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SENSE

THE NEWSLETTER OF THE AMERICAN ACADEMY OF EMERGENCY MEDICINE



PRESIDENT'S MESSAGE

The Future of Emergency Medicine

Larry D. Weiss, MD JD FAAEM

In early July, Joe Wood, MD FAAEM, Mike Ybarra, MD, and I traveled to Dallas to represent AAEM at a "Future of Emergency Medicine" summit meeting involving virtually every emergency medicine society in the United States. Despite the title of the meeting, the agenda only dealt with the projected workforce shortage in emergency medicine. Despite the number of organizations represented, we had few disagreements during the two days of deliberations. However, we did not discuss the "future of emergency medicine," but only one specific issue.

All organizations agreed we will not have enough board certified emergency physicians in the foreseeable future. We cannot fill every emergency department with board certified emergency physicians. In our detailed discussions, all organizations agreed that only ABEM or AOBEM diplomates may rightfully call themselves emergency medicine specialists. With the exception of the original practice-eligible diplomates, one must complete residency training in emergency medicine to call oneself a specialist in emergency medicine. We felt gratified to hear this consensus from around the room, including representatives from the American College of Emergency Physicians (ACEP).

The group worked on developing a consensus regarding quantification of the demand for emergency services, regionalization and categorization of emergency departments, quality standards, increasing GME funding for emergency medicine, increasing the number of emergency physicians and the use of non-physician and non-EM

trained physicians. ACEP, the sponsoring organization of this summit meeting, plans to write a white paper from the proceedings of this meeting. We expect the white paper to include AAEM's views on these issues.

Even though the organizers of this meeting restricted the agenda to workforce issues, each organization did have an adequate opportunity to express their concerns for the future of emergency medicine. We had the opportunity to discuss our imperiled practice rights and ongoing threats to the academic integrity of emergency medicine, as well as the ever-increasing threats to our professional integrity from lay corporate ownership of emergency medicine practices, often operating in violation of state laws.

During this meeting, many attendees approached us to express their appreciation for our advocacy, especially in the area of emergency physician practice rights. I left the meeting with a strong reaffirmation that AAEM's principles reflect the mainstream of organized medicine. We consistently advocated for physician practice rights, we consistently advocated for high academic standards in emergency medicine and we consistently advocated to maintain the professional integrity of medical practice by opposing illegal lay corporate practice models. We see a future where violations of physician practice rights will no longer occur, where other physicians will respect emergency medicine as a strong academic discipline, and where no emergency physician will work under the control of lay people.

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AAEM would like to introduce the new member's only area of the website.

- Check your membership status or payment history.
- Update your contact information.
- Pay your membership dues.
- 2010 Membership applications now being accepted!

To set up your initial login account, please visit <http://aaem.execinc.com/edibo/LoginHelp>.

Visit www.aaem.org to learn more and watch for new features coming soon! Please contact info@aaem.org or 800-884-2236 with any questions.



Editor's Letter

David D. Vega, MD FAAEM

Tort Reform

With healthcare reform occupying so much of the political stage this year, the relative paucity of discussion about tort reform is disappointing, although not terribly surprising. Only recently have lawmakers begun to publicly mention tort reform as an option. Trial lawyers have been tremendously successful in their lobbying campaigns, striking fear of hefty political retribution in lawmakers, many of whom have trained and practiced as trial lawyers themselves. According to the Federal Election Commission¹, the American Association for Justice (formerly the Association of Trial Lawyers of America) was one of the top 10 contributors to candidates in the 2008 election cycle, out of over 4,000 political action committees. At a recent town hall meeting in Reston, Virginia, Howard Dean noted the following:

"The reason why tort reform is not in the [health care] bill is because the people who wrote it did not want to take on the trial lawyers ... and that is the plain and simple truth."²

Placing reasonable limits on non-economic damages is an important step in the move towards true healthcare reform. Keep in mind that these tort awards are above and beyond reimbursement for medical costs, lost wages and other direct economic damages; a fact that often gets obscured in public discussion of tort reform. States that have placed limits on non-economic damages have been able to stabilize and even reduce liability premiums, which has helped to reverse the efflux of physicians from their borders. Unfortunately, only a minority of states have been able to enact legislation which mandates this sort of cap. Federally-placed maximum awards would help to even the playing field for states in their ability to recruit and retain adequate numbers of physicians, particularly in higher-risk specialties.

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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: \$125 (Non-voting status)

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

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

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

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CDC Report on ED Capacity

Kathleen Ream, Director of Government Affairs

The Centers for Disease Control and Prevention (CDC) recently released a report entitled **Estimates of Emergency Department Capacity: United States, 2007**. This report is based on data from the CDC's 2007 National Hospital Ambulatory Medical Care Survey (NHAMCS). Inaugurated in 1992, the NHAMCS is now the longest continuously running national survey of hospital ED use.

The report notes that over the last several decades, the role of the ED has expanded from primarily treating seriously ill and injured patients. The report recognizes that EDs now also provide urgent and unscheduled care to patients unable to access their providers in a timely fashion and provide primary care to Medicaid beneficiaries and uninsured patients. As a result, EDs are frequently overcrowded with the most common contributing factor being the inability to transfer ED patients to an inpatient bed once the decision is made to admit them. "As the ED begins to 'board' patients, the space, the staff, and the resources available to treat new patients are further reduced," the report states. It continues, "A consequence of overcrowded EDs is ambulance diversion, in which EDs close their doors to incoming ambulances. The resulting treatment delay can be catastrophic for the patient."

According to the CDC survey, approximately 500,000 ambulances are diverted annually in the United States. The survey also shows that large EDs serving more than 50,000 patients each year represent just 17.7% of all EDs in the nation, but account for 43.8% of all ED visits in 2007. The implication, according to the report, is that small EDs with annual visit volumes of less than 20,000 patients may not experience crowding.

Other data from the survey show that about one-half of all hospitals with EDs had a bed coordinator or "bed czar," 58% had elective surgeries scheduled five days a week, and 66% had bed census data available instantaneously. Electronic medical records (EMRs), either all electronic or part paper and part electronic, were used in 62% of EDs. Basic EMR systems containing patient demographics, problem lists, clinical notes, prescription orders, and laboratory and imaging results were reported in 15% of EDs. However, the CDC could not accurately determine the prevalence of fully functional EMRs that also include features such as electronic transfer of prescription orders, warnings of drug interactions or contraindications, and reminders for guideline-based interventions.

Additional survey data show:

- Overall, 62.5% of EDs reported that they board admitted ED patients for more than two hours while waiting for an inpatient bed. Among EDs that board patients, 14.8% use inpatient hallways or other space outside of the ED when critically overloaded. A "full capacity protocol" that allows some admitted patients to move from the ED to inpatient corridors while awaiting a bed was used by 21.1% of EDs.
- EDs with more than 20,000 annual visits comprised more than 70% of EDs in metropolitan statistical areas (MSAs). When compared to EDs in rural areas, EDs in MSAs were more than twice as likely to board patients for more than two hours in the ED while waiting for an inpatient bed (77.4% versus 32.8%).
- More than one-third of EDs had an observation or clinical decision unit. About a third of EDs used a separate fast track unit for non-urgent care.
- In the previous two years, 24.3% of EDs increased their number of standard treatment spaces, and 19.5% expanded their physical

space. Of those EDs that did not expand their physical space, 31.5% plan to do so within the next two years.

- Zone nursing was employed in 35.3% of EDs. "Pool nurses" that can be pulled to the ED to respond to surges in demand were available in 33.2% of EDs.
- Bedside registration was used in 66.1% of EDs, with 40% using computer-assisted triage. Electronic dashboards were utilized by 35.2% of EDs, and 9.8% used radio frequency identification tracking.

GAO Study Finds ED Crowding Continues

According to a Government Accountability Office (GAO) report released June 1, hospital EDs continue to be overcrowded, with lack of access to inpatient beds continuing as the main contributing factor. The GAO first reported that most emergency departments experienced some degree of crowding in 2003 (*Hospital Emergency Departments: Crowded Conditions Vary among Hospitals and Communities*, GAO-03-460). The GAO was asked to revisit this issue in response to several studies that have associated crowded conditions in EDs with adverse effects on patient quality of care.

The GAO examined three indicators of ED crowding – ambulance diversion, wait times, and patient boarding – along with various factors that contribute to crowding. In doing so, the GAO reviewed national data, conducted a literature review of 197 articles, and interviewed individual subject-matter experts and officials from the Department of Health and Human Services (HHS) and professional and research organizations.

National data showed that about one-fourth of hospitals reported going on ambulance diversion at least once in 2006. According to the GAO's analysis of 2006 data from the HHS's National Center for Health Statistics, average wait times continued to increase, with significant numbers of visits exceeding recommended wait times based on patient acuity levels, as summarized here:

- Patients needing immediate care (recommended maximum wait to see a physician of less than one minute) waited an average of 28 minutes to be seen by a physician. 73.9% of these patients waited longer than the one-minute recommendation.
- Patients with emergent conditions (recommended maximum wait of 14 minutes) waited an average of 37 minutes to see a physician. 50.4% of emergent patients waited longer than 14 minutes.
- Patients with urgent complaints (recommended to be seen within 60 minutes) waited an average of 50 minutes, with 20.7% of patients waiting longer than 60 minutes.
- Semi-urgent conditions (two-hour maximum wait recommended) had an average wait time of 68 minutes, with 13.3% of patients waiting longer than the maximum recommended timeframe.
- Non-urgent patients (24-hour recommended timeframe) had an average wait time of 76 minutes, with no ED reporting wait times to see a physician in excess of 24 hours.

Although national data on patient boarding is limited, the articles reviewed by the GAO and the experts interviewed reported that the practice is a continuing problem due to the lack of access to inpatient beds. In turn, the lack of access to inpatient beds is due to

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the competition for available beds between hospital admissions from the ED and scheduled admissions, such as elective surgeries, that can be more profitable for the hospital.

While the GAO found that studies on solutions to ED crowding are also limited, strategies have been successfully implemented in isolated cases. One solution found in case studies conducted at several hospitals was to streamline elective surgery schedules, thereby increasing the opportunity for ED admissions. Regarding ambulance diversion, some local communities have established policies that make diversion the last resort for any hospital, as it often leads to critical cases not receiving the immediate care they need. Other strategies include the use of on-call physicians to determine the best ambulance destination for each patient or state policy prohibiting hospitals from going on diversion unless under inoperable conditions.

Strategies to decrease ED wait times included increasing the speed with which laboratory results are available, accelerating care during the triage process by eliminating some of the administrative work associated with patients entering the ED, and implementing a system allowing non-urgent patients to be seen by a medical provider other than a physician. However, none of the strategies to address crowding have been assessed on a state or national level.

The GAO found that there are several other frequently reported causes for ED crowding, including a lack of access to primary care; a shortage of available on-call specialists; and difficulties in transferring, admitting, or discharging psychiatric patients. Less commonly cited causes of ED crowding included an aging population, increasing acuity of patients, staff shortages, hospital processes, and financial factors.

For the full report, go to <http://www.gao.gov/new.items/d09347.pdf>.

Recent EMTALA Cases

EMTALA Screening and Stabilization Claims Rejected

On May 28, 2009, the US District Court for the District of Puerto Rico dismissed claims alleging that a hospital and staff failed to examine, stabilize and treat a pregnant woman, thereby causing her to miscarry her pregnancy and later to suffer infertility (*Vázquez-Rivera v. Hospital Episcopal San Lucas, D.P.R.*, No. 08-2223, 5/28/09).

The Facts

Nora Vázquez-Rivera presented on October 27, 2006, at 6:59am at the Hospital Episcopal San Lucas' ED seeking emergency medical attention. Vázquez, sixteen weeks pregnant at the time, complained that she was experiencing vaginal bleeding and severe abdominal pain. A nurse took Vázquez's vital signs and urine and blood samples. Ultrasonography was also performed by a technician who informed Vázquez that "the baby looked fine." No further diagnostic tests or examinations were performed to determine the cause of the bleeding, nor was an attempt made to stop the bleeding.

Still bleeding and suffering from severe abdominal pain, at approximately 5:00pm on that same day, Vázquez was informed that she would be admitted to the hospital maternity ward. Vázquez was told by her regular obstetrician, Dr. Maryrose Concepción-Girón, that she was being admitted to the hospital to determine the cause of her bleeding, but that since Concepción would not be available to treat her, Vázquez would be under the care of Dr. Luis A. Acosta-García.

Vázquez was brought to the maternity ward and left unattended. Early on October 28, 2006, Vázquez suffered a miscarriage. She was treated only by the nursing staff and was not examined by a physician until 6:00pm that day, at which time Acosta informed Vázquez that her condition would require curettage. This procedure was performed the following day, October 29, 2006, and Vázquez was discharged a few hours after the surgery.

In the days following the surgery, Vázquez began to feel ill. She saw another gynecologist who determined that the initial curettage had not removed all the placental and fetal remains. Vázquez had another curettage but acquired a serious, chronic infection requiring several life-threatening surgeries that rendered her sterile.

Nora Vázquez-Rivera and her husband filed suit pursuant to EMTALA, alleging that defendants Hospital San Lucas, Dr. Acosta-García, and Dr. Concepción-Girón failed to adequately screen, stabilize and treat Vázquez's condition. The plaintiff further alleged that as a result of the defendants' negligent acts and omissions, she suffered, and will continue to suffer, the loss of an unborn child, mental anguish, physical suffering and the loss of the ability to procreate. The defendants moved to dismiss the complaint, contending that the plaintiff lacked a viable claim under EMTALA and that Vázquez's supplemental medical malpractice claims should be dismissed for lack of jurisdiction.

The Ruling

While the plaintiff alleged that the hospital's screening was inadequate and that no attempt was made to identify the cause of the plaintiff's bleeding, the federal court found that Vázquez's complaint did not survive a motion to dismiss on the screening requirement. Because the plaintiff did not claim that the "Hospital refused to screen Plaintiff Vázquez or that the screening that the Hospital provided to Plaintiff was inconsistent with regular screening procedures for similarly-situated patients," the court wrote, "...Plaintiffs have failed to state a claim under EMTALA's screening provision upon which relief can be granted."

Regarding the stabilization complaint, the court determined that Vázquez's allegations "satisfy the emergency medical condition element of EMTALA's stabilization requirement," insofar as the ED staff "identified Plaintiff's signs and symptoms as an emergency medical condition." However, the court found that once plaintiff Vázquez was admitted as an inpatient for further treatment, the defendants' statutory duty to stabilize under EMTALA was fulfilled.

For those reasons, the court granted the defendants' motion to dismiss Plaintiff Vázquez's EMTALA claims and refused to exercise supplemental jurisdiction over the plaintiff's claims alleging negligence under Puerto Rico law.

EMTALA: Appropriate Medical Screening Claim

The US District Court for the District of New Jersey on April 15, 2009, ruled that records of other patients presenting to a hospital's ED are relevant to a patient's EMTALA claim that the patient did not receive an "appropriate medical screening examination." The court also granted the plaintiff's motion to compel production of the documents based upon the plaintiff's discovery request (*Gonzalez v. Choudhary, D.N.J.*, No. 08-0076, 4/15/09).

The Facts

On February 1, 2007, plaintiff Grisselle Gonzalez presented to the ED of defendant South Jersey Healthcare Regional Medical Center

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(SJHRMC) seeking treatment for a purported emergency medical condition. Gonzalez reported experiencing chest pain, "rating her chest pain as eight out of 10 in severity and associated with shortness of breath ... neck pain, throat pain, jaw pain, and pain radiating down her arm." Gonzalez was evaluated by a physician, who diagnosed extra-pyramidal symptoms and dystonia. Gonzalez alleged that SJHRMC, failing to perform "adequate cardiac testing" or provide supplemental oxygen, nitroglycerine, or aspirin, discharged her from the ED the same day, only to return two days later "again seeking treatment for a complaint of chest pain, neck pain, throat pain, jaw pain, and pain radiating down her arm."

Maintaining that on February 3 she developed severe difficulty breathing and suffered a cardiac arrest while in the ED triage area, Gonzalez claimed that SJHRMC violated EMTALA by failing to provide her an "appropriate medical screening examination" on February 1 because of her lack of insurance, indigency, appearance, race, gender and/or age." Furthermore, Gonzalez alleged that in addition to providing negligent and reckless care and treatment on February 1, SJHRMC "deviated from appropriate standards of medical care in a manner that purportedly proximately caused injury."

Gonzalez filed a complaint alleging that SJHRMC violated EMTALA when she presented to the ED on February 1, 2007. In the motion considered by the district court, the plaintiff sought to compel SJHRMC to produce redacted medical records of all patients with a chief complaint of chest pain who presented to the ED during a two week period contemporaneous to her February 1 visit to the defendant's ED. The plaintiff asserted that she needed the records to support her claim that defendant failed to provide an "appropriate medical screening examination."

Opposing the motion, the defendant represented that 96 charts fell into the category of documents identified by the plaintiff, but that the records are not discoverable because the plaintiff received from them her February 1, 2007, admission chart. The defendant also contended that the 96 charts were not discoverable because the plaintiff took depositions of the triage nurse and ED physician, at

which time the plaintiff had the opportunity to inquire of the policies and procedures followed when SJHRMC ED physicians see patients.

SJHRMC contended that they had "a number of written policies and procedures, albeit none that specifically addressed the screening of a patient who presented to the ED with a complaint of chest pain." The defendant further disputed the relevancy of the medical records on the grounds that patients do not present to the ED with identical symptoms and that this case is one of "faulty medical screening" rather than a case of "inadequate medical screening."

The Ruling

The court rejected the various arguments offered by the defendant, finding no basis to limit or preclude the plaintiff from obtaining further discovery on the issue. The court, disagreeing with SJHRMC's argument that the medical records are not discoverable because Plaintiff's claim is for "faulty medical screening" rather than an "inadequate medical screening" claim, instead noted that the "same evidence that supports a medical malpractice claim under state law may, in some circumstances, also constitute evidence of differential treatment sufficient to support a claim for failure to give an 'appropriate medical screening' under EMTALA."

Citing federal civil procedure where relevancy is more liberally and broadly construed at the discovery stage than at trial, the federal court determined that, in meeting the EMTALA burden to present evidence that a hospital treated a patient differently than any other patient who came to the ED with similar injuries and symptoms, a plaintiff may look to sources other than the express standard policies of the hospital.

The court also stated that in regard to hospital policies, the defendant produced the hospital's general written policies for screening patients who present to the ED rather than any documents setting forth a particular screening procedure for patients complaining of chest pain. Thus the court found the plaintiff's discovery request seeking medical records of other patients with similar injuries and symptoms presenting at the ED is "relevant to the EMTALA claim for failure to provide an 'appropriate medical screening examination.'"

OTHER REGIONAL NEWS

Missouri's Emergency Medical System is Expanding to Better Treat Trauma, Stroke and STEMI

Samar Muzaffar, MD MPH

Missouri nurses, physicians, paramedics and other emergency medicine specialists will be introducing a new emergency medical system statewide in 2010. The Time Critical Diagnosis (TCD) system uses the trauma system model for emergency treatment of stroke and ST elevation myocardial infarction (STEMI).

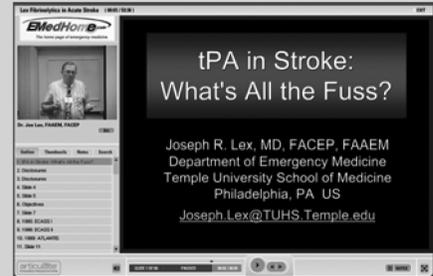
More than 250 medical professionals, healthcare leaders and emergency medical care providers from across the state, including members of the American Academy of Emergency Medicine (AAEM), have been meeting regularly since September 2008 to formulate regulations and guidelines for the TCD system. The regulations are currently in draft form and will go through professional and legal reviews before they are filed with the Secretary of State's Office in 2010.

While the TCD system will be adopted statewide, participation by hospitals is completely voluntary. The regulations will outline standards for centers providing four distinct levels of care for stroke and STEMI patients. Hospitals must meet these standards including staffing, equipment, specialized services and hours of availability to become designated as stroke and STEMI centers.

Health professionals were invited to attend one of six public meetings being held throughout the state in late September and early October 2009. These meetings provided an overview regarding the TCD system and reviewed the key standards being proposed for stroke and STEMI centers. Attendees were encouraged to provide feedback on the draft regulations and to share their thoughts.

For more information, please visit www.dhss.mo.gov/TCD_System/Implementation.html.

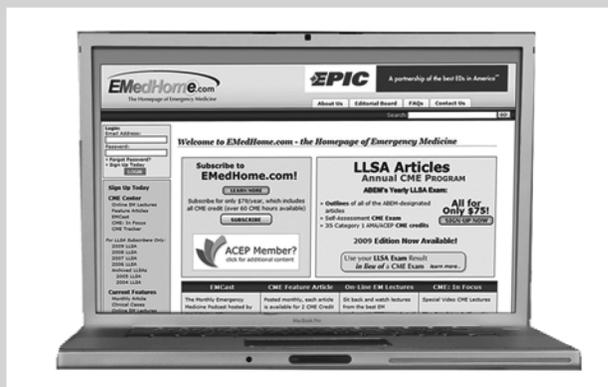
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Before Discount!

Rationing: Four-letter Word or Fact of Life?

Andy Walker, MD FAAEM
AAEM Board of Directors

"The Health Benefits Advisory Committee shall ensure that essential benefits coverage does not lead to rationing of health care."

—from the discussion draft of the House healthcare reform bill written by the Democratic leadership

"The Democrats' plan will increase taxes, raise health care costs and ration care for middle class families."

—from the website of the House Republican leader, John Boehner of Ohio

"We are concerned that some believe that comparative effectiveness could lead to rationing of health care. This is simply not true."

—from a letter to Nancy Pelosi (Speaker of the House of Representatives) and Harry Reid (Majority Leader of the Senate), signed by the American Association of Retired Persons, Blue Cross/Blue Shield Association, the AFL-CIO, the American College of Physicians and others

"A plague o' both your houses."

—the dying Mercutio, in Shakespeare's *Romeo and Juliet*

The debate on healthcare reform has been raging on for months. Political leaders from both parties, from the White House to the Senate to the House of Representatives, have promised that healthcare "reform" does not mean medical care will be rationed. This is completely untrue. Of course medical care will be rationed. It always has been and always will be. It is rationed now, mainly by insurance companies that make it hard for even insured, middle class people to get care. Whoever pays the bills rations the care; and right now most of the bills are paid by insurance companies. These companies have a clear financial incentive to deny care. That (and the cost of the system) is the main reason everybody agrees that our current situation is untenable. The choice we are faced with is not whether care should be rationed or not; the choice is about who does the rationing and how it is accomplished.

Decades ago, when most patients paid for medical care out of pocket, patients rationed their own care. They listened to their physicians, asked questions about risks and benefits, and then made decisions based on what they were willing and able to pay for. People like me who have high-deductible health insurance policies and health savings accounts still do that today.

In countries with single-payer systems like the United Kingdom, Canada and Sweden, taxes pay for nearly all medical care, and care is rationed by the national or provincial government. The government decides on an annual healthcare budget that determines the resources available. The available resources determine how long people have to wait for care, and that has an effect on morbidity and

mortality. Sometimes people die waiting for care. On the other hand, I doubt that emergency physicians in the UK ever see patients like the one I saw in the ED about three weeks ago - severely demented, confined to a nursing home, close to ninety, blind, bedridden and on dialysis. Does anyone think that is a wise use of resources?

Some countries, Switzerland and the Netherlands, for example, have a mix of public and private healthcare. Residents are required to purchase a basic, government-approved plan and then choose whether to purchase additional insurance or pay for additional expenses out of pocket. Premiums for the poor are subsidized by taxes. Obviously, such countries mix government-driven and patient-driven rationing.

If we are going to improve the healthcare system in the United States, much less "fix" it, we have to start with an honest debate. We can argue about which system is best. Some believe we should dramatically reduce the role of the federal government in healthcare and move back towards the free market, combined with basic regulatory reforms that would force insurance companies to go back to competing based on price and customer service rather than patient selection (such reforms would include things like community rating, guaranteed issue and allowing interstate health insurance sales, among others). Some believe we should go to a completely single-payer system, with the efficiencies derived from that sort of arrangement. Some believe we should pick and choose from both models, going for something like the Swiss or Dutch systems. Does anybody argue for the status quo? No matter what your opinion, progress starts with an honest debate that recognizes reality. Medical care is expensive, and there is an infinite demand for "free" care. Medical care has to be rationed; and it will be rationed, one way or another.

We must force our political leaders to face reality and speak honestly or healthcare reform will be yet another disastrous federal boondoggle. Government entities in the US already spend as much on medical care per person as most of Europe does. In fact, they spend more per person than the governments of Japan, Italy and the UK (*The Economist*, June 27-July 3, 2009, p. 75). Medicare goes insolvent in just eight years. The only thing going up faster than the amount of charity care we render in our emergency departments (and our tax burden) is the federal debt. Reality continues to operate whether we believe in it or not, and we ignore it at our country's peril. Communicate with the President, your senators and representatives. Demand an honest debate. Remind them of Ayn Rand's warning, "We can evade reality, but we cannot evade the consequences of evading reality."

AAEM Member Named Honorary Chair of American Cancer Society Event

David Eitel, MD MBA FAAEM, has been chosen as Honorary Chair of the American Cancer Society's Fifth Annual Benefit of Hope Gala to be held November 14, 2009, in York, Pennsylvania. Dr. Eitel, chair of the Operations Management Committee, successfully fought a battle with Enteropathy-Associated T-cell Lymphoma. He is an active emergency physician at Gettysburg Hospital in Gettysburg, Pennsylvania.

The theme for the event will be "An Evening at the White House." Attendees will have the opportunity to sample a state dinner menu and wine pairing developed by former White House Chef Walter Scheib. Further information about reservations or donations can be obtained by contacting Danielle Lavetan at 717-846-2561 or Danielle.Lavetan@cancer.org.

Women in Medicine Interest Group

N. Nounou Taleghani, MD PhD FAAEM, with

Lisa D. Mills, MD FAAEM – Chair, Women in Medicine Interest Group

I received an email in early 2009 that read in part:

*Dear AAEM Members,
Dr. Larry Weiss, AAEM President, and Dr. Lisa Mills, Chair of
AAEM's Women's Interest Group, invite all women members
of AAEM to join the Women's Interest Group.*

I remember thinking (aside from the fact that I am a woman interested in medicine), "what could this group provide for me that I am not already getting from AAEM as a whole?" After all, I have no grievances, no complaints and no hardships as a woman practicing emergency medicine. Isn't that what "interest groups" are? People getting together discussing their mutual problems and trying to make it better?

I signed up to participate in the first conference call thinking, "let me see what this is all about." I was quiet during the first few minutes of the conference call as I listened to other women in emergency medicine talk about what they thought the group mission should be. That is when I heard stories of past experiences of these women. Stories of inequitable and unfair practices, of hardship endured, of the paucity of resources for women entering the field of emergency medicine. With chagrin, I interjected, "But I have never experienced any of these things."

I was lucky enough to be part of a residency training program at an institution where the issue of gender never came up. Sure, I had read stories about the surgeon who had a difficult time getting in the "boy's club," but I honestly cannot remember a single day or a single event where I felt I was not treated fairly because of my gender.

I realized it was those women on the phone that had been the trailblazers, enduring the difficulty and fighting the battles, so the younger generation of women physicians can have it easier, as I had. If this is to continue, we need to pay it forward, be role models and provide the medium for the next generation of young women entering emergency medicine.

To that end, the mission statement of this new group encompasses those goals, and under the leadership of Dr. Mills, we hope to be able to function as a resource for young women entering our field. It is our hope that residency program directors will encourage their residents to join our group, for the power is in numbers.

Contact Dr. Lisa Mills (LMORR11@aol.com) or Kate Filipiak (kfilipiak@aaem.org) for more information. To fill out an online application, you may go to <http://www.aaem.org/committees/application.php>.

Award Nominations Sought for AAEM Awards

Deadline: November 16, 2009 - 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.

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 16, 2009. The AAEM Executive Committee will review the nominees and select recipients for all awards except the EM Program Director of the Year Award (see page 18 for more information), 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 16th Annual Scientific Assembly to be held in Las Vegas, NV, February 15-17, 2010.

Please submit all nominations to:
AAEM
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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 6/24/09 to 9/3/09.

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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Future issues of *Common Sense* will continue to acknowledge the outstanding academic and professional achievements of AAEM members. Please send announcements to be included in this section to info@aaem.org. Submissions will be reviewed for accuracy and appropriateness prior to being accepted for publishing.

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Editor's Letter - continued from page 2

Another strategy that deserves discussion on the national front involves placing limitations on attorney's fees in medical malpractice cases. Various versions of this idea, including both flat and graduated limits, have been proposed, all looking to reduce the incentive for trial lawyers to pursue "jackpot" awards and frivolous lawsuits. Currently, a trial lawyer might look to keep about one third of the total amount awarded to the plaintiff. Putting this in perspective, with a single tort award of \$10 million, a trial lawyer would earn more than an average emergency physician would earn in about 13 years! While attorneys deserve to receive compensation for their work, there must be a reasonable limit to the amount of their clients' awards that they commandeer.

Unlimited tort places a very heavy burden on the healthcare system. The AMA estimates that \$99 to \$179 billion is spent each year on defensive medicine.³ The arguments in favor of tort reform are many and a full discussion is beyond the scope of this editorial. Readers are encouraged to educate themselves thoroughly on

this topic and contact lawmakers now, while the opportunity for change is present. With legislators looking desperately for options to help control costs, tort reform should be a high priority on their agendas. Political motivations, however, may keep tort reform out of major healthcare proposals for the near future. Clearly we need to continue our efforts, both individually and collectively, in educating patients, colleagues, and legislators about the need for tort reform.

1. "Summary Campaign Finance Data Files." *Federal Election Commission Home Page*. Web. 31 Aug. 2009. <<http://www.fec.gov/finance/disclosure/ftpsum.shtml>>.
2. "News Releases." *ATRA: The American Tort Reform Association*. Web. 31 Aug. 2009. <<http://www.atra.org/newsroom/releases.php?id=8405>>.
3. *Medical Liability Reform - NOW!* Publication. Chicago: American Medical Association, 2008. Available online at <<http://www.ama-assn.org/ama/pub/advocacy/current-topics-advocacy/practice-management/medical-liability-reform.shtml>>.

AAEM 2010 Elections

Nomination Deadline: November 16, 2009

Nominations are currently being accepted for the positions of president, vice president, secretary-treasurer and three at-large directors on the AAEM board of directors. Any Academy member may nominate any full voting member for a seat on the board. Self-nominations are also encouraged. In addition, nominations are being sought for the Young Physicians Section (YPS) director position on the AAEM board. Candidates for the YPS director position must be YPS members to be eligible for election.

Elections for the AAEM board of directors will be held at AAEM's 16th Annual Scientific Assembly, February 15-17, 2010, in Las Vegas, NV. Although balloting arrangements will be made for those unable to attend the Assembly, all members are encouraged to hold their votes until the time of the meeting.

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

To nominate yourself or another full voting member for a board position, please complete the nomination form at www.aaem.org/elections/2010nominationform.pdf and send the information listed below to the AAEM office before midnight CST, on November 16, 2009.

1. Name of nominee. Each nominee may have only three individuals as nominators/endorsers.
2. Name of nominee's medical school and year of graduation.
3. Board certification status of nominee, including name of board(s) and year completed.
4. Number of clinical hours worked in the ED 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.
6. Any emergency medicine related business activity in which the nominee has a financial interest.
7. A copy of the nominee's CV.

Candidate statements 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 part of what sets 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 member can be nominated and elected to the AAEM board of directors.

ABEM President Announcement:

AAEM congratulates Debra G. Perina, MD, on assuming the presidency of the American Board of Emergency Medicine (ABEM). Dr. Perina has served ABEM as a Director since 2003.



AAEM President, Larry Weiss, MD FAAEM, speaks on "The Future of Emergency Medicine" at the National Medical Association's Annual Convention & Scientific Assembly on July 26, 2009.

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Upcoming AAEM–Sponsored and Endorsed Conferences for 2009-2010

AAEM is featuring the following upcoming sponsored, endorsed 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

November 4, 2009

- Louisiana State Chapter Annual Meeting and Business Luncheon
New Orleans, LA
www.aaem.org/statechapters/

November 12, 2009

- Delaware Valley AAEM 2009 Residents' Day
Philadelphia, PA
www.aaem.org/statechapters/

February 15-17, 2010

- 16th Annual Scientific Assembly
Las Vegas, NV
www.aaem.org

April 7-8, 2010

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

April 17-18, 2010

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

December 6-11, 2009

- Current Concepts in Emergency Care – 30th Annual
Wailea, HI
www.ieme.com

January 31-February 4, 2010

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

February 1-3, 2010

- The Best Evidence in Emergency Medicine (BEEM)
Kelowna, BC, Canada
www.beemcourse.com

March 7-12, 2010

- NYSORA World Anesthesia Congress (NWAC)
Dubai, UAE
www.nysoraworld.com

May 21-23, 2010

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

June 11-13, 2010

- The Difficult Airway Course-Emergency™
Washington D.C.
www.theairwaysite.com

September 10-12, 2010

- The Difficult Airway Course-Emergency™
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www.theairwaysite.com

October 22-24, 2010

- The Difficult Airway Course-Emergency™
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November 19-21, 2010

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AAEM–Endorsed Conferences

November 13-15, 2009

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

November 15-19, 2009

- ACTION09 – The Annual Scientific Meeting of ACEM
Melbourne, Australia
acem09.eventplanners.com.au/Home/tabid/816/Default.aspx

November 23-26, 2009

- Emergency Medicine in the Developing World Conference – Disaster and Mass Gathering Medicine in a Developing World Setting
Cape Town, South Africa
www.emssa2009.co.za

December 4, 2009

- Utilization of the Emergency Department for Psychiatric Patients: Update on Behavioral emergencies
Chicago, IL
Trena.burke@rosalindfranklin.edu

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

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

AAEM Young Physicians Section

The Second Post-Graduate Year and Beyond; Making Yourself Valuable

Brian Potts, MD MBA FAAEM
YPS Vice President



Last year, I reflected on completing my first year out of residency and provided some advice for new graduates. After making it through that transition phase, our careers move into an important development phase. I'll provide some brief ideas about how recent graduates who are two to three years out of residency might approach this next phase.

Emergency physicians practice in a variety of settings, whether as a partner in a group, an employee in an academic setting, an independent contractor in a locum tenens position, or in a range of other possibilities. Whatever your specific situation, you want to make yourself into a valuable member of your group. What can you do to add value as an employee, partner or faculty member? There are many ways to accomplish this.

In this article, I will focus on the non-clinical aspects of emergency medicine. Clearly, sound clinical skills and good productivity are desirable. A physician with strong clinical skills and a good bedside manner who is efficient (patients per hour, RVUs, or whatever metric you want to use) and works well with the rest of the team will always be seen as a valuable contributor to their group. But, what other activities can compliment this?

Group Management – For any group to operate successfully, it needs individuals who want to be involved in the management of the group. There are many opportunities for this, from executive leadership (chair, CEO, CFO, treasurer) to management (medical director) to committee leadership (quality assurance, peer review, finance, education, risk management). These positions and committees are important for creating a strong group, operationally and financially. Seek out one or two positions in your group as a starting point. As your leadership recognizes your interest, you will likely find yourself being given opportunities to move up the ranks within your group. Groups with a more robust leadership team tend to be more successful and will place a high value on people who contribute.

Hospital Committees – Hospital and medical staff committees are another way to become more involved with your colleagues and benefit your group. Your group will want a strong voice on those committees whose guidelines and decisions can dramatically affect the emergency department. Like many organizations or companies, hospitals can be very “political,” pitting different interests against each other. When budgets are being reviewed, capital improvement decisions are being made, and patient care protocols are being created, you want your group to have representation at the table.

Weak departments or groups that do not have representation on key committees tend to get stepped on by more powerful players. You will be a more valuable part of the group if you become an active and influential member of one of these committees. You can benefit by representing your group, as well as networking and getting to know the hospital leadership and other active members of the medical staff. When push comes to shove, you want these individuals in your corner.

Community Work and Volunteerism – Volunteerism is a very rewarding experience, and the range of opportunities is too wide to mention everything possible. Volunteers get to help out the community where they work and provide education or other assistance. Often, local physicians are asked to help out at community fairs for things like blood pressure screenings or staff an education tent sponsored by the hospital. Other events are looking for speakers to talk about health related topics. Consider taking on a role as the person in your department who helps to coordinate your group's participation in local community events and volunteer activities.

Research and Teaching – Working in a community ED since graduating from residency, I will keep this section short, but that should not minimize its importance. For those of you working in the academic realm, this could be at the top of the list in terms of adding value within your department. Other YPS members involved with academics have written articles providing guidance for young faculty. The best advice I can give is to find a good mentor in your department and figure out a niche that you can investigate and make your own. Be diligent and involve medical students or residents in your plans. You can accomplish more if you work with a good team. The most academically productive people I have seen usually have a good cadre of talent around them.

Public Policy and Organized Medicine – Last but not least, this is an obvious one that I would like to have stick in your mind after reading this article. Seek out a role with your county or state medical association. Meet with public policy makers or other influential organizations and work to benefit your community and local hospitals, as well as your own emergency department. Become more involved in national organizations such as AAEM. Join your state chapter and an AAEM committee. Help guide AAEM's efforts with education and advocacy. If you are a recent graduate, I hope that you continue your membership with AAEM for years to come. Run for a position on the Young Physician Section Board of Directors. You can make a difference, and your group should value and encourage involvement in organized medicine.

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Chief Editors
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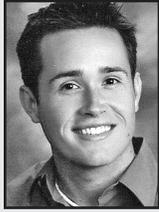
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Resident & Student Association



RESIDENT PRESIDENT'S MESSAGE

Healthcare in America: The Buzzwords of Tomorrow

Michael Ybarra, MD
AAEM/RSA President

As the debate over the future of healthcare rages, the solutions become more and more complex: a public option, a co-op, a medical home. Terms that were foreign to most residents six months ago litter the news today as our potential future.

In this environment, it is hard to know which buzzwords are passing fads and which really are the wave of the future. Like EMTALA and Diagnosis Related Groups (DRGs) were to the physicians of the 1990s, terms such as "medical home" and "comparative effectiveness" are likely to be both driving forces and possibly major headaches for physicians of the future.

The Medical Home

The medical home, sometimes called the patient-centered medical home, is a concept championed by the American Academy of Family Physicians (AAFP) and many policymakers within the Obama administration as one potential solution to the problem of access in the United States. The AAFP, realizing the challenging future that faces family physicians, embraced this concept as part of their Future of Family Medicine Project.¹

The medical home has six pillars and is based on the principle that every person has a personal physician. That physician leads a team of individuals, including specialists, who care for the patient. The personal physician provides all of the patient care up until the point that they need a specialist. The care is coordinated among providers using electronic medical records. Quality and safety are paramount, patients have enhanced access to care, and payment reflects the value of work provided.

This model has been supported by a number of states and has worked its way into the healthcare reform bills navigating through Congress. Critics of the medical home argue for more open access and compare the model to that of an HMO. Many specialty organizations have expressed apprehension about who is considered the specialist or expert. This is of particular interest to emergency physicians – experts in providing emergency care. Residents and practicing physicians should take an active role in evaluating models such as the medical home to understand where we, as specialists in emergency medicine, fit in.

Comparative Effectiveness

Comparative effectiveness is a growing body of funded research that seeks to find the most effective forms of treatment and determine which specific patients would benefit most from those treatments. This body of research is supported by many in the medical community as an effective way to determine quality of care and control costs. Different from clinical trials, which

study the efficacy of a treatment in a controlled environment, this type of research studies the benefit a treatment has in routine clinical practice.²

Critics of comparative effectiveness research (CER) are concerned that the conclusions drawn from these studies will be used to calculate reimbursement from insurance companies and the federal government, much like how Medicare Core Measures affects reimbursement today. Pharmaceutical companies and medical-device manufacturers are particularly skeptical. Others argue that these trials will ultimately limit patient options.

Regardless of the fallout, CER is gaining momentum. The President's \$760 billion stimulus bill that passed Congress earlier this year provides \$1.1 billion for this research.³

Health Insurance Cooperatives

Health insurance cooperatives (co-ops) are gaining in popularity as an alternative to private, for-profit insurance companies as well as a government sponsored public insurance plan. These cooperatives are non-profit and individually governed insurance plans. Individuals buy shares in the co-op and have a vote in electing the group's leaders. A private insurance company must answer to stockholders and investors; in a co-op, the leadership must answer to the members.

Co-ops that currently exist offer insurance plans for a lower rate than private insurance companies because they are non-profit (and therefore do not pass profits on to investors), have low administrative costs and insure a smaller number of people, minimizing risk.

Currently, there are working co-ops; the choices vary, but most offer catastrophic coverage, an HMO and an open-access plan.⁴ Skeptics of this solution argue that co-ops have existed in the US for approximately fifty years and have failed to drive down costs and attract a large number of enrollees. Regardless, the co-op option is on the table and is likely to play a role in the reform bill that passes Congress.

Health Insurance Exchange

Health insurance exchange offers a solution to the complex regulations that govern the market for health insurance. There is no easy way to compare plans side by side, because costs and coverage vary by locality depending on state laws. President Obama has said that any reform bill must have a health insurance exchange.

continued on page 17



Resident & Student Association

Resident President's Message - continued from page 16

An exchange would allow consumers to shop for health insurance much like they do car insurance, or even for plane tickets. A consumer could go to the marketplace and compare the local plans available, seeing the costs and coverages, as well as the government aid available to them. This concept has been compared to travel websites that offer a fast and easy way to understand what options exist when planning a trip. Due to a number of complex federal and state laws, no such marketplace for health insurance exists at this time.

Knowing the nomenclature of healthcare reform is the first step to actively participating in the debate. It is hard to predict the future, but my best guess is these topics will play an important role.

1. <http://www.aafp.org/online/en/home/membership/initiatives/pcmh.html>
2. <http://www.hhs.gov/recovery/programs/cer/index.html>
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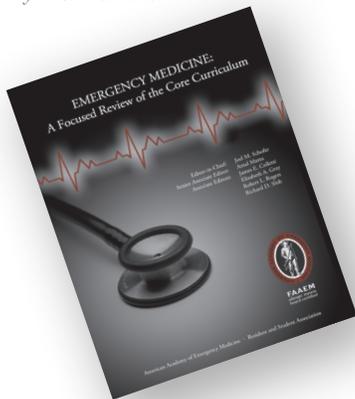
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Scope of Practice

RESIDENT EDITOR'S LETTER

Ryan Shanahan, MD
AAEM/RSA Resident Editor



Board certification and emergency medicine residency training are primary concerns of AAEM. There are those, however, who argue that residency training in some specialties, other than emergency medicine, qualify someone to be proficient in emergency medicine. Certainly, there are physicians practicing in emergency departments across the country who are not board certified. At the very least, their training

has not been geared to ensure and verify their ability to perform the diversity of specific skills necessary to care for the broad spectrum of patients seen in the emergency department. Just today, for example, I sutured a simple laceration as an intern that an upper level internal medicine resident admitted he would have needed help doing.

As a relatively new field, emergency medicine continues to carve out a scope of practice in the wider world of medicine. Some skills had to be included in our practice repertoire from the beginning, such as intubation, laceration repair and defibrillation. Other procedures were not included – appendectomy and colonoscopy, for example. There are other areas where our specialty is actively trying to expand its scope; critical care subspecialty certification and ED procedural sedation are two areas, among many others, where battles continue to be fought between emergency medicine and other specialties.

Inarguably, we are well trained in the acute management of the critically ill patient. Certainly, we can argue that at some residency

programs we spend more time in the ICU than an internal medicine resident. Does this training, though, adequately prepare a residency graduate for fellowship training in critical care medicine and subsequent practice in an ICU? Propofol is an amazing and relatively safe drug - but can we be as expert in its administration as an anesthesiologist? How can we prove to our questioning colleagues that we do, in fact, have the training and ability to safely include these areas in our scope of practice?

The answer, I think, lies in a powerful Residency Review Committee (RRC) and greater standardization of the Emergency Medicine Curriculum. While we all may grumble that the only thing the RRC seems to do is increase our paperwork burden, it is also the group that gives teeth to any argument for expansion of practice. ED ultrasonography used to be one of these fringe areas before the RRC made it a part of the standard curriculum and set minimum requirements for training. Since this change, the field has had much greater success integrating bedside ultrasound into clinical practice in both academic and non-academic practice environments. When other specialties push back against our attempts to integrate an element of their scope of practice into our own, it is not enough to simply say that we can do it; our patients and our status as specialists demand that we prove it. It would be hypocritical to insist on board certification for specialists in our field and require anything less than measured competency as the standard for additions to our scope of practice.

Program Director of the Year Award Nominations Sought

Deadline: November 16, 2009

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 16, 2009, 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 16th Annual Scientific Assembly to be held in Las Vegas, NV, February 15-17, 2010.

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



Resident Journal Review: September-October 2009

Trushar Naik, MD MBA; Michael Yee, MD; Christopher Doty, MD FAAEM; and Amal Mattu MD FAAEM

This is a continuing column providing 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 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 over a two month period. These selections are from papers published in May and June 2009.

Bailitz J, Starr F, Beecroft M, et al. CT should replace three-view radiographs as the initial screening test in patients at high, moderate, and low risk for blunt cervical spine injury: a prospective comparison. J Trauma 2009;66:1605-1609.

Evaluating for cervical spine injuries (CSI) in the emergency department is a common occurrence. Since the publication of the NEXUS criteria and Canadian C-spine rule, much focus has been placed on determining which patients do not need imaging. However, this paper looks to evaluate whether or not the imaging that is typically obtained – three-view radiographs – is sufficient.

This single ED prospective, observational study included 1,505 patients. These subjects (ages 16 and older) presented with blunt cervical trauma and had one or more positive NEXUS criteria. Each patient had both cervical spine radiographs (CSR) and a cervical CT scan (CCT). Readings of each were done by separate, blinded radiology attending physicians. The outcome measure was clinically significant injury (CSI), defined as those requiring operative procedure, halo application and/or rigid collar.

CSIs were present in 78 patients; all were detected by CCT, whereas CSR detected only 18 of these cases (sensitivity 36%). However, it is important to note that not all patients who had cervical radiographs had complete studies. Although not defined by the authors, “adequate studies” were done in only 16 of the 78 patients. CSR still had a false negative rate of 20.5% in these 16 patients. While this paper may suggest that CCTs be performed in all suspected blunt C-spine injury patients, there are obvious disadvantages of CCT including significant costs, radiation (particularly to the thyroid) and potential loss of time and resources in order to perform these studies. This paper does show the inadequacies of three-view CSR, and further studies such as the utility of five-view CSR may need to be done before a change in routine practice can be recommended.

Suzuki T, Distante A, Zizza A, et al. Diagnosis of acute aortic dissection by D-dimer: the international registry of acute aortic dissection substudy on biomarkers (IRAD-BIO) experience. Circulation 2009;119:2702-2707.

Acute aortic dissection (AD) is associated with high morbidity and mortality. Delays in diagnosis can be catastrophic, highlighting the need for a quick, sensitive test to aid in the evaluation of this disease. D-dimer, a breakdown product of fibrin, has been used as a “rule-out” test in low-risk patients for pulmonary embolism (PE) and more recently been reported to have a similar role in acute AD as well.

In this multi-center, prospective substudy, 220 subjects from 14 centers were enrolled; each subject was suspected of having AD within the first 24 hours of symptom onset and was to undergo an imaging test for its evaluation. D-dimer levels were taken at the time of presentation.

Of the 220 patients, there were 87 cases of radiographically-proven AD. These subjects had a mean D-dimer level of 3213 ng/ml (SD +/- 1465) for Type A dissection and 3574 ng/ml (SD +/- 1430) for Type B dissection. This level was higher than those for MI, angina, PE and other diagnoses. Using a cutoff of 500ng/ml, the same as that commonly used for evaluation of PE, D-dimer had a sensitivity of 96.6% and specificity of 46.6%. The negative likelihood ratio was 0.07 and negative predictive value was 95%.

This study suggests that D-dimer is useful as a rule-out test given its high sensitivity in AD. Limitations included the small sample size and non-defined criteria for suspicion of disease. Notably, funding for this study was provided by Biosite, the maker of the D-dimer test used in these centers. It was also not specified what type of assay was used. With these items in mind, D-dimer testing in suspected aortic dissection may have a role as a rule-out test. Further studies are needed to reproduce and validate these results before routine use in the ED.

Lim SH, Anantharaman V, Teo WS, et al. Slow infusion of calcium channel blockers compared with intravenous adenosine in the emergency treatment of supraventricular tachycardia. Resuscitation. May 2009;80(5):523-528.

For nearly two decades, adenosine has been considered the drug of choice for the management of supraventricular tachycardia (SVT). Prior to this time, intravenous bolus verapamil was used frequently; however, its role was diminished due to concern over significant hypotension. Few authors have examined slow infusions of calcium channel blockers for treatment of SVT. The authors of this study sought to examine the safety and efficacy of slow infusion of calcium channel blockers as compared to adenosine for SVT.

In this prospective RCT, 206 patients age 10 or older were enrolled, after excluding unstable patients, pregnant patients and those in rhythms other than SVT. Adenosine (6mg then 12mg) was compared against verapamil (1 mg/min) and diltiazem (2.5 mg/min) given as intravenous infusion. Drips were discontinued when conversion to sinus rhythm occurred. Vitals were recorded every two minutes along with total doses of medications and times to conversion.

Patients receiving verapamil and diltiazem were significantly more likely to convert to sinus rhythm than patients receiving adenosine (97.9% and 98.1% vs. 86.5%, respectively). Mean post-conversion BP change for verapamil and diltiazem was -13.0/-8.0 mmHg and -7.1/-9.4 mmHg, respectively, while there was no change in blood pressure for the adenosine group. The total doses of verapamil and diltiazem needed to convert 75% of patients was 7.69 mg and 18.13 mg, respectively. In 66.3% of patients given adenosine, conversion occurred with the first 6 mg push. One patient in the verapamil group

continued on page 20



Resident Journal Review - continued from page 19

developed hypotension (122/81 to 74/61 after 7.5 mg infusion) requiring synchronized cardioversion; however, none of the other groups had any significant complication.

In this study, calcium channel blockers were more efficacious in converting SVT to sinus rhythm after a short intravenous infusion compared to adenosine. Blood pressure significantly decreased in these groups; however, only one patient developed significant hypotension. Slow infusion of CCB may in fact be safely used as a first line agent in the management of SVT with low risk of causing significant hypotension.

Plint AC, Johnson DW, Patel H, et al. Epinephrine and dexamethasone in children with bronchiolitis. NEJM 2009; 360:2079-2089.

Bronchiolitis in infancy is the most common acute infection of the lower respiratory tract. Typically caused by RSV, patients may present with rhinorrhea, cough, wheezing, respiratory distress and hypoxemia. Treatment for bronchiolitis has largely been with bronchodilators and corticosteroids, but neither has been routinely recommended. Nebulized beta-agonists have failed to show any consistent benefit whereas nebulized epinephrine has been suggested to decrease clinical symptoms.

In this double-blinded, placebo-controlled study, 800 infants (ages 6 weeks - 12 months) who presented with bronchiolitis were enrolled from eight Canadian pediatric EDs. Each was randomized to one of four groups: group one received two nebulized epinephrine treatments (3ml 1:1000 solution) in the ED and six days of oral dexamethasone (1mg/kg in the ED and then 0.6mg/kg daily for five additional days at home); group two received nebulized epinephrine and six treatments of oral placebo; group three received nebulized placebo and oral dexamethasone; group four received nebulized placebo and oral placebo. Primary outcome was hospital admission by day seven after enrollment.

Of the subjects in group one, 17.1% were admitted in the first seven days; in group two, 23.7% were admitted; group three, 25.6%; and group four, 26.4%. The relative risk of admission for group one compared to group four was 0.65 (95% CI, unadjusted 0.45-0.95, adjusted 0.41-1.03). No significant risk reduction was seen for infants in the epinephrine-alone or the dexamethasone-alone groups.

The authors suggest there is a synergistic effect between epinephrine and dexamethasone in infants with bronchiolitis. If using the unadjusted confidence interval, the NNT would be 11 to prevent one subsequent admission. However, the adjusted confidence interval just crosses 1.0, indicating a lack of statistical significance. Nonetheless, there was a trend towards benefit. Further study may show a more definitive role for epinephrine and dexamethasone in the treatment of bronchiolitis, especially considering the relative safety of the treatments and the potential benefits for the patient.

Annane D, Bellissant E, Bollaert PE, et al. Corticosteroids in the treatment of severe sepsis and septic shock in adults: a systematic review. JAMA. Jun 10 2009;301(22):2362-2375.

The use of corticosteroids in severe sepsis and septic shock has long been a subject of debate and uncertainty. Many authors have studied the topic with various patient populations, preparations, doses and lengths of treatment. The authors of this study performed a systematic review to attempt to find a more conclusive answer to the role of corticosteroids in sepsis.

The authors conducted a structured search of the literature, along with a hand search of reference lists and communications with authors when necessary. Only randomized or quasi-randomized trials (systematic method) were included, with or without blinding. Doses less than 300mg hydrocortisone/day (or steroid equivalent) were considered low doses. Courses of therapy lasting longer than five days were considered long courses. Control interventions included standard therapy or placebo. The primary outcome was 28 day all-cause mortality. Secondary outcomes included ICU and hospital mortality, length of stay, shock reversal and adverse events. After applying search criteria, 22 studies were included.

Analyzing data from 17 randomized trials (n=2138), 28 day all-cause mortality was not shown to be significantly different among those patients treated with corticosteroids versus control (35.3% vs. 38.5%). This finding was also true for quasi-randomized trials. Subgroup analysis of 12 randomized trials investigating prolonged low-dose corticosteroids found a significant benefit in 28 day mortality (37.5% vs. 44.1%). The prolonged low dose corticosteroid subgroup also showed decreased ICU LOS by 4.49 days and increased shock reversal by day seven. Despite higher rates of hyperglycemia and hypernatremia, the other studied adverse events, GI bleeding, superinfections, and neuromuscular weakness, were not found to be higher in the corticosteroid group.

For the studies included in this systematic review and meta-analysis, corticosteroid therapy did not show a clear mortality benefit when data from all preparations, doses, and lengths of treatment were aggregated. However, for prolonged low-dose corticosteroids (which has been the predominant treatment modality used in the past decade) corticosteroids did in fact show significant decreases in mortality and ICU LOS with an increased rate of shock reversal. Significant adverse events were not increased. This analysis provides clarity to the role of corticosteroids in severe sepsis and septic shock. Prolonged, low dose corticosteroids therapy has a more solidified role in decreasing the mortality of this morbid condition.

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STUDENT PRESIDENT'S MESSAGE

Jamie "Akiva" Kahn

President, AAEM/RSA Medical Student Council



We are in the midst of potential policy change from the current White House administration. If you have had your head in the books or been living in the hospital and haven't been following the news, here's a quick brief to catch you up!

Perhaps the most visible sign of the need for healthcare reform is that 46 million Americans are currently without health insurance. The

Council of Economic Advisors' projections suggest that this number will rise to about 72 million by 2040 in the absence of reform. Their study of the current system leads to a focus on two key components of successful healthcare reform: 1) genuine containment of growth rate of healthcare costs, and 2) expansion of insurance coverage.

Progress:

Children's Health Insurance Program Reauthorization Act – Signed into law on February 4, 2009, this act reauthorizes the State Children's Health Insurance Program (SCHIP) through 2013. It also expands the program, enabling states to enroll an additional 11 million children in the program.

American Recovery and Reinvestment Act – Among a wide variety of spending provisions and tax cuts, this legislation temporarily provides a 65% COBRA subsidy aimed at making health coverage more affordable to those Americans who lose their jobs. This act approves expenditure of over \$19 billion in computerized medical records with the hope of reducing costs and improving quality while ensuring patient privacy. Additionally, it provides \$1 billion in funding for prevention and wellness programs to improve America's health and reduce long-term costs, \$10 billion in funding for NIH research and facilities, and \$500 million to address shortages by training primary healthcare providers including physicians, dentists and nurses.

Administration's Aspirations:

- Reduce long-term growth of healthcare costs for businesses and government.
- Protect families from bankruptcy or debt because of healthcare costs.
- Guarantee choice of doctors and health plans.
- Invest in prevention and wellness.
- Improve patient safety and quality of care.
- Assure affordable, quality health coverage for all Americans.
- Maintain coverage when you change or lose your job.
- End barriers to coverage for people with pre-existing medical conditions.

The Administration believes their proposals will adjust incentives so that the best, not the most expensive, care is provided to patients. In order to accomplish this, they want to create the "MedPAC Program" comprised of an independent group of physicians and medical experts empowered to eliminate waste and inefficiency in Medicare.

Potential Problems:

There are definite concerns regarding the proposed reform. Mention of tort reform is completely absent, leading to concerns that overall expenses within the industry will not be decreased. Potential Medicare cuts threaten to further reduce physician reimbursement. Using Massachusetts as a potential example for the nation's future, some feel that there may be a redistribution of funds without reduction of costs. According to the Chairman of the Department of Emergency Medicine of Boston Medical Center and Boston University School of Medicine, Dr. Jon Olshaker, "the challenge that Massachusetts is facing is that the program is underfunded, reimbursing only 60-70% of the cost of care for the patient. Therefore, many hospitals and physicians won't accept patients with the insurance since they will lose money. The program, Commonwealth Care, removes previous subsidies to hospitals such as Boston Medical Center that previously helped care for the underinsured population, but since the state insurance also doesn't fully cover the patient, there is a huge gap. This, coupled with cuts in Medicaid, make delivery of affordable care to patients, extremely difficult for hospitals." Recent data out of Massachusetts suggests that patient volume in emergency departments is increasing. The assumption that people will go to their primary care provider (PCP) instead seems inaccurate, especially since there is a shortage of PCP's to cover all of these additional patients. Additionally, the state still has an uninsured population, which on a national level would still be extensive due to undocumented workers who would not be covered by their employer.

So what happens next? Medical students, go back to rounding and studying. Sleep when you can, eat when you can, and read the news...when you can.

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1. http://www.whitehouse.gov/issues/health_care/
2. <http://www.slate.com/id/2220222/>
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The deadline for submissions for the Call for Photos, Call for Morbidity and Mortality Cases and The AAEM/JEM Resident and Student Competition is November 6, 2009.