initial evaluation, the Quick Care physician indicated that Abney needed to be transferred to UMC for "higher care." Abney and her fiancé, Raffinee Dewberry, went to the UMC emergency department (ED). UMC personnel asked Abney if there were "a chance she could be pregnant and she answered yes. When asked about her pain level, Abney indicated that she was in the worse pain of her life." When Dewberry attempted to shorten Abney's wait time by petitioning various UMC staff, the "staff called security and made it clear that there was no certain time when Abney would be seen by a doctor." Abney waited for medical treatment in the ED for over five hours, during which time "she claims the UMC nursing staff berated, belittled, and embarrassed both her and her fiancé."

Abney and Dewberry left the UMC ED and drove to Valley Hospital to obtain medical care. After telling Valley's staff that they were not seen at the UMC ED after a five-hour wait, a Valley representative "allegedly responded by asking why they believed they would be seen any sooner at Valley than UMC." The couple left Valley to return to their home. Once at home, Abney's water broke and she began to deliver a baby. Dewberry called 9-1-1. The paramedics arrived and delivered the baby girl, who went into distress. Although the paramedics immediately transported the mother and child back to UMC, the baby did not survive. The baby's gestational age was estimated to be around 26 weeks (plus or minus three weeks).

Abney and Dewberry filed suit alleging EMTALA violations for failure to screen and treat Abney, and for "negligent infliction of emotional distress." On December 24, 2009, plaintiffs moved for partial summary judgment to evaluate the applicability of NRS 41A.035 and NRS 41.035 to plaintiffs' federal disparate screen claims arising under EMTALA.

continued on page 4

The Ruling

The district court granted the plaintiffs' motion in part and denied the motion in part, drawing on the enforcement provisions under EMTALA, which include both civil money penalties and private causes of action. Under the civil money penalties provision, negligent violations of EMTALA's requirements . . . are subject to money penalties not to exceed \$50,000, whereas EMTALA's provision for civil enforcement offers a private right of action for any individual who suffers personal harm as a direct result of a hospital's violation to "obtain those damages available for personal injury under the law of the state in which the hospital is located . . ." The court suggested that by enacting this provision, "Congress explicitly directed federal courts to look to state law in the state where the hospital is located to determine both the type and amount of damages available in EMTALA actions."

Under NRS 41A.035, an injured plaintiff may recover noneconomic damages in a tort action "based upon professional negligence" against a "provider of health care," but the amount of noneconomic damages cannot exceed \$350,000. The underlying conduct at issue in Abney's motion was the defendants' alleged disparate screening of Abney. To recover on an EMTALA disparate screening claim, a plaintiff must set forth evidence sufficient to support a finding that she "received a materially different screening than that provided to others in his condition." The court found that "the underlying conduct Plaintiffs describe supports a disparate screening claim, which is not based on professional negligence or subject to NRS 41A.035." Since disparate screening claims under EMTALA are not based on underlying conduct or legal theory amounting to professional negligence, the federal district court ruled that NRS 41A.035, did not apply.

In turning to NRS 41.035, the plaintiffs asked the court to declare this statute inapplicable to their EMTALA claims, asserting that NRS 41.035 "should not be applied to their claims because this action is based upon alleged violations of EMTALA, a federal statute that provides a private right of action independent of any state tort law. In distinguishing NRS 41.035, this state statute awards for damages in a tort action brought against a state actor "arising out of an act or omission within the scope of his public duties or employment may not exceed the sum of \$75,000."

The plaintiffs argued that the application of NRS 41.035 to their claims would amount to a partial sovereign immunity, which would conflict with EMTALA, as determined in an Eighth Circuit case holding that "EMTALA preempted a Missouri sovereign immunity statute, which would have precluded a hospital's EMTALA liability, because the federal and state laws were in direct conflict." The federal court disagreed, citing the EMTALA provision 42 U.S.C. § 1395dd(d)(2)(A) by stating that such a reading of NRS 41.035 "ignores EMTALA's plain language that allows for 'those damages available for personal injury under the law of the state in which the hospital is located.'"

The court wrote that the plaintiffs are not "precluded from recovering on an EMTALA claim under NRS 41.035, rather they are limited to a fixed statutory amount. Federal statutes only override state law 'when state law is in actual conflict with federal law.'" The Court found that NRS 41.035 was not in "actual conflict with EMTALA because it does not obstruct Congressional intent to establish a private right of action for an EMTALA violation." Absent EMTALA preempting the application of NRS 41.035 to Abney's claims, the court concluded that NRS 41.035 applied to plaintiffs' claims against UMC.

To examine the court decision, go to: http://media.lasvegassun.com/media/pdfs/blogs/documents/2010/04/12/30_Abney_Damages_Order.040810.pdf

Inadequate Screening Claim Denied Again on Reconsideration Motion

On April 19, 2010, the U.S. District Court for the Eastern District of Oklahoma denied the plaintiffs' motion for reconsideration by finding that the plaintiffs' allegations are insufficient to state an EMTALA medical screening claim (*Zinn v. Valley View Hospital*, E.D. Okla., No. 09-425, 4/19/10).

The Facts

On February 15, 2008, following a motor vehicle accident, Dawn Zinn was transported to Valley View Regional Hospital's ED. Advanced life support services were rendered to Zinn during transport and the fetal heart tones of Zinn's unborn child were measured at 150 to 160 beats per minute. Upon arrival in the ED, the fetal heart tones were measured at 136-141 beats per minute. A request was made for a fetal monitor within five minutes of Zinn's arrival, but the monitor was never applied to Zinn in the ED. Approximately two hours later, when Zinn was moved to a bed, a large quantity of blood and fluid was discovered. An obstetrical physician was notified of Zinn's condition and an ultrasound machine was brought to the ED. Zinn was then moved to the obstetrical department where an emergency cesarean section was performed. Zinn's baby boy was delivered and pronounced dead, all within forty minutes of finding Zinn in distress in the ED bed.

Zinn and her husband filed an EMTALA claim contending that Valley View failed to provide "an appropriate medical screening" of Dawn Zinn and her unborn child to determine if an emergency medical condition existed. The plaintiffs also claimed that the hospital failed to stabilize Zinn's medical condition and failed to transfer her to another health care facility. Valley View moved to dismiss, arguing that "EMTALA is inapplicable to the facts as alleged . . . and that the Court should decline to exercise supplemental jurisdiction over the remaining state law medical negligence/wrongful death claims." On January 19, 2010, the court agreed with defendants, ordering that the case be dismissed in its entirety.

The plaintiffs then responded by filing a Motion to Alter or Amend a Judgment, contending that the court erred in dismissing their EMTALA claims. The Zinns argued in the motion to reconsider that "the issue of whether an appropriate medical screening was provided under EMTALA is a question of fact," not capable of being resolved by the Federal Rules of Civil Procedure Rule 12(b)(6) motion to dismiss lawsuits with insufficient legal theories underlying their cause of action.

The Ruling

In the federal court's January decision considering Valley View's motion to dismiss, the court noted that the standard of review for dismissal requires that "the complaint must give the court reason to believe that this plaintiff has a reasonable likelihood of mustering factual support for these claims. . . . when evaluating an EMTALA claim . . . the relevant inquiry is not whether the emergency room procedures were adequate, but 'only whether the hospital adhered to its own procedures.'" While the Zinns' claim speculated that what the hospital did was inadequate, it did not specify how the screening on Dawn Zinn deviated from that provided to other patients with similar injuries. The court found that the plaintiffs' complaint contained "no allegations concerning Valley View's

continued on page 5

emergency room screening procedures or a recitation of how Valley View supposedly violated those procedures with respect to their treatment and evaluation of Dawn Zinn.” Absent such content, the plaintiffs’ EMTALA claim failed because it could not cross the hurdle of rising above the speculative level. Even so, the federal court did add that “[w]hether further screening could have been performed, or whether the requested fetal monitor should have been delivered to the emergency room and applied to Dawn Zinn, are issues to be addressed in the context of state malpractice law.”

Given this prior context, the court determined in April that the plaintiffs’ arguments and related authorities for their motion to reconsider the court’s first judgment “in connection with the propriety of resolving the EMTALA claims on Valley View’s motion to dismiss . . . are virtually the same arguments and authorities considered by the court in its previous ruling.” In these procedural rules, a motion to reconsider “is appropriate where the court has misapprehended the facts, a party’s position, or the controlling law;” but such a motion “is not appropriate to revisit issues already addressed or advance arguments that could have been raised in prior briefing.”

As a result, the court found “no error in its application of the controlling law, specifically, the standard for evaluating a motion to dismiss.” Nor did it find that the court “misapprehended any of the facts or Plaintiffs’ position with respect to the allegations of

their complaint.” “Plaintiffs’ allegations are insufficient to state an EMTALA medical screening claim,” the court wrote in its decision, thus denying the plaintiffs’ Motion to Alter or Amend a Judgment.

However, the federal court again determined that the Zinns’ allegations are “properly addressable in the context of the medical negligence action filed by Plaintiffs in the District Court of Pontotoc County, Oklahoma.” Also, the court iterated its prior finding that “even assuming Plaintiffs had adequately pled a medical screening claim under EMTALA, the undisputed evidence of treatment, i.e., the emergency cesarean section precludes recovery under EMTALA’s medical screening provision.”

AAEM Antitrust Compliance Plan:

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

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View from the Fishbowl

Joel M. Schofer, MD, RDMS

Member, AAEM Board of Directors

Lieutenant Commander, Medical Corps, US Navy

Emergency Ultrasound Director, Emergency Department

Naval Medical Center Portsmouth, Portsmouth, Virginia

My duties in the Navy can take me far and wide. I recently was in charge of a medical humanitarian mission at a medical clinic in a small Indonesian village. To say that this village was impoverished is a gross understatement.

In three and a half days, a dentist, another physician, and I saw 568 patients. The complaints ranged from typical fast track stuff to conditions normally requiring hospitalization or surgery. We were equipped to handle only the most basic of complaints. Anything requiring more care than we could provide was to be referred to the local hospital. The problem was that none of them were willing to go...

Having taken care of these 568 patients, I have to say that the medicine was not all that different from a typical ED practice. The most common things we saw included musculoskeletal complaints, rashes, headache, abdominal pain, and cough/cold symptoms. There were some things I had to do that were a little outside of my typical scope of practice, but nothing too crazy. What were different...vastly different...were the patients.

Out of 568 patients, we had one patient complaint. One. Let me do the math...that is a patient complaint rate of 0.18 percent, a figure I would bet any ED in the country would be proud to call their own.

What was our left without being seen rate? To my knowledge, it was zero. None. Not one patient who registered left.

The one guy who complained was a 70 something year old with severe Parkinsonian tremors who could no longer conduct his activities of daily living. His biggest complaint was that he couldn't drink out of a cup without spilling it all over himself from the shaking.

I felt bad for him. I really did. But none of the acetaminophen or ibuprofen we were dishing out was going to help him. I couldn't even scrounge up some benzodiazepines for him. We had no controlled substances. I explained that nothing we had would help his tremors.

"Do you have any pain?" I asked through our interpreter.

His denial of pain robbed me of a chance to give him some pain meds and to have him walk away from our clinic with something in his hand.

But he was not the only patient for whom I could do nothing.

Five miscarriages? Sorry. The best she got from me was a recommendation to "keep on trying." She left with a smile after thanking me for my time.

Your child was normal until the age of 2...she got a fever...now she's 5 and hasn't spoken since? Sorry. I explained that I had nothing that would help and that, even in the US, her child would require multiple specialists and probably years of therapy for a chance of recovery. Again, we parted with a smile and a thank you.

I learned to say "sorry" in Indonesian. "Ma auf" would be my best phonetic translation.

Each time I couldn't give them anything or do anything for their problem, I'd pray they'd have some kind of pain so that I could give them two or three days of acetaminophen and have them walk away with something. Anything.

But people came and went. A lot of them got nothing. And only one complained.

One elderly gentleman who had been blind for 17 years came to see me. I knew I couldn't do a thing for him, but I did a quick physical examination just so he'd feel I did something. I shined a penlight in his eyes. No light could possibly get through those pearly white opacified corneas. I examined his conjunctiva. I listened to his heart and lungs. I pushed on his abdomen. In all, it took 30 seconds (or less) and I could do nothing for him.

I gave him my typical "ma auf" (sorry) and shook his hand. He let loose a torrent of Indonesian words while repeatedly shaking my hand and smiling from ear to ear.

I turned to my interpreter. "What did he just say?"

"He is very impressed with you because you took the time to examine him. He thinks you are very kind. He would like to invite you to his house."

I think I'm pretty nice to my patients in the ED, but the next time one invites me to their house would be the first...especially one who waited hours, spent less than 5 minutes with me, and got nothing but a "sorry, I've got nothing for you." If only the patients we typically see in the ED could be like this guy.

Then I noticed that he had a teenage daughter escorting him around the clinic, and my interpreter said to me...

"Not only did he want you to go to his house, but he wanted you to marry his daughter."

(Contact Dr. Schofer with any comments at jschofer@gmail.com. No marriage proposals, please. Or at least check with my wife first. She's probably had enough of me...)

**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.*

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EMS APPROVED AS AN EMERGENCY MEDICINE SUBSPECIALTY

East Lansing, MI – September 29, 2010 -- The American Board of Emergency Medicine (ABEM) announces that the subspecialty of Emergency Medical Services (EMS) was approved by the American Board of Medical Specialties (ABMS) at the General Assembly of its members on September 23, 2010. EMS is a medical subspecialty that involves prehospital emergency patient care, including initial patient stabilization, treatment, and transport in specially equipped ambulances or helicopters to hospitals.

"The purpose of subspecialty certification in EMS is to standardize physician training and qualifications for EMS practice, to improve patient safety and enhance the quality of emergency medical care provided to patients in the prehospital environment, and to facilitate further integration of prehospital patient treatment into the continuum of patient care. We are pleased that EMS has been recognized by ABMS as a clinical discipline that extends emergency care to the acutely ill and injured patient in the prehospital venue," stated Mark T. Steele, MD, ABEM President.

EMS becomes the sixth subspecialty available to ABEM diplomates along with Medical Toxicology, Pediatric Emergency Medicine, Sports Medicine, Undersea and Hyperbaric Medicine, and Hospice and Palliative Medicine. The development of EMS as a subspecialty has been discussed for many years but it was through the concerted efforts of the National Association of EMS Physicians, the American College of Emergency Physicians, the Society for Academic Emergency Medicine, and ABEM that certification in the subspecialty was approved.

ABEM has assembled an EMS Examination Task Force composed of 12 EMS physicians that is working on the development of the EMS subspecialty examination and maintenance of certification program. It is anticipated that the first examination will be given in the fall of 2013.

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

The ABEM mission is to protect the public by promoting and sustaining the integrity, quality, and standards of training in and practice of Emergency Medicine.
A Member Board of the American Board of Medical Specialties

Recognition Given to Foundation Donors

Levels of recognition to those who donate to the AAEM Foundation have been established. The information below includes a list of the different levels of contributions. The Foundation would like to thank the individuals below that contributed from 1/1/2010 to 9/24/2010.

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

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continued on page 9

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continued on page 10

The AAEM Foundation thanks

Kevin Beier, MD FAAEM

for his generous donation in support of emergency medicine education, practice rights and patient care.

The AAEM Foundation thanks an

Anonymous Donor

for a generous donation in recognition of the support received from Robert M. McNamara, MD FAAEM, and Joseph P. Wood, MD JD FAAEM.

Advocacy

Erik Kochert, MD

Summer is winding down, the kids have returned to school, the leaves are changing, and we are nearing another November that will surely have lasting political implications for the entire United States. Yes, the mid-term elections are approaching, but that is not all. The latest patch to the SGR is due to expire on November 30th, and I for one am tired of marking my calendar. Today medicine is ripe with change. If physicians would like to have any say in the changing American health care system, and we all would, now is the time to recognize that advocacy is a core competency for medical practice.

It is easy to become frustrated with politics. The constant partisan bickering and “he said, she said” dialogues broadcast daily can be overwhelming and lead to disinterest. Emergency physicians are not immune to this phenomenon; as a result, we are grossly underrepresented and uninformed. When the political process involves topics of health care reform, reimbursement, medical malpractice and practice management, our interest is piqued but we are frequently let down by what we see as ineffective change or no change at all. Faced with these frustrations, we need to understand that our lack of representation and our relative absence of input are major parts of the problem.

As physicians we pride ourselves on our willingness to help those in need, speak up for those who cannot speak for themselves, and work tirelessly to mend the ills of our patients. The vast majority of us do this by providing direct patient care in our emergency departments each hour of every day. While these efforts are critical to the needs of our patients, we must recognize that our efforts in state and national political reform are just as critical to the health of our patients, families and communities. It is imperative that each and every one of us become an advocate. Are you ready to be an advocate? Well, let me offer you a few steps to get started.

The first step is to get involved and join the efforts of organized medicine. AAEM, the AMA, and other organizations all have dedicated individuals who continually track legislation and attempt to educate and influence our lawmakers in Washington, DC. In addition, local chapters of AAEM and state medical societies provide similar functions in our state capitals. Each of these organizations provides information and resources by which one can become informed on the issues at hand. Membership in these societies helps to organize our efforts, educate our peers and speak with a more unified voice. I encourage emergency physicians to join these organizations.

Once involved, speak up. State and national organizations provide the forum for discussion, but it is up to each and every one of us to share our unique experiences and perspectives. Join a committee in your state or national chapter. We must engage with all stakeholders: health care providers, policymakers, and the public. Get to know your representatives in the state capital and in Washington, DC. They like to hear from constituents and will be interested to learn from our unique perspective. The value of a phone call to your congressmen before a key vote should not be underestimated. It is said that two things run politics, money and votes. Be generous in your giving to medical political action committees (PACs). The dollars donated to medical PACs go to support the campaigns of candidates who make physicians and payments a top priority. Importantly, don't forget to support those candidates with your vote at election time!

The American health system is strapped with problems related to access to care, ED crowding, SGR reform, tort reform, physician shortages, and so on, but you can make a difference by becoming an advocate for emergency medicine. Be more involved with organized medicine and become informed. Speak up to help lead the way, and don't forget that November will be here very soon.

AAEM 2011 Elections

Nomination Deadline: November 29, 2010

Five 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 17th Annual Scientific Assembly, February 28-March 2, 2011, in Orlando, FL. 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/2011nominationform.pdf> and send the information listed below to the AAEM office before midnight CST, on November 29, 2010, Central Standard Time. 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.

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.

Call For Committee Members

AAEM announces the formation of three new committees. Members are encouraged to volunteer for any committee matching their talents, experience and interest.

- **Finance Committee:** The finance committee will be chaired by the AAEM Secretary Treasurer. It will consist of two additional AAEM members. Its primary charge will be to advise the board of directors concerning the investment of any reserves held by the Academy.
- **Public Relations Committee:** This committee will develop announcements for both the lay media and healthcare specific press.
- **Practice Management Committee:** Chaired by current Vice President William Durkin, MD, this committee will develop resources to assist AAEM members who are interested in establishing their own practices.

AAEM members wishing to apply for any of these committees should sign up online at <http://www.aaem.org/committees/> or contact the Academy at info@aaem.org. Please include a statement of why you are interested and a current curriculum vitae.

CHANGE OF ADDRESS

If you have changed your home address or your email address, please log on to www.aaem.org to update your information. Or, you may contact the AAEM office at (800) 884-2236 or email info@aaem.org to update your information.

AAEM ED Group Membership

NEW AND IMPROVED!

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

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

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

Award Nominations Sought for AAEM Awards Deadline: November 29, 2010 – midnight CST

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 Keane 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.

Program Director of the Year Award Nominations Sought

Deadline: November 29, 2010

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 29, 2010, 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 17th Annual Scientific Assembly to be held in Orlando, FL, February 28-March 2, 2011.

Please submit all nominations to: info@aaemrsa.org.

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 29, 2010. The AAEM executive committee will review the nominees and select recipients for all awards except the EM Program Director of the Year Award, which will be selected by the AAEM Resident and Student Association.

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.

Award presentations will be made to the recipients at the 17th Annual Scientific Assembly to be held February 28-March 2, 2011, in Orlando, FL.

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

OSU EMERGENCY MEDICINE PHYSICIAN IS **Professor of the Year**

Dr. David P. Bahner, an emergency medicine physician at The Ohio State University Medical Center, has been named 2010 Professor of the Year, which is the highest honor a faculty member can receive from the graduating medical school class. Since 1931, the award has been presented to a professor who has demonstrated excellence and dedication to teaching as well as serving as a role model to the class. This is the first time in the history of the award that an emergency medicine physician has received this honor.

Upcoming AAEM–Sponsored and Recommended Conferences for 2010-2011

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

February 28–March 2, 2011

- 17th Annual Scientific Assembly
Orlando, FL
www.aaem.org

April 6-7, 2011

- AAEM Pearls of Wisdom Oral Board Review Course
Las Vegas, NV
www.aaem.org

April 16-17, 2011

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

AAEM–Recommended Conferences

November 6, 2010

- Inflammatory Neuropathies: The Impact of Clinical Practice on Outcome
Valley Forge, PA
www.gbs-cidp.org

November 8-11, 2010

- 39th Annual Topics in Emergency Medicine
San Francisco, CA
www.cme.ucsf.edu

November 15-17, 2010

- The Heart Course-Emergency™
Las Vegas, NV
www.theheartcourse.com

November 19-21, 2010

- The Difficult Airway Course-Emergency™
Las Vegas, NV
www.theairwaysite.com

December 2-3, 2010

- Update on Behavioral Emergencies
Las Vegas, NV
burtr@sinai.org

December 3-6, 2010

- Critical Points in Emergency Medicine
Las Vegas, NV
www.criticalpoints.net

December 5-10, 2010

- Current Concepts in Emergency Care 31st Annual
Maui, HI
www.ieme.com

January 9, 2011

- 4th Annual Steven Z. Miller Pediatric Emergency Medicine Course
New York, NY
www.columbiacme.org

January 29 – February 2, 2011

- Western States Winter Conference on Emergency Medicine
Park City, UT
www.wswcem.com

April 8-10, 2011

- The Difficult Airway Course-Emergency™
Las Vegas, NV
www.theairwaysite.com

May 13-15, 2011

- The Difficult Airway Course-Emergency™
Boston, MA
www.theairwaysite.com

May 25-27, 2011

- High Risk Emergency Medicine
San Francisco, CA
www.highriskem.com

June 10-12, 2011

- The Difficult Airway Course-Emergency™
Chicago, IL
www.theairwaysite.com

September 23-25, 2011

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

October 28-30, 2011

- The Difficult Airway Course-Emergency™
Atlanta, GA
www.theairwaysite.com

November 18-20, 2011

- The Difficult Airway Course-Emergency™
Las Vegas, NV
www.theairwaysite.com

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

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



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AAEM Young Physicians Section

Get the Troops Going!

Jennifer Kanapicki, MD

So, as we all know residency can be tough. Long nights, constantly changing schedules, always some lecture to give or requirement to fulfill. So you're asking, how do we break the monotony for our residents? And my answer lies in AAEM's Scientific Assembly. As a chief resident last year, one of the best things I think I did for the residency was to get all twelve of my second year residents to Scientific Assembly. The residents got out of the daily grind of residency and on a plane to Vegas. Here are the four reasons I think it was such a great idea.

1. Resident Morale.

Through the trials and tribulations of residency, sometimes morale can be a roller coaster. What better way to climb to the top than with a trip where all your residents can get on a plane, travel to an exciting new city and spend time with each other for three days. Forget everyone being at different hospitals or on different shifts, forget the rectals, forget the intoxicated combative patients. To just be with each other with the common goal of learning, gave my busy second years a much needed breather in the hectic world of residency.

2. Education.

Scientific Assembly puts together an amazing array of lectures. Whether it's the guru of cardiology, Dr. Mattu, giving an ACS lecture or Dr. Maha's latest trauma updates, your residents are learning, and they are discovering the latest innovations of medicine from the leaders of the field. They bring back to your program new ways of thinking and possibly improvements in the way they practice. They might get ideas to submit a poster at next year's conference. They might decide to run for a board position on AAEM/RSA. The possibilities are endless, but your residents will never know about them unless they get the chance to experience them.

3. Networking.

One of my favorite things about going to a conference is the people I meet. You are exposing yourself to leaders in our field from all over the nation. I remember having cocktails at the Scientific Assembly reception with Dr. Swadron and sitting next to Dr. Weiss at a lecture. I also can remember meeting a resident from George Washington and sharing ideas of how to make our residencies even better, or the resident from Orlando about their protocols for STEMIs. This exposure to the people and workings of EDs all over the nation is priceless. After a three day conference, you have connections in EM all over the nation.

4. Future.

Our residents are the future of EM. By getting involved early in a national organization, like AAEM, we are planting the seeds to allow our residents to be more active and vocal early on in their careers. We are giving them the opportunity to discover what's out there and the foundation to create new pathways to get there. We are making future leaders.

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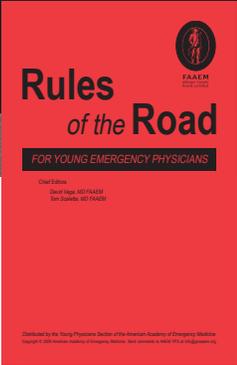
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RESIDENT PRESIDENT'S MESSAGE

Why AAEM: A Resident's Perspective

Ryan Shanahan, MD
AAEM/RSA President

Let's face it. We are all emergency medicine residents or students interested in emergency medicine. There are two groups that represent emergency medicine residents and these two groups are affiliated with two other groups that represent emergency medicine physicians in general. I speak of course of AAEM/RSA and EMRA and their relationships to AAEM and ACEP respectively. Why two groups? Which group should you look to for educational resources and to provide your voice on a national stage?

I am going to make the suggestion you not choose between us, at least as residents. Work with both. I am a proud member of EMRA and greatly enjoy reading their newsletter, access to EM:RAP and other things they provide. I am obviously more involved with AAEM but respect EMRA greatly.

That said, I am going to make the case that AAEM/RSA is a valuable resource not to be ignored. I am also going to mention some of the things that we stand for that at one point did, and in some cases still do, set us apart from ACEP and EMRA. We agree with each other more than we disagree, and we should work together far more than we do, but differences remain.

A good place to start would be the benefits we provide. The highlight of this would obviously be our annual conference, Scientific Assembly, which will be held next year in Orlando, FL, February 28 through March 2. The conference registration is free to all members (not just residents), a perk not available with any other organization and something to consider when paying the attending registration fees for other conferences. Scientific Assembly has a resident track and a student track, in addition to outstanding lectures from some of the best speakers in the business. I am still amazed at all the topics discussed last year. We also have a board review book that has been very well reviewed by many residents and is quickly being adapted as a self-contained board review course. Our "Rules of the Road" series details important things that every physician needs to know as they make the transitions to each new level. We recently released the newest edition of the resident version with a lot of information on job searches and what to look out for in contracts.

So why are there two organizations in the first place? I often get asked this question and hope those who know this history will bear with me. As I have alluded to earlier, the differences between the residency organizations is small, though the differences between our parent organizations are sometimes stark.

AAEM was founded in 1993 partly in response to the original members' concerns that there was no professional society willing to support residency training by restricting membership to board certified/board eligible members. In the early years of our specialty, there was a practice track for board certification to allow those pioneers who did not have the option of residency training to become board certified. That track ended after 10 years and

since 1990 there has been no way to obtain board certification without residency training. This did not stop ACEP from continuing to offer full voting membership to "qualified emergency providers" without residency training in emergency medicine through 2000 and FACEP designation to non-residency trained physicians as recently as 2008.

EMRA claims to have pushed ACEP to change its policy in 2000 and to the extent EMRA did, we applaud them. That said, the parent organization still cannot say, to this day, that all fellows of the organization are board certified, or even eligible to sit for the boards in emergency medicine. This is something our parent organization, AAEM, has required since inception and something, as a resident, I fully support.

Today we continue to be concerned that emergency medicine is being run by large organizations that are more concerned with filling slots in a calendar and expanding the number of contracts they hold than delivering quality emergency care with qualified providers. As residents we have been blessed with a great RRC and dedicated program directors who ensure that we all gain similar exposures and education. After residency, however, many possible options are available.

AAEM/RSA feels that EM physicians should be employed fairly in open and democratic groups. EM physicians should be board certified, which since 1988 has required residency training in EM. The money physicians earn should go mostly to those same physicians, with open account books that allow providers to know how much they are paying for professional and management services. Physicians should be able to appeal to the hospital board and be allowed due process if their employment is terminated. Physicians changing jobs should not be forced out of a city because of restrictive covenants in their contracts. Emergency physicians ideally are members of the hospital staff and key players in the care provided in the hospital, not just a cog to be put in for shifts. AAEM and AAEM/RSA have consistently fought for these principles where others have stood silently by.

If you would like to learn more about the organization you can always visit our website, www.aaemrsa.org for more information. We would love for you to be an active member of RSA and we would also love for you to continue your membership for the lifetime of your career. AAEM has always worked for the practicing emergency medicine physician and we will continue to support you through your career.

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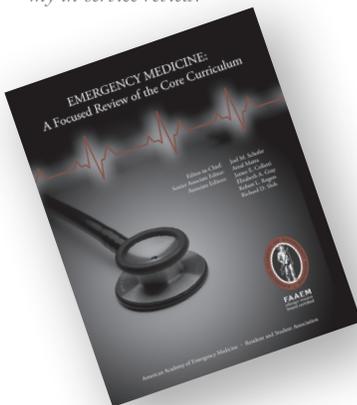
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RESIDENT EDITOR'S LETTER

Putting the Focus Back on Diagnosis

Leana S. Wen, MD MSc
AAEM/RSA Resident Editor



Last week, Jerry got the scare of his life. Jerry is a 48-year old mechanic who is in good health. His parents are healthy, and he recently got a “clean bill of health” during his annual check-up. Over the weekend, he helped his brother move across town. Monday morning, he woke with tightness in his chest. He described it as a “spasm” and thought that he might have pulled something while he was lifting the sleeper sofa.

But someone in his neighborhood had a heart attack recently, and Jerry's wife persuaded him to go to the ED to get it checked out.

A generation ago, Jerry's family doctor would probably have told him that he had a muscle strain. He would have left with some Motrin and feel better. Not so on this particular day. The nurse who greeted Jerry noted his chief complaint of chest pain and quickly called over a tech who helped Jerry take off his shirt and attached him to a cardiac monitor. He was given four baby aspirin to chew on. He was brought to a treatment room where a young doctor came in and asked a series of questions about his chest pain while a second nurse drew several vials of blood and then sent him off for x-rays of his chest.

Hours passed. Finally, the doctor in charge, we'll call him Dr. M, came in and told Jerry that everything looked OK so far, but that he needed to stay overnight for some more tests.

Jerry didn't want to stay. He had already missed his son's lacrosse game; he didn't want to miss his daughter's choir performance too. Dr. M told him that he could still be having a heart attack, and that sounded scary. So Jerry dutifully stayed the night. The next morning, he found out that he hadn't had a heart attack. That was good news, but his ordeal wasn't over yet. Dr. M told him that they still could not be sure what was causing his chest pain or that there weren't problems with his heart. “You should see your primary care doctor to follow-up on this,” Dr. M cautioned. “He'll probably want to order some more advanced tests.”

Jerry went home, far from reassured and more confused than ever. If he didn't have a heart attack, what could it be? The discharge instructions just said that he had a diagnosis of “chest pain.” But isn't that a symptom, not a diagnosis? His chest was still a little sore—it got worse after his kids pounced on him when he got home—should he be worried about this? Is it OK to keep working, what with crawling under all those cars? Is he going to be OK?

...

Emergency physicians are taught to always think about the most dangerous things that our patients could have. Headache? Most likely it's something benign, but we need to think about subarachnoid hemorrhage. Back pain? Probably it's something chronic, but we always ask about continence and assess for saddle anesthesia and such to make sure it's not cord compression. Chest pain? Even in a patient who probably pulled a muscle, we do have to think about dissection and MI.

It's the nature of our job to make sure that we assess for potentially life-threatening conditions. It should also be part of our responsibility

to provide our patients with a diagnosis. Too often, we focus on the “rule-out” of the really bad stuff: the head bleeds, the strokes, the appys. When we find that our patients don't have these (admittedly quite bad) diagnoses, we are relieved. We tell our patients that they don't have something terrible, and for a second, they are relieved too. Then, they wonder what it is they actually have. To treat a problem, it helps to figure out what the problem is. It's part of our duty to provide a diagnosis of not just what patients don't have, but what they have, and to tell them what to do about this less-than-life-threatening condition.

“How can I do this? We're really busy; I can't sit down and go over every single thing on the differential and what to do about that! Besides, we often can't offer any diagnosis at all.”

I would argue that there often is a diagnosis or a “most likely” diagnosis. The key is to involve our patients in the thought process. Tell your patients what you are thinking. Involve them in your thinking through the differential and the decisions about what tests to do. We can say that tests so far show it is unlikely you have this terrible life-threatening condition. Based on your symptoms and physical exam, we think it is most likely this diagnosis. This is what you can expect in your symptoms based on the natural history of your disease. This is what you can do about it to alleviate the symptoms. This is why you should follow-up with your PCP, and here are danger signs to look for that should prompt you to come to the ED. Our patients are our partners, and it's part of good care to provide them an answer that guides their treatment.

In Jerry's case, think about how differently he would have felt if Dr. M had involved him in the decision-making from the beginning. His symptoms starting after the moving and feeling like “spasms” and his lack of significant risk factors might not have even prompted a workup for ACS in the first place. Instead of being frightened about the risk of a heart attack, Jerry could have been involved in the decision-making from the get-go and could have avoided staying for lab work. At the very least, he could have been told after the two sets of x-rays AND stress test that his diagnosis was not just “chest pain,” but musculoskeletal chest pain. He could have been told that the pain could worsen in the next 24-48 hours, but that it was safe to resume work and exercise. He could take ibuprofen 600mg every 6 hours with food to help with the pain. He should see his PCP to follow-up in a week if symptoms persist, and to come back to the ED if he has warning signs of something worse (i.e., crushing chest pain, shortness of breath, etc). If he had been given a diagnosis followed by these explicit instructions for treatment, Jerry would have gone home sooner, happier and far more reassured.

Patients come to their doctors to feel better. Let's make sure that even in the busy, often uncertain and unfortunately litigious environment of the ED, we strive to figure out not just how to rule out the bad stuff, but to provide patients the answer of what is actually causing their problems. Let's put the focus back on diagnosis.

(I welcome your comments to this article and the approach to patient care outlined. Please email me, wen.leana@gmail.com.)



Resident Journal Review: September-October 2010

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

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

Midazolam Versus Diazepam For The Treatment Of Status Epilepticus In Children And Young Adults: A Meta-Analysis. McMullan J, Sasson C, Pancioli A, et al. Acad Emer Med. Jun 2010; 17(6): 575-582.

Epilepsy is a common emergency department (ED) complaint. Whereas most cases are self-limited, approximately 6% of cases will progress to status epilepticus (SE). There is significant morbidity and mortality with SE including aspiration, anoxic brain injury, neuronal injury, cardiac instability and autonomic dysfunction. Delays in therapy can lead to worsened neurological recovery and may make the condition refractory to further treatments. Benzodiazepines are widely accepted as the first line intervention for SE, but the best drug and route when intravenous (IV) access is unavailable is unclear. The authors of this meta-analysis evaluate whether non-intravenous (non-IV) midazolam is as effective as diazepam (IV or rectal) in terminating SE.

Six randomized or controlled studies with 774 subjects were included. All compared IV or rectal diazepam with buccal, intramuscular or intranasal midazolam for the treatment of SE (defined as seizure >5 minutes or at arrival to ED). The results showed that there was no difference between seizure cessation or time to seizure cessation between non-IV midazolam and IV diazepam despite a faster time to administration (average 2.46 minutes). In three studies that compared buccal midazolam versus rectal diazepam, buccal midazolam was more successful in achieving seizure cessation (RR= 1.54; CI= 1.29-1.85). In 750 subjects there were only 5 instances of respiratory depression requiring intubation or ventilatory support (0.7%). There was no difference between the two treatment groups in this regard.

From this study, non-IV midazolam is shown to be just as fast and effective as IV diazepam for children and young adults. When comparing rectal diazepam to buccal midazolam, the latter is better likely due to the variable absorption rate of the rectal diazepam. This is most relevant for pre-hospital care practices and guidelines where such medications would be used the most. Although this study was initially intended to include adults as well as children, the subjects in the studies were ages 0 months to 22 years. The majority were less than 15 years old. Therefore, no conclusions can be made for the adult and elderly population.

Utility Of Initial Bolus Insulin In The Treatment Of Diabetic Ketoacidosis. Goyal N, Miller JB, Sankey SS, et al. J of Emer Med. 2010; 38(4): 422-427.

Diabetic ketoacidosis (DKA) is managed with IV fluid administration, correction of electrolyte abnormalities, and IV insulin. Recommended insulin therapy in adults often includes a continuous infusion after an initial bolus. It is hypothesized that the bolus is useful to overcome a relatively insulin-resistant state in DKA. This practice goes against

pediatric guidelines for DKA treatment, where there are concerns for causing hypoglycemia and abrupt changes in serum osmolarity. In this study, the authors investigated the utility of an initial insulin bolus in the treatment of DKA in adults.

This was a single-center, prospective, observational cohort study at a tertiary care center in Detroit, Michigan. Adult patients who had a diagnosis of DKA, ketoacidosis or metabolic acidosis were included. Patients were excluded if their acidosis was due to causes other than DKA, if they did not receive an insulin infusion, or if data on outcome measures were not available. The decisions to give an insulin bolus, electrolyte supplementation, and fluid administration were at the discretion of the ED physician.

There were 157 patients included in the analysis. Seventy-eight patients received an initial insulin bolus and 79 did not. Between the two groups there were no significant differences in initial baseline characteristics including initial glucose levels and initial anion gap. There were no differences in the incidence of hypoglycemia requiring dextrose administration, the amount of IV fluids administered, the rate of change in glucose level, rate of change in anion gap, overall ED length of stay (LOS), or hospital LOS.

The major limitations of this study were the lack of patient randomization, the lack of blinding to treatment, and the variability in management between the two groups. Treatment decisions were left up to the managing ED physician and there was no standard treatment algorithm used. It is surprising that the rates of change of the glucose level and anion gap were the same between the two groups. It raises the question of whether or not there were other contributing variables that were not included in the study, such as the type of fluids given or the amount and route of insulin bolus (IV versus subcutaneous (SQ)). At this time, no firm conclusions can be made based on this study on the use of an initial insulin bolus in the management of DKA.

Inferior Vena Cava Diameter Correlates With Invasive Hemodynamic Measures In Mechanically Ventilated Intensive Care Unit Patients With Sepsis. Schefold JC, Storm C, Bercker S, et al. J Emerg Med. Jun;38(5):632-637.

Assessment of fluid status has been a challenging problem in the treatment of critically ill patients. In patients with sepsis, volume resuscitation and optimization of fluid balance is of critical importance. Historically, assessment of fluid status has been accomplished by monitoring various clinical parameters as well as invasive hemodynamic monitoring. The authors of this study sought to assess the correlation of inferior vena cava (IVC) diameter, as measured by bedside ultrasound, with invasive hemodynamic measures.

continued on page 21



Resident Journal Review - continued from page 20

This was a small prospective study of 30 consecutive mechanically ventilated intensive care unit (ICU) patients admitted with a diagnosis of septic shock. Patients with signs of elevated intrabdominal pressure or liver disease were excluded. End-inspiratory and end-expiratory IVC (iIVC, eIVC, respectively) diameters were measured with a 3.5 Mhz transducer (abdominal setting) at the subxiphoid location in the longitudinal plane 2 cm distal to the IVC-hepatic vein junction. Among other invasive indices, central venous pressure (CVP), extra-vascular lung water index (EVLWI) and PaO₂/FiO₂ ratios were measured using the PiCCO system (Pulsion Medical Systems, CVC probe and arterial probe) using a single-pass, transthermal dilution technique.

iIVC diameter correlated with CVP ($p < 0.001$, $r = 0.92$), EVLWI ($p < 0.001$, $r = 0.59$), and the PaO₂/FiO₂ ratio ($p = 0.007$, $r = 0.48$). eIVC diameter also correlated with CVP ($p = 0.001$, $r = 0.56$), EVLWI ($p < 0.001$, $r = 0.63$), and the PaO₂/FiO₂ ($p = 0.008$, $r = 0.48$). The delta IVC diameter (change between inspiration and expiration) did not correlate with measured parameters.

This study adds to the growing body of evidence for the use of bedside ultrasound IVC diameter measurements in assessing volume status. In this study, this widely accessible, non-invasive measurement technique was found to correlate with invasively measured CVP, EVLWI, and PaO₂/FiO₂ measurements. Contrary to prior studies, the change in diameter with respiration did not correlate with CVP. However, this may be explained by the fact that this patient population had already been resuscitated prior to ICU admission, with mean CVP readings of 15cm H₂O. Clearly, this study was limited by the small sample size. Furthermore, the results may not be entirely generalizable given the fact that patients were mechanically ventilated and already had some degree of volume resuscitation prior to initial measurement capture. Lastly, the reference standard used for the measurement of hemodynamic status in this study may not be optimal, although a clear gold standard method of volume status measurement has not emerged after many years of debate. Nevertheless, measurement of IVC diameter shows promise as a non-invasive method to measure volume status in critically ill patients.

Emergency Department Information System Adoption In The United States. Landman AB, Bernstein SL, Hsiao AL, Desai RA. Acad Emerg Med. May;17(5):536-544.

Wide-spread "meaningful-use" of health informational technology (HIT) is an important tenet of health system reform enacted to advance safe, efficient, and cost-effective care in the United States (US). Health information systems may provide clinicians with more complete, accurate, accessible patient histories, safe order entry systems, clinical decision support tools, data analysis tools, and may help automate patient flow. To promote HIT adoption, the American Recovery and Reinvestment Act (ARRA) of 2009 provides financial incentives for the development and use of health information systems. To date, limited national data has been published on the rate of HIT use in EDs. The authors of this study sought to characterize the current state of adoption and feature-based use of HIT in US EDs.

This study was a secondary analysis of the National Hospital Ambulatory Medical Care Survey (NHAMCS) conducted by the National Center for Health Statistics (NCHS) and Centers for Disease Control and Prevention (CDC). NHAMCS used a four stage probability sampling to identify a nationally representative sample of US EDs. A more detailed survey questionnaire was developed (from prior NHAMCS survey) to identify practically relevant, feature-based use of HIT. Based on specific feature adoption, ED information systems (EDIS) were then classified into the following strata: fully functional, basic, none, and "other". For example, a basic EDIS included patient demographics, medication order entry, laboratory results, imaging results, and clinical notes. Fully functional ED had an additional eight features that included clinical decision support tools, warnings, reminders, and transmission of data to other services. Features assessed in the survey were based on prior HIT research that purported the importance of such features. Additional demographic data (hospital geographic region, ownership type, teaching status, population and patient characteristics, etc) was collected as part of the NHAMCS survey.

Three hundred and fifty-six EDs representing the 4622 EDs in the US were included. Using the feature based classification scheme, 1.7% of the EDs had a fully functional EDIS, 12.3% had a basic EDIS, 32.1% had "other", and 53.9% had none. Urban EDs were more likely to have a fully functional or basic EDIS than rural EDs.

Strikingly, more than half of our nation's EDs have no information systems (or have systems so limited as to be classified as none), and less than 2% have an EDIS robust enough to be classified as "fully functional". The survey and classification scheme used in this analysis provides a more detailed analysis of EDIS adoption stratified by functionality than prior surveys. While the features to be included in each EDIS class may be debatable and cause ambiguity in the true rate and degree of EDIS adoption in the US, the data from this analysis reveals a shockingly limited adoption of HIT in EDs nationwide. Furthermore, the data is a reflection of the state of emergency care in the US. Continued attention, support, and incentives are needed to encourage HIT adoption if the goal of wide spread meaningful use is to be achieved.

Resident Journal Review articles are now being translated to Spanish! Beginning with the November/December issue of *Common Sense*, you can view the translated Resident Journal Review articles at www.aem.org/international/

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MEDICAL STUDENT COUNCIL PRESIDENT'S MESSAGE Persevering Through New Challenges

Brett Rosen
AAEM/RSA Medical Student Council President



As I sat down trying to think of what to write for my message in this issue, I could not help but think about the experiences I have had over my first two months of emergency medicine as a medical student. Most of us in our fourth year realize at this point how far we have come from the first year student we once were, sitting in a classroom wondering what it would be like to assume primary care of a patient one day. At this point in the year, all of us, including our faculty, are experiencing new challenges. There are new students in each year of medical school adjusting to a different aspect of their training and a whole class of new interns that are now learning what it is like to be a physician. We have all had to persevere through the many challenges that are presented to us to reach this stage of our careers.

As Thomas Edison once said, "Our greatest weakness lies in giving up. The most certain way to succeed is always to try just one more time." We will learn so much in training that will not come naturally on the first attempt and it is about continuing to practice until we finally get it. As someone who was not particularly strong with the ultrasound machine, it was on a recent clinical shift where I was able

to get the "nice job, I'm impressed" from my supervising resident when I obtained the images on my own after a long time practicing (the latter of which she did not know!). The passion and desire needed to accomplish tasks either in the classroom or in practice is best exemplified by the American icon Benjamin Franklin who said, "Energy and persistence conquer all things." By using our energy and enthusiasm to persevere through the most difficult times, we will all be able to conquer the goal of entering into the wonderful and exciting field of emergency medicine.

AAEM/RSA is still accepting sponsorship applications for EMIGs that would like to host their own symposium! It is also time to make a note on your calendar to start preparing to come to the AAEM Scientific Assembly in beautiful Orlando, Florida, starting at the end of February.

Best of luck as we start a new year, especially to the third years starting out in their first clinical rotations and to the fourth years entering the residency application process! Remember to take advantage of all of the great benefits that AAEM/RSA provides, including EM Select, our unique residency application tracking program to help you organize your applications in one central location.

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