



FAAEM
always means
board certified

SENSE

THE NEWSLETTER OF THE AMERICAN ACADEMY OF EMERGENCY MEDICINE



PRESIDENT'S MESSAGE

Our Role in Organized Medicine

Larry D. Weiss, MD JD FAAEM

While AAEM advocates vigorously for individual emergency physicians and our patients, some issues affect all physicians and require the concerted action of physicians from all specialties. Some obvious current examples include the various health care reform proposals under debate in Congress, the continued use of Medicare's sustainable growth rate (SGR) formula for physician reimbursement, and the consequences of our aberrant tort system. Existing in isolation, no specialty society can resolve these issues. Only through coordinated efforts of all of organized medicine may we even attempt to participate in the resolution of problems facing the entire medical profession and our patients.

The American Medical Association (AMA), though experiencing a steadily declining membership, still forms the largest association of physicians and attempts to advocate for all physicians in the United States. The AMA plays a central advocacy role in most of the important issues of general relevance to physicians. Even though the AMA recently lowered the threshold for specialty societies to enter their House of Delegates (HOD), AAEM still does not qualify for a seat because too few of our members belong to the AMA.

Over the past several years, I spoke with many of our members about the AMA. Some members told me they quit the AMA because they disagreed with the AMA's position on specific issues. Quite a few of our members told me the AMA was too reactionary, while others complained the AMA was too progressive. Regardless of our individual views on specific issues, we must all recognize the primacy of the AMA in representing our profession. If you do not like the way the AMA represents your profession, then you should become more involved in the AMA and its component societies. If you do not currently belong to the AMA, your disagreement with any of their stated positions should compel you to join the AMA. Why allow others to represent your profession, and why not express your opinions to your county and state medical societies as well as the AMA?

Indeed, I became far more involved in my county and state medical societies when I became dissatisfied with

the performance of my state medical society. I served each year as a delegate to the state house of delegates, presented many resolutions in support of individual practice rights, and openly expressed my opinions in a highly democratic forum. During this process, I worked closely with physicians from a number of other specialties who I came to admire and respect. When issues of importance to emergency medicine arose, many physicians from other specialties supported us because we supported them in their times of need. Through my involvement in my county and state medical societies, I became increasingly involved in AMA activities, especially the annual visits each March to Capitol Hill.

Some of our members also belong to the National Medical Association (NMA), thereby maintaining their link with general organized medicine. Initially founded to represent minority physicians, the NMA warmly welcomes all physicians and consistently represents progressive interests of physicians and patients. The NMA has a large and dynamic emergency medicine section which maintains a prominent position in the NMA. Our members who maintain their membership in the NMA also serve as a vital link between AAEM and general organized medicine. The NMA consistently recognizes the importance of AAEM by inviting the AAEM president to deliver an address at its annual meeting.

However, emergency physicians still have a relative lack of involvement in organized medicine. We must end this lack of involvement. By remaining on the sidelines, we cannot hope to generate much support for the issues that primarily impact emergency medicine. Without having a seat on the AMA's HOD, how can we possibly gather support from other physicians regarding the issues that threaten emergency medicine? Even though AAEM lacks a formal presence in the HOD, the AMA Litigation Center lent a sympathetic ear to our current corporate practice of medicine (CPOM) case and provided an amicus brief on our behalf through the Texas Medical Association.

Yes, the AMA has a consistent record of opposing the lay ownership of medical practices. The AMA strongly supports due process rights for physicians and generally

INSIDE THIS ISSUE

- 1 President's Message
- 3 International Emergency Medicine
- 5 Washington Watch
- 7 AAEM Activities
- 11 AAEM Sponsored & Endorsed Conferences
- 12 State Chapters
- 15 AAEM Committee Update
- 17 Young Physicians Section
- 20 AAEM/RSA Activities
- 27 Job Bank

continued on page 3



Editor's Letter

David D. Vega, MD FAAEM

The State Perspective

Recently, in Pennsylvania, the Medical Care Availability and Reduction of Error (Mcare) fund was raided to help balance the state budget. Mcare was created in 2002 as a special fund within the State Treasury to pay damages awarded in medical liability actions in excess of required basic insurance coverage.¹ The money in this fund comes from special assessments on physicians and other health care providers. By vote of the Pennsylvania legislature, despite many protests from providers and physician organizations, \$100 million was diverted from this fund to balance the state budget.

Issues like this are certainly not unique to Pennsylvania. In Michigan, legislators recently considered an unfair "doctor tax" on physician revenues (see page 15 for details). At the same time, the American Board of Physician Specialties (ABPS) has mounted a multi-state campaign to have physicians without emergency medicine residency training recognized as board certified in emergency medicine. A multitude of other issues requiring physician advocacy exist in various states. To help draw additional attention to these state-based issues, *Common Sense* will be featuring regular articles from its state chapters.

Though national health care issues may garner a great deal of our interest, each of us must remain vigilant of the battles being played out in our home states. AAEM's members help to serve as the eyes and ears of the organization for local, state and regional events affecting the practice of emergency medicine. With early notice from members about potential issues, AAEM is better able to take quick action in support of the board certified specialist in emergency medicine.

1. Medical Care Availability and Reduction of Error Fund. Pennsylvania Insurance Department, 1 Mar. 2008. <http://www.mcare.state.pa.us/mclrf/lib/mclrf/about_mcare_as_of_3.1.08.pdf>. Accessed Dec. 6, 2009.



Officers

Larry D. Weiss, MD JD
President
Howard Blumstein, MD
Vice President
William T. Durkin Jr., MD MBA
Secretary-Treasurer
Tom Scaletta, MD
Immediate Past President
Joseph Wood, MD JD
Past Presidents Council
Representative

Board Members

Kevin Beier, MD
Christopher Lee, MD
Andrew Mayer, MD
Lisa D. Mills, MD
Mark Reiter, MD MBA
Indrani Sheridan, MD
Andy Walker, MD
Joanne Williams, MD

YPS Director — David D. Vega, MD

AAEM/RSA President 2009-2010

Michael Ybarra, MD

JEM Editor — Ex-Officio Board Member

Stephen R. Hayden, MD

Common Sense Editors

David D. Vega, MD, Editor
Ryan Shanahan, MD, Resident Editor
Jody Bath, Managing Editor

Articles appearing in *Common Sense* are intended for the individual use of AAEM members. They may not be duplicated or distributed without the explicit permission of AAEM. Permission is granted in some instances in the interest of public education. Requests for reprints should be directed to Jody Bath, Managing Editor, at: AAEM, 555 East Wells Street, Suite 1100, Milwaukee, WI 53202, Tel: (800) 884-2236, Fax: (414) 276-3349, Email: jbath@aaem.org.

AAEM Mission Statement

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

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

Membership Information

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

*Associate Member: \$250

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

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

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

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

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

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

Send check or money order to : AAEM, 555 East Wells Street,
Suite 1100, Milwaukee, WI 53202

Tel: (800) 884-2236, Fax (414) 276-3349, Email: info@aaem.org.

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

Announcement: Formation of the African Federation for Emergency Medicine

“Supporting Emergency Care Across Africa”

Cape Town, South Africa, November 26, 2009

We are proud to announce the formation of the African Federation for Emergency Medicine (AFEM), dedicated to “Supporting Emergency Care Across Africa.” Lee Wallis, President of the Emergency Medicine Society for South Africa (EMSSA), organized several meetings on this and other topics during the 2nd EMSSA “EM in the Developing World” Conference, held from 24-26 November, 2009, at the Cape Town International Conference Centre. The AFEM will act as a formative “umbrella” organization for all the existing and future African National EM Societies. EMSSA is the largest national EM Society in Africa, but many more are in the early stages or are on the brink of formation, including Botswana, Ghana, Kenya, Ethiopia and others. AFEM is also proud to announce that they will accept as full members and/or member societies other health professionals and health professional societies, including EM nursing, EMT’s and paramedics, in recognition of the multi-lateral, multi-disciplinary, multi-professional nature of emergency medicine and acute care. The conference also saw the official formation of the Emergency Nursing Society of South Africa (ENSSA), as an equal-member subgroup of EMSSA, as a further reflection of our natural partnership with the specialty of emergency nursing. The current AFEM interim executive committee of nine elected persons will determine over the oncoming months the ultimate structure of AFEM; five initial committees (Identity, Governance, Membership, Terms of Reference and Services) were formed to assist in this most crucial phase.

The interim executive committee is:

Chair – Lee Wallis

Vice Chair – Conrad Buckle

Secretary – Charles Otieno

Officers – Petra Brysiewicz, Bob Corder, Heike Geduld, Steve Justus, Valerie Krym, Hein Lamprecht, Terry Mulligan, Sebastian Spencer

Also announced at the EMSSA conference during these same talks was the formation of the *African Journal of Emergency Medicine*, a peer-reviewed, indexed journal to be dedicated to clinical, academic and developmental aspects of emergency medicine in the many and varied nations of Africa and elsewhere in the developing world. While the exact details of this journal and the plans for its ultimate structure remain in the planning stages, we are proud to announce this new addition to the growing family of academic and scientific emergency medicine journals.

We welcome the advice and participation of our colleagues in emergency medicine, emergency nursing, pre-hospital emergency care and in all areas of acute care and emergency medicine to join with us and to assist us in the formation of this monumental organization, and we look forward to your active membership in the months and years to come.

For more information, or if you have questions/comments, please contact admin@afem.info or visit www.afem.info.

President’s Message - continued from page 1

opposes unfair restrictive covenants. The AMA has a long history of strongly supporting medical schools, as well as residency training and continuing medical education. Perhaps the AMA now has a more progressive position on a number of social issues including alcohol, drug and tobacco abuse, as well as tort reform, universal health care coverage, and the professional rights of women and minorities. Your national advocacy organization deserves your support. If you disagree, then you should join so that you may help represent your opinions in the “house of medicine.”

Our adversaries do not quibble over nuances, as 100% of all attorneys in almost every state belong to their state bar associations. The American Association for Justice, the newly renamed national plaintiff attorney organization, and their state component societies, far outspend medical societies in issues of importance to their membership. We must realize the obvious reasons why the plaintiff bar can lobby in a far more effective way, because most physicians remain uninvolved in organized medicine. We cannot afford the luxury of uninvolvedness.

The same issues that motivated you to join AAEM should also motivate you to either join or maintain your membership in the AMA. In the near future, you may see a routine question on our membership forms simply asking whether you belong to the AMA. If you belong, please designate AAEM as your specialty society. In that way, perhaps we will soon qualify for a seat on the AMA HOD and your concerns will be heard in a loud and clear manner before the entire house of medicine.

Member Opportunity

AAEM announces the reformation of its

Legal Committee



This committee will be directly involved with
AAEM legal advocacy issues. Members with an interest
in serving on this committee should send an email
with contact information to

info@aaem.org

The Coldest Summer I Ever Spent

Kenneth V. Iserson, MD MBA FAAEM
Professor Emeritus, The University of Arizona

Going south generally means, for most people, a chance to get warmer. Going way, way south, however, produces a much different climatologic experience. That's what I'm finding in my newest "international" medical practice in Antarctica, or specifically, McMurdo Station on the Ross Ice Shelf, where I will be from August 2009 through late February 2010.

As the main U.S. scientific base and the staging area for U.S., New Zealand and Italian Antarctic scientific teams, McMurdo is a bustling town. At its annual peak, it has a population of more than 1,100 scientists and support personnel. Nearly everyone, including the science community, is involved in potentially dangerous activities, many involving heavy machinery. For example, as I write this, we have crews preparing the "Ice Runway" used to land the enormous Air Force C-17 and smaller C-130 aircraft that deliver people and supplies to us. The runways are built on the permanent ice lying over the Southern Ocean several miles distant from the Station – and from solid land.

I arrived in mid-August at the end of the Antarctic winter, on the first of four WinFly (Winter Fly-In) flights. Although it is the end of the winter here, it was about -80° F windchill. White, white everywhere; and, of course, blowing snow. It hasn't warmed up much since my arrival. We've been at Condition Two now for nearly 24 hours. Condition two is observed when any one of the following is true:

- Wind speed is greater than 48 knots but less than or equal to 55 knots (a knot is 1.15 miles/hour), OR
- Visibility is greater than 100 feet but less than or equal to 1/4 mile, OR
- Windchill temperature is greater than -100°F but less than or equal to -75°F.

We are usually at Condition Three; better weather than listed above. However, after we landed, and several times since then, it has been Condition Two. It was Condition One (worse weather) for a very short period, but we expect to see more of it in the coming weeks. By the way, if the windchill is above -50°F, it isn't too bad—unless it's blowing directly at you.

My patients are what you might find in a small, isolated town with heavy industry and an unforgiving climate. "Crud," the URI that pervades the station, is a constant. While attempts have been made to find the infectious agent or, at least, to stop the spread, neither has been highly effective. Our big concern this year is to prevent both influenza and GI virus epidemics. We have administered seasonal flu shots (the Southern Hemisphere variety) to everyone as they transited New Zealand on their way to the Ice. As soon as the H1N1 vaccine is available, we'll inoculate everyone. As my infectious disease colleagues describe it, a comparable model to us is a refugee camp; lots of folks eating, sleeping and working together in a small closed environment. And, with Norovirus raising its ugly head in New Zealand, we are doing our best to contain any GI outbreaks.

As a result of the heavy emphasis on safety, both at work and during recreation, injuries are much less common than might be expected. Cold injuries (other than just being reallllly cold at times) are uncommon, as are industrial accidents. Of course, when any injury occurs, our location alone means that the management can be very difficult.

The logistics of getting someone off the Ice to our nearest referral facility in Christchurch, New Zealand, can be daunting. The flight itself takes between five hours (C-17 aircraft) and eight hours (C-130) once the plane is here and ready to fly. At present (early September), no aircraft are scheduled to make an appearance for nearly a month. If we desperately need a MedEvac, the plane will either have to come from Hickam Air Force Base in Hawaii or be sent by the New Zealand Air Force. They, of course, would take many hours to days to arrive. That makes McMurdo a prime example of remote medicine.

Most colleagues ask about our personnel and facilities/equipment. At present, I am the only physician. We also have a physician assistant, dentist, physical therapist (who is very busy) and medical technologist. Note that we don't have an X-ray tech until the end of this month, so we are taking our own (very good, if I do say so myself) radiographs. Two other physicians (one a flight doc) and two flight nurses will appear in the next month or so. We also, especially if a mass casualty situation occurs, rely on our fire department (three paramedics), search and rescue team, and our mass casualty incident augmentees: the various other personnel around the station with a medical background. Many people with excess education take any available job to get down here. Our janitor, for example, is a new RN.

Our medical building has three inpatient beds, four ED beds, a physical therapy room, X-ray suite, lab, dental clinic, hyperbaric chamber, pharmacy, various offices and storerooms; even a kitchen and a bed to sleep in when caring for an inpatient. With no pharmacist, we also do that job, keeping track of medications, printing labels and controlling narcotics. The hyperbaric chamber is for diving accidents. Yes, there is an active research dive schedule that begins next week. Luckily, the very experienced dive director is also a chamber operator.

But everything is not work. The food is excellent! We have professional chefs that make a wide variety of dishes out of what is available. The biggest lack is "freshies," or fresh fruits and vegetables. But the soups are amazing, as are the baked goods offered at every meal. Recreation is abundant. There are far more scheduled activities available every evening than anyone could handle. These include games at one of the two gyms, stargazing (I'm going tomorrow night to possibly see an aurora), and a multitude of classes. That doesn't include the hiking (I've been to Scott's hut), trips (I observed the annual night C-17 landing on the Ice Runway), special dinners (our team is going to the New Zealand base tonight), individual games, unusual movies, reading in the comfortable library, watching a DVD from the loan section of the store, and socializing in the two bars and one coffeehouse.

So, what is medical practice in Antarctica, or at least McMurdo Station, like? Exciting, very personal, and if you think about it too long, like doctoring while standing on your head in a freezer. Of note is that I found this position through an ad in this newsletter!

I'm continuing to document my Antarctic adventure as well as my other international and disaster medical experiences on my blog: www.international-disaster-med.blogspot.com. Enjoy!

It's Not Over until It's Over: Reconsideration Denied

Kathleen Ream, Director of Government Affairs

An August 2009 decision by the U.S. District Court for the Northern District of West Virginia granted in part and denied in part the defendant's motion for summary judgment of claims, brought by a driver involved in a racetrack accident, alleging that a hospital violated EMTALA screening and stabilization requirements (*Ramonas v. West Virginia University Hospital-East*, N.D. W.Va., No. 3:08-cv-136, 8/7/09). Following the August decision, plaintiff George Ramonas submitted a motion to the federal district court seeking reconsideration of the portion of the court's decision in which summary judgment was granted in favor of defendant Jefferson Memorial Hospital (JMH). On October 13, 2009, the court denied plaintiff's motion to reconsider and affirmed its August order granting in part and denying in part the defendant's motion for summary judgment (*Ramonas v. West Virginia University Hospitals-East*, N.D. W.Va., No. 3:08-cv-136, 10/13/09).

In examining all the relevant facts and applicable standards for disposition of EMTALA cases, the court iterated in no uncertain terms that plaintiff's claims fell short. The court decision carefully describes the plaintiff's flaws in reasoning, and even suggests better logic as demonstrated by the following excerpt regarding the plaintiff urging the court to reconsider its ruling that no disparate treatment has been established:

"...EMTALA's requirement that individuals seeking emergency care receive an 'appropriate screening examination' obligates hospitals to 'apply uniform screening procedures to all individuals coming to the emergency room'...Here, the plaintiff attempts to assert a violation of this requirement by alleging that Ramonas received less screening, both in quantity and quality, than required by JHM's own policies rather than comparing it to those other patients presenting these same medical conditions. A more properly stated claim under EMTALA's screening provision would follow as such: Ramonas received less treatment than 'other patients presenting in this same medical condition,' which would invoke the language of disparate treatment, the linchpin of an EMTALA claim. The argument runs essentially as follows: Ramonas arrived at the emergency room with 'severe' pain; patients who suffer from such severe pain normally undergo diagnostic testing for internal injury; because Ramonas received only pain treatment and not testing for internal injuries, he was treated disparately from other individuals presenting in the same medical condition."

Texas District Court Dismisses Inappropriate Screening and Transfer Claims

On June 16, 2009, the U.S. District Court for the Southern District of Texas found that a hospital did not violate EMTALA in handling a boy treated and later transferred by the hospital's emergency department (*Guzman v. Memorial Hermann Hospital System*, S.D. Tex., No. 4:07-cv-3973, 6/16/09).

The Facts

Feeling ill on February 12, 2006, seven year old Tristan was taken to the ED at Memorial Hermann in Houston, Texas, by his mother, Wendy Guzman. Arriving at the hospital at 7:39 a.m., they were taken to the triage area. Guzman reported that her son had vomited during the night and had been running a fever. The triage nurse recorded the child's temperature as 98.1 degrees, his blood pressure as 110/67, and his heart rate as 145. Under Memorial Hermann policy, all pediatric patients with a heart rate above 140 are categorized as

Emergent Level 2 and must be seen by a physician. In accordance with this policy, the nurse took the child to an examination room to be seen by Dr. Haynes.

At 8:00 a.m., Haynes first took Tristan's medical history, learning that the boy had been coughing, vomiting and complaining of nausea. Haynes examined Tristan, determining that the child was "clinically stable and his saturation on room air was normal. He had clear breath sounds bilaterally, had no retractions, was in no respiratory distress."

Believing that Tristan likely had a virus, Haynes ordered several laboratory tests, including a complete blood count (CBC). Since the automated processor for the CBC had generated an abnormality flag, a manual white blood cell differential test was required. Although the manual test results were available by 9:35 a.m., Haynes did not see them that day. Haynes did check on Tristan, ensuring that he was getting fluids and everything he needed. Haynes also was told that the Guzmanns were interested in going home, wanted to know their son's lab values, and what the doctor planned. By 9:58 a.m., Tristan's heart rate had decreased to 105-110, leading Haynes to believe the earlier elevated heart rate had been caused by an inhaler treatment or slight dehydration from vomiting. Absent knowing the white blood cell differential test results, Haynes diagnosed viral syndrome. Haynes made the decision to discharge, and Tristan was released from the hospital at approximately 10:15 a.m.

Upon discharge, Haynes told the Guzmanns that their son's condition should begin to improve within 24 hours but to return to the ED if it did not. The Guzmanns brought their son back to the Memorial Hermann ED the following morning, February 13, 2006, arriving around 7:00 a.m. Tristan was complaining of fever, abdominal and chest pain, was vomiting, and had diarrhea. Classified again as Emergent Level 2, Tristan was placed in an exam room. Dr. Mohammed Siddiqi performed a physical examination, ordering laboratory tests and a chest X-ray. After examining the test results, Siddiqi diagnosed Tristan with pneumonia around 9:45 a.m.

Tristan's condition worsened. At 11:23 a.m., Siddiqi ordered Tristan transferred to the pediatric intensive care unit. At 12:03 p.m., with a pulse of 148, blood pressure at 85/62, and respiratory rate of 48, Siddiqi first suspected that Tristan may have sepsis. At 12:30 p.m., Memorial Hermann Children's accepted the transfer request but indicated that a "Response in 30 min." would not occur due to the "Extenuating Circumstance" of "Bed Control." By 1:00 p.m., however, the child's pulse was 162, his respiratory rate was 62, and his temperature was 99.1 degrees. Twenty minutes later, Siddiqi came to re-evaluate Tristan and discuss the transfer process with the Guzmanns. Deciding at 1:35 p.m. that Tristan needed to be intubated to protect his airway and respiratory system, Siddiqi "thoroughly explained [the] need for intubation to [the] patient's parents, who verbalize[d] understanding."

Shortly thereafter, Siddiqi spoke with Dr. Erickson at Memorial Hermann Children's Hospital, who told Siddiqi that he would first have to prepare a bed in the pediatric ICU. Erickson also told Dr. Siddiqi that he wanted the child to be transported by the Memorial Hermann Children's pediatric transport team, but that the team was currently en route to Beaumont, Texas, to pick up another patient. Siddiqi was aware of the time it would take to transfer Tristan, but agreed with Erickson that the pediatric transport would be better, and so

continued on page 6

decided to wait. Siddiqi intubated Tristan at 1:50 p.m. The standard ambulance team arrived at 2:25 p.m. Siddiqi called Erickson, who iterated that he wanted Tristan transported by the pediatric transport team and that there still was no available pediatric ICU bed. At 3:15 p.m., Siddiqi went to "discuss plan of care with patient's parents and [the] delay of transfer."

Tristan then had a severe allergic reaction to one of the medications used for the intubation, causing his body temperature to increase to 107.9 degrees. Siddiqi's shift had ended, so at 3:52 p.m. a nurse notified ED physician Dr. David Nguyen of Tristan's elevated temperature. By 4:00 p.m. Nguyen had ordered cooling blankets, and ice packs were applied. Within five minutes, Tristan's temperature had reached 111.2 degrees. At 4:13 p.m., Nguyen and Erickson spoke, agreeing that Tristan needed to be transported to Memorial Hermann Children's via Life Flight helicopter. The helicopter arrived at 4:45 p.m., transporting Tristan to Memorial Hermann Children's Hospital, where he received immediate care and was hospitalized in the intensive care unit.

Tristan remained at Memorial Hermann Children's Hospital for several weeks. Diagnosed with septic shock, which caused organ injury, Tristan still requires follow-up medical care and therapy. In November 2007, the Guzmans sued Memorial Hermann claiming that the hospital violated EMTALA. In a second amended complaint, Guzman alleged that Memorial Hermann committed three EMTALA violations: failing to provide an "appropriate medical screening examination" on February 12, 2006, when Tristan was examined by Haynes; failing to stabilize the child's emergency medical condition before discharging him that day; and failing to effect an appropriate transfer on February 13, 2006.

The Ruling

The district court granted Memorial Hermann's motion for summary judgment. Specifically, in regard to Guzman's appropriate medical screening claim on the first visit to the ED, the court iterated that "negligence in the screening process or providing a faulty screening or making a misdiagnosis, as opposed to refusing to screen or providing disparate screening, does not violate EMTALA, although it may violate state malpractice law." Finding that "Guzman's allegations and the summary judgment evidence, taken in the light favorable to her, do not as a matter of law support a claim under EMTALA that the screening examination was not appropriate." Thus, summary judgment was granted on Guzman's EMTALA screening claim.

Also on the first visit to the ED, Guzman claimed a failure to stabilize an emergency medical condition. "Whether a patient is in fact suffering from an emergency medical condition is 'irrelevant for purposes of [EMTALA]," wrote the court. "The statutory language makes clear that 'what matters is the hospital's determination of the patient's medical status. The standard is a subjective one.'" Determining that there was no dispute as to the hospital's actual lack of knowledge of an emergency medical condition and that Guzman did not present any evidence of a difference of opinion within the hospital staff as to Tristan's condition, the district court ruled "Memorial Hermann's motion for partial summary judgment on the EMTALA failure to stabilize claim based on the initial visit to the emergency room is granted."

The appropriate transfer claim on Tristan's second visit to the ED also resulted in the court granting Memorial Hermann's motion for partial summary judgment. Under EMTALA, Memorial Hermann

could not transfer Tristan to another hospital unless: 1) the parents requested in writing to be transferred to another hospital; or 2) a physician signed a certification that the medical benefits reasonably expected from medical treatment at another hospital outweighed the risks from the transfer. Although the evidence gave rise to a fact issue as to whether Siddiqi or another member of the Memorial Hermann medical staff told Guzman about the hospital's EMTALA obligations before she signed the form, the court did find ample evidence in the record showing that Siddiqi actually and repeatedly weighed the risks and benefits of transferring Tristan to Memorial Hermann Children's Hospital. "[E]ven though he did not specifically list those risks and benefits, the physician certification requirement was met in this case by undisputed evidence of actual deliberation," the court stated. "The record evidence shows that the transfer in this case was appropriate as a matter of law."

Third Circuit Affirms EMTALA Inapplicable to Later-discovered EMCs

On September 2, 2009, the U.S. Court of Appeals for the Third Circuit affirmed the grant of summary judgment in a case previously decided January 2008 by the U.S. District Court for the Eastern District of Pennsylvania. The Court dismissed the EMTALA claim that several hospitals and physicians failed to stabilize and inappropriately transfer a patient when the patient with a high-risk pregnancy did not present in an emergent state and was not in an emergent state until she began to undergo monitoring at the primary hospital (*Torretti v. Main Line Hospitals Inc. d/b/a Paoli Memorial Hospital*, 3d Cir., No. 08-1525, 9/2/09).

The Facts

This case concerns appellants Christopher and Honey Torretti's son, Christopher, who was born with severe brain damage after Ms. Torretti's high-risk pregnancy went awry. While her first child was born healthy, both pregnancies were high-risk owing to her insulin-dependent diabetes. Because of her diabetic condition, Torretti's primary obstetrician, Dr. Patricia McConnell, referred Torretti to the Paoli Hospital Perinatal Testing Center (Paoli) for monitoring throughout both pregnancies. Paoli is a center for fetal monitoring and consultation only and is located in a building next to Paoli Hospital, also owned by Main Line Health. The two Main Line Health hospitals are approximately twenty miles apart. (Dr. McConnell is a member of the Peden Group, an obstetrics practice group based out of Lankenau Hospital (Lankenau), which is part of the Main Line Health system.)

In her third trimester, Torretti began having complications, primarily premature contractions. During this time, Torretti's monitoring appointments at Paoli were increased to twice per week; and on one occasion, she was monitored as an outpatient at Lankenau. Two weeks later, on April 30 at a routine monitoring, the Paoli medical staff detected pre-term labor. They directed Torretti to Lankenau where she was hospitalized for three days. On that occasion, she drove herself from Paoli to Lankenau.

Two days prior to a routine monitoring appointment during her 34th week, Torretti phoned McConnell twice, first complaining of contractions and then explaining that she was uncomfortable because of her large size and had noticed a decrease in fetal movement. She asked about the possibility of receiving a therapeutic amniocentesis. McConnell advised Torretti to drink a glass of

continued on page 7

ice water to stir the baby. Torretti detected increased movement. McConnell told Torretti that she could come to Lankenau but that nothing could be accomplished until Monday when she was coming in for a routine appointment. Torretti chose not to go the hospital that weekend, believing her condition was not emergent.

On May 23, the Torrettis drove to Paoli for the routine appointment, which included an ultrasound and a fetal non-stress test. Upon arrival at Paoli, Torretti was feeling general discomfort, but she was not alarmed about her condition and did not feel that she was in an emergent state. Torretti told Dr. Andrew Gerson, a perinatologist on Paoli's staff, about her conversation with McConnell over the weekend, that she had a great deal of discomfort mainly due to her large size and had noticed a decrease in fetal movement. Gerson began the non-stress test, and over a 28-minute period, the test showed no decelerations. About the same time the non-stress test began, Torretti's contractions returned. The non-stress test indicated 16 contractions in the 28 minutes of fetal monitoring, with contractions lasting about 50 to 70 seconds and 1½ to 2½ minutes apart. Gerson was aware of Torretti's diabetic condition, noting also in her medical documents that her abdominal circumference was large, and the fetus weighed approximately eleven pounds. The ultrasound test indicated excess amniotic fluid, but that the fetus "was moving its limbs and body."

Preliminary test results and Torretti's diabetic condition led Gerson to terminate the non-stress test, send Torretti to Lankenau for longer-term monitoring, and consult by telephone with McConnell. Gerson testified that this plan appeared to be "perfectly safe" based on the "best information we had," and that even though Torretti was having contractions, which were commonplace throughout her third trimester, "delivery wasn't necessarily going to be imminent...and it was appropriate for her to go to Lankenau Hospital." While Ms. Torretti determined that "[t]here was no urgency," Mr. Torretti asked whether it was an emergency and if they should travel by ambulance. Gerson replied that it was not that urgent, but he requested that

they go directly to Lankenau. En route to Lankenau, however, the Torrettis stopped at their home, making the 20-mile trip between hospitals in about 45 minutes.

Gerson had sent a customary explanatory letter to the Lankenau medical personnel with the Torrettis. Torretti had to wait 15 to 20 minutes for a Lankenau room. When Torretti was first connected to the monitor, her condition seemed to be about the same as it had been at Paoli, but then "it worsened very quickly." Shortly thereafter, another doctor with Torretti's regular Peden Group checked on Torretti and immediately rushed Torretti into surgery. Baby Christopher was birthed via caesarean section, and he had severe brain damage.

The Torrettis sued the hospitals and doctors under EMTALA, as well as state statutory and common-law claims. They asserted a federal question under EMTALA, which places three burdens on a hospital: appropriate medical screening, stabilizing treatment of a known emergency medical condition (EMC), and restricting transfer until a patient is stabilized. Defendants moved for summary judgment on the EMTALA claim. The U.S. District Court for the Eastern District of Pennsylvania ruled that the Torrettis did not offer sufficient evidence to raise a reasonable inference that defendants knew Torretti presented a medical emergency, and thus plaintiffs failed to sustain their burden under EMTALA. The district court granted the motion for summary judgment (*Torretti v. Paoli Mem. Hosp.*, No. 06-3003, E.D. Pa. 01/29/08). Plaintiffs appealed the federal district court decision to Third Circuit Court of Appeals.

The Ruling

The federal appeals court stated that *Torretti v. Main Line Hospitals, Inc.* presented the court its "first opportunity to confront the Emergency Medical Treatment and Active Labor Act." It ruled that the appeal tested "the boundaries of EMTALA, which is not a federal

continued on page 25

Board of Directors Approves New Ethics Rules

Howard Blumstein, MD FAAEM
AAEM Vice President

Over the past two years, the AAEM board of directors has completely revised the Academy's ethics rules. All members should review these new rules, which took effect on January 1, 2010.

Previously, the AAEM bylaws included ethics rules that primarily addressed issues of conflict of interest among officers and board members. The new ethics rules expand the ethics construct to define ethical behaviors in other areas, particularly business practices, and now apply to all members as well as those in leadership positions. Additional descriptions of unethical behaviors, mainly practices that are contradictory to the AAEM vision statement, are included.

The new ethics system is posted on the AAEM website at <http://www.aaem.org/aboutaaem/codeofethics.php>. It is divided into several sections including:

- General Principles
- Business Ethics

- Conflict of Interest
- Procedures in Ethics

Indrani Sheridan, MD FAAEM, James Li, MD FAAEM, and I, borrowing heavily from the previous ethics rules in the bylaws and the American Medical Association rules where appropriate, developed draft ethics rules. This draft was amended and approved by the board of directors. Finally, the AAEM bylaws were amended to strike the old ethics rules and adopt the new ones.

Some members, especially those who employ other physicians or hold contracts for staffing hospitals, may find that their various contracts are in violation of the ethics rules. Thus, it is important for these physicians to review their contracts in the light of the ethics rules.

Members with questions should contact the AAEM office at info@aaem.org.

Give a Shift a Week to the Company: An Analysis of the TeamHealth IPO

Robert McNamara, MD FAAEM

On October 5, 2009, TeamHealth Holdings LLC, a subsidiary of the Blackstone group, filed for an initial public offering (IPO) with the Securities and Exchange Commission. The document is available for public inspection¹ and EM physicians should strongly consider taking a look at it. One will find that TeamHealth is operating with a gross profit margin of 22% in a business predominantly based in the specialty of emergency medicine. This 22% figure represents what is in play when EM physicians place their economic destiny in the hands of a corporation. From an analysis of the IPO, it is highly plausible that each emergency physician is turning over control of up to \$76,000 per year to this corporation. Looked at differently, this amounts to giving one 8-hour shift per week to the company. The question to ask is, how much of that 22% could be invested in the emergency department or the emergency physicians in a non-corporate arrangement?

By doubling the reported IPO figures ending June 30, 2009, one can project that TeamHealth will have net revenue of \$1.42 billion and a gross profit of \$318 million (22%) for 2009. Gross profit is defined in the IPO as the net revenue minus the "professional service expenses" and liability costs. On page 57 of the IPO, the professional service expenses are further defined as "physician and other provider costs, billing and collection expenses and other professional expenses." So, the major costs of the practice—paying the providers, malpractice expense and billing—are taken out before gross profit is calculated. This is what the IPO says; it is not my interpretation. One must ask, what else is there in terms of expenses for the specialty of emergency medicine? Looking at the IPO, one can see what TeamHealth deducts from the gross profit before arriving at earnings of \$83.4 million (5.9%) for the year. TeamHealth lists things such as administrative expenses, management fees, depreciation and interest on debt (debt often incurred from buying a practice), that a local group would not have, or at least not to the scale listed here.

Let's look at the potential impact on the individual emergency physician. The total number of doctors engaged with TeamHealth is 3,500, with 2,800 of those being independent contractors. About 3,000 of TeamHealth's doctors are emergency physicians, with hospitalists comprising the next largest part of the group at 260 doctors. There are 2,500 other health care professionals, primarily PA and NP positions for the EM part of operations. The IPO on page 1 states that 79% of the net revenue comes from the ED and hospitalist operations. That would amount to a total of \$1.12 billion for 2009. For calculations in this article, all of the revenue is assigned to the physicians, as it is likely that the majority of the EM extenders work with a physician who supervises them and co-signs their charts. In an independent EM practice, the extender revenue would be directed to the physician, which is the arrangement this needs to be compared with. In this simplified analysis, at a total of \$1.12 billion for 2009, each of the 3,260 EM and hospitalist physicians is generating an average \$344,000 of net revenue for the year.

Applying the gross profit margin of 22% to the average revenue generated by each EM and hospitalist physician, the average gross profit per physician is \$75,680 for the year 2009. For that amount of money, it would be prudent for these physicians to know what expenses beyond salaries, billing costs and malpractice would be necessary if they owned the practice themselves. There really is not much else to pay for. Sure there are expenses; someone needs

to get paid administrative time to run the show and interface with the hospital, and there may be need for a non-physician business manager, but what else? Benefits do not apply for the mostly independent contractor doctors of TeamHealth, and they likely fall under "professional services expenses" for the 700 employed physicians. Certainly, at the end of the day, a good sized portion of that \$76,000 would be available to further compensate the emergency physicians. Additionally, this arrangement for physicians includes negatives that need to be considered, such as the possibility of termination without cause and a routine two year restrictive covenant detailed in the IPO.

Obviously, the exact figures for individual EM physicians depends on what revenue they generate prior to the application of the 22% gross profit margin. Clearly, however, there is the potential of added salary if one was to practice independent of this corporation. Even if the opportunity lost was \$50,000 per year, it would still represent a million dollars over 20 years; something that one could use for their kid's college fund. In this analysis, we can also see the reason physicians who work for corporations generally do not see what is collected in their name. If the corporate expenses and derived earnings were reasonable to the eye of the EM physician, there should be no cause to shield them from this data. The potential amount of money involved per doctor also points to why it is highly advantageous for TeamHealth to be viewed as an accepted part of the fabric of emergency medicine through a relationship with EM professional meetings and organizations. Take the IPO information, and perform your own analysis; you may see it differently, but at least you will have explored this important issue. At the potential cost of a shift per week, one ought to take this matter seriously.

References:

1. <<http://www.sec.gov/Archives/edgar/data/1082754/000119312509203703/ds1.htm>>

AAEM Thanks the Following 100% ED Groups for Their 2010 Membership

Bay Care Clinic LLP
Drexel University
Dubuque Emergency Physicians
Edward Hospital
Fredericksburg Emergency Medical Alliance, Inc.
Front Line Emergency Care Specialists
Memorial Medical Center
Physician Now, LLC
Providence-Newberg (ESO)
Salinas Valley Memorial Hospital
Santa Cruz Emergency Physicians (SCEP)
SCEMA
Temple University Hospital
University of Louisville
West Jefferson Emergency Physician Group

Something's Missing...

George Hossfeld, MD FAAEM

Department of Emergency Medicine, University of Illinois-Chicago

It has been decades since a physician could simply do what was best for his patients and call it a day. No, we have been in a "CYA era" for so long that the majority of us do not remember anything else. That is a heartbreak from which we will never recover.

I am picturing the 2009 version of the classic Norman Rockwell painting; the one with the old doctor using his stethoscope to "care for" the little girl's doll. In today's version, the kindly old doctor wears a worried expression and furrowed brow as he mulls over today's patients. In the back of his mind are lingering doubts that maybe he should be ordering a few more tests and putting a few more patients in the hospital "just to keep an eye on them overnight." Maybe CT scans for all is the more prudent way to practice. He had cared for several generations of many of his patients with kindness and dedication, but what if one of them in their grief gets an idea that "they deserve fair compensation" for a loved one's inevitable passing? What if they feel that while his personal care might have been filled with generosity and compassion, it just "did not meet the standard of care" as viewed by some know-it-all in the future? Doesn't exactly make you feel warm and fuzzy, does it?

The cost of defensive medicine is so great (some estimate as high as 30% of all health care costs) that it is the proverbial "low hanging fruit" of health care reform. Its magnitude is so great that by eliminating it, we could insure everyone and still have money left over. Don't just believe me; look at your own head CT scan statistics, percentage of chest pain admissions who "rule in," or percentage of extremity X-rays that yield either foreign bodies or fractures. Not just tests that showed something, but tests that showed something that appreciably changed patient care. Put it to the calculator test.

When something seems this obvious, but is not being done, there must be a very good reason. There is. It is called the trial lawyers lobby, and they are fast taking over every aspect of American life, just as they have ravaged the medical system in wholesale proportions. True estimates of their political contributions are difficult, since it is not just their own PACs, but many others controlled by them. Groups like Public Citizen, The Center for Justice and Democracy and Alliance for Consumer Rights all sound like grandly named public-minded groups but are merely fronts for the trial lawyers lobby. Cumulatively, they contributed over \$182 million in the federal elections alone last cycle. It is estimated that state and local elections, including judicial elections, result in even more dollars contributed. Trial lawyer contributions far outweigh those of others in the health care sector (physicians, hospitals, pharmaceutical companies, nursing homes, etc). It is no surprise that their richly supported congresspersons treat tort reform like a leper with a bad cough. It is very sad for our country and utterly criminal that this has been ignored by the media. Howard Dean, MD, Chairman of the Democratic National Committee said it clearest; "no one is willing to take on the trial lawyers."

That does not mean that political contributions will prevail. As physicians, we are really quite influential with our patients when we take the time to educate them. I do not think it is bad taste, inappropriate or unwarranted to take a minute to inform our patients. The future of our health care system hangs in the balance, and we are starting about 30 years late. Yes it is late, but it is not over yet...

The Professional Management Team

- Billing Management Services
- Clinically Trained Team
- Reimbursement Coding By Registered Nurses
- All of Our Clients are References



Contact:

Andrea Brault, MD FAAEM MMM

444 East Huntington Drive, Suite 300

Arcadia, California 91006

(877) 346-2211

email: andrea@emergencygroupsoffice.com

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 11/11/2009 to 1/12/2010.

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.

2009 Foundation Donations

(11/11/09-12/31/09)

BENEFACTOR

Crystal Cassidy, MD FAAEM
William T. Durkin, Jr., MD MBA FAAEM

DONOR

Paul E. Kleinschmidt, MD FAAEM
Allen L. Roberts, MD FAAEM
James J. Schlesinger, MD DDS FAAEM
Tyler M. Steptis, MD FAAEM

CONTRIBUTOR

Bobby Abrams, MD FAAEM
Terence J. Alost, MD FAAEM
Jonathan D. Apfelbaum, MD FAAEM
W. Lynn Augenstein, MD FAAEM
Kian J. Azimian, MD FAAEM
Andrew G. Ball, MD FAAEM
Robert J. Balogh, Jr., MD FAAEM
Brian F. Beirne, DO FAAEM
Kevin J. Bonner, MD FAAEM
Peter D. Bosco, MD FAAEM
Sudip Bose, MD FAAEM
Michael R. Bowen, MD FAAEM
Mark W. Brodeur, MD FAAEM
Michael S. Bush, MD FAAEM
Steven Caldwell, MD FAAEM
James W. Callaghan, MD FAAEM
Gregory Carroll, MD FAAEM
Carlos H. Castellon, MD FAAEM

FACEP

Donald A. Chiulli, MD FAAEM
Garrett Clanton, II, MD FAAEM
Domenic F. Coletta, Jr., MD FAAEM
Christopher Xavier Daly, MD FAAEM
Thomas D'Aprix, MD FAAEM
Christopher I. Doty, MD FAAEM
David M. Ebbitt, MD FAAEM
John I. Ellis, MD FAAEM
Emile El-Shammaa, MD FAAEM
Albert B. Fiorello, MD FAAEM
Joseph Flynn, DO FAAEM
Ryan P. Frank, DO FAAEM
William T. Freeman, MD FAAEM
Hoyt W. Frenzel, MD FAAEM FACEP
Russ E. Galloway, MD FAAEM
Sherry J. Galloway, MD FAAEM
David E. Garces, MD FAAEM
Richard Russell Gill, MD FAAEM
Eric Goldlust, MD PhD

Matthew C. Gratton, MD FAAEM
Rohit Gupta, MD FAAEM
Edward Heneveld, MD FAAEM
David Anthony Hnatow, MD FAAEM
Anita H. Hodson, MD FAAEM
Gregory R. Hoffman, MD FAAEM
James D. Hogue, DO FAAEM
Dominic A. Johnson, MD FAAEM
Robert Benjamin Johnston, MD FAAEM
Costas A. Kaiafas, MD FAAEM
Amin Antoine Kazzi, MD FAAEM
John H. Kelsey, MD FAAEM
Eric M. Ketcham, MD FAAEM
Ron Koury, DO FAAEM
Gerhard Anton Krembs, MD FAAEM
Melisa W. Lai Becker, MD FAAEM
Mark I. Langdorf, MD MHPE FAAEM
David A. Leeman, MD FAAEM
Benjamin Lerman, MD FAAEM
Stephen R. Levinson, MD FAAEM
David B. Levy, DO FAAEM
Michael Kevin Levy, MD FAAEM
Christopher C. Lorentz, MD FAAEM
Harvey Louzon, MD FAAEM
Freda Lozanoff, MD DO FAAEM
J. Michael Lynch, MD FAAEM
Richard G. Lyons, MD FAAEM
David L. Malmud, MD FAAEM
Keith L. Mausner, MD FAAEM
Nimish Mehta, MD FAAEM
Ronald L. Pearson, DO MPH FAAEM
Aryeh Joseph Pessah, MD PA FAAEM
Brian R. Potts, MD MBA FAAEM
Vitaut N. Ragula, MD FAAEM
Robert C. Rosenbloom, MD FAAEM
FACEP
Stephen A. Schillinger, DO FAAEM
Miles Shaw, MD FAAEM
Richard D. Shih, MD FAAEM
Lee W. Shockley, MD FAAEM
Paul R. Sierzenski, MD RDMS FAAEM
P. John Simic, MD FAAEM
Mark J. Singsank, MD FAAEM
Evans S. Smith, MD FAAEM
Ronald R. Sommerfeldt, MD FAAEM
Mark E. Stevens, MD FAAEM
Steven P. Strobel, MD FAAEM
Gregory J. Sviland, MD FAAEM
Douglas G. Sward, MD FAAEM
Ryan L. Tenzer, MD FAAEM
Wenzel Tirheimer, MD FAAEM

Robert B. Tober, MD FAAEM
Arlene M. Vernon, MD FAAEM
Steven M. Walkotte, MD FAAEM
Bert A. Weiner, MD FAAEM
Ellen J. Westdorp, MD FAAEM
Robert R. Westermeyer, MD FAAEM
Christopher R. Westfall, DO FAAEM
Brian J. Wieczorek, MD FAAEM
William David Wilcox, MD FAAEM
George Robert Woodward, DO FAAEM

2010 Foundation Donations

(1/1/10-1/12/10)

SPONSOR

Kevin Beier, MD FAAEM

DONOR

Keith D. Stamler, MD FAAEM

CONTRIBUTOR

Kevin S. Barlotta, MD FAAEM
Paul S. Batmanis, MD FAAEM
Owen Chadwick, MD FAAEM
Peter M.C. De Blieux, MD FAAEM
Anthony J. Dean, MD FAAEM
Tom J. Deskin, MD FAAEM
Damon Dietrich, MD FAAEM
Duane J. Dyson, MD FAAEM
Gus M. Garmel, MD FAAEM FACEP
Samuel H. Glassner, MD FAAEM
Robert E. Gruner, MD FAAEM
Richard G. Houle, MD FAAEM
Jacqueline A. Jeffery, MD FAAEM
Kathleen P. Kelly, MD FAAEM
Michael Klein, MD FAAEM
Ann Loudermilk, MD FAAEM
John R. Matjucha, MD FAAEM
Mark Matouka, MD FAAEM
Robert Mazur, MD FAAEM
David E. Meacher, MD FAAEM
Heather M. Murphy-Lavoie, MD FAAEM
Bertram I. Okorie, MD FAAEM
Allan Preciado, MD
Jonathan S. Rubens, MD MHPE FAAEM
Brad L. Sandleback, MD FAAEM
Michael Slater, MD FAAEM
B. Richard Stiles, DO FAAEM
Richard J. Tabor, MD FAAEM
Michael R. Thomas, MD FAAEM
David M. Trantham, MD FAAEM
Anita M. Ziemak, MD FAAEM

Upcoming AAEM–Sponsored and Endorsed Conferences for 2010

AAEM is featuring the following upcoming endorsed, 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

Pre-conference Workshops at the 16th Annual Scientific Assembly include:

February 13-14

- Resuscitation for Emergency Physicians: The AAEM Course

February 14

- Advanced Ultrasound
 - Coming to an ED Near You – Bringing Military Medical Advancements to the Civilian Emergency Physicians
 - LLSA Review 2009
 - Pediatric Emergencies
 - Presentation and PowerPoint® Skills for Emergency Physicians
 - Regional Anesthesia Skills Lab
 - Resident In-Service; What to Expect on Your Test
- Las Vegas, NV
www.aaem.org

February 15-17

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

April 7-8

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

April 17-18

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

March 22-26

- Vietnam Emergency Medicine Symposium
- Hue, Vietnam
www.vietnamem.org

April 7-8

- 10th Annual Symposium on Emergency Medicine, Standards of Care 2010 featuring Advances for the Clinician and Best Evidence in Emergency Medicine
- Orlando, FL
www.floridaep.com

April 8-10

- 2010 Critical Concepts in Emergency Medicine
- New Orleans, LA
cme@lsuhsc.edu

April 16-18

- St. Luke's Wilderness Medicine 2010
- Skytop, PA
www.slhnwildernessmedicine.org

May 19-21

- InterAmerican Emergency Medicine Conference
- Buenos Aires, Argentina
www.international-em.org

May 21-23

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

June 11-13

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

June 27-30

- Giant Steps in Emergency Medicine 2010
- San Diego, CA
www.giantsteps-em.com

September 10-12

- The Difficult Airway Course-Emergency™
- St. Louis, MO
www.theairwaysite.com

October 22-24

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

November 19-21

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

AAEM–Endorsed Conferences

January 31 - February 4

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

February 1-3

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

February 27 - March 3

- Rocky Mountain Winter Conference on Emergency Medicine
- Copper Mountain, CO
www.rockymtn.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: kfilipiak@aaem.org.

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

Emergency Medicine in California 2009

Steven Gabaeff, MD FAAEM

There were days in California, the old timers remember, when the sun shone bright, the weather was fair, and the future looked guaranteed to be filled with the fruit of future labors. The roads, the schools, the parks, even the system for indigent health care worked because there was enough. Medical advances were impacting health care in positive ways. Residencies in EM sprouted like poppies, and we enjoyed a dreamy time.

Future battles with greed tearing apart our world was a script that had not been written yet. With time, the state would no longer have "enough." Institutions were slowly hobbled and then crippled, and some recently killed off, by underfunding. Underfunding begat dysfunctionality and confusion and that, in turn, became fodder for increasingly severe criticism and more cuts. In a truly brutal vilification of EPs in California in 2008 and 2009, the insurance companies demonized us in the press as greedy and predatory in a strategy to increase their own profits.

For a time, through the vast EM political machine run by CAL/ACEP, we heard our essential work in the safety net lionized, and we deluded ourselves that we had friends in high places interested in EM. These thoughts, right or wrong, provided a psychological mitigation for a deteriorating revenue picture with its dire consequences. We would tolerate hall beds, no back up panels, overcrowding and work stress, and keep showing up to do our best because we really do care. We took pride in our abilities to "take it," as we struggled with new problems that did not even exist in those more dreamy days of times long gone. Now we find ourselves constantly worrying about collections, dealing with impossible operational conundrums born of "not enough" resources, and suffering through new metrics applied to our efforts that more accurately measure system failure.

While we struggled to maintain the revenue needed to have a working safety net, the assaults on our profession (EM) by government institutions were relentless. Over the years, cuts in revenue were parried by efforts to maintain the system through special funding. In the latest budget crisis of 2009, the fund for supplementing EMS for the increasing number of uninsured in California was taken away (\$25 million from 3,000 MDs).

For years, those who could pay (the wealthy insurance companies) felt they were entitled to pay much less because the government paid less via Medicaid and Medicare; a rather contorted piece of logic. The insurance companies organized around the "balanced billing issue." They wanted EPs to take Medicare (or lower) rates without any contract with the providers AND to have no standing to collect the balance from the patients. They had worked for years to buy that result, but the trial court and the appellate court, where this legal controversy played out, ruled in our favor. We won, and we thought that big insurance would have to pay reasonable fees for our essential services.

The insurance industry would not give up, though. They had the money to fight, and they kept at it. They appealed to the Supreme Court who, in violation of contract law principles, rubber stamped a destructive policy which said that EPs did not have the right to balance bill anyone. This "policy," without ever being voted upon, would become state law. The Supreme Court intentionally refused to

address the issue of fair payment so they could infer that whatever we were billing was unreasonable, echoing state agencies and the insurance companies' attacks on EPs. The insurance companies can pay what they want, and we can only challenge them through an impractical case by case dispute resolution process run by the state. Our previous victory unraveled in a depressing day of confusion and anger that still lingers. The day-to-day grind continued, and we had to suffer an immediate 12% reduction in income in our group.

We carry on. We deal with the financial adversity. We hope for help. The old timers wish they could retire but cannot, and young doctors just work harder. We all develop different coping strategies with this new mess, which now seems like equal parts patient care and honing a survival plan for a deteriorating system. There is talk of strikes and organizing surface from time to time, but the sense of caring keeps the average EP from endorsing such moves.

California has stood out as a leader in EM trends in the past. While our predicament is vexing, we seek to help others avoid a similar fate. The recent budget crisis may lead to cuts in home health (\$263 million), Medicaid (\$1.4 billion), childcare services for the poor (\$528 million), children's health insurance coverage (\$174 million), and child welfare services (\$79 million), while halving the budget of poison control after the governor had wanted to defund it completely. Cuts in AIDS prevention (\$52 million), aid to developmentally disabled infants and toddlers (\$50 million), and domestic violence protection (\$16 million) are more of the cuts we face. At the same time, other non-EP health care providers are backing away at full speed from indigent care. Clinic funding is cut, and we are being told by the health care administrators to make due with less.

A new day will dawn tomorrow, and the first patient will show up in the ED desperately needing our services. We can all hope we have the wherewithal to take care of him, and ourselves, that day and the day after. Anybody with a good idea, stand up and raise your voice, and hope that someone who will help you will be listening.

Have an opinion about something
you've read in *Common Sense*?

Want to share your views on EM issues with
thousands of other AAEM members?

Send your thoughts to CSeditor@aaem.org and your comments may be
published in a future issue of *Common Sense*!

CAL/AAEM Update

Ingrid Lim, MD FAAEM
President, CAL/AAEM

Founded in 1998, CAL/AAEM had very humble beginnings. In eleven years, though, we have certainly come a long way and have a lot for which to be proud. CAL/AAEM's mission has always been to ensure workplace fairness and to advocate for the interests of the individual emergency physician in California. We stand up for the little guy, support the individual, and protect physicians from contract abuse and unfair employment practices. We strive to support and share the principles of our national organization with our members.

We have also excelled in the academic arena. Along with the University of California, Irvine, we are extremely proud to be co-founder of the *Western Journal of Emergency Medicine* (WestJEM), formerly the *California Journal of Emergency Medicine*. Robert Derlet, founding editor; Antoine Kazzi, initial managing editor; Robert Rodriguez, editor from 2002-2007; and the enormous contributions of the editorial board over the years have been instrumental to the academic success of the journal. As the fifth journal in emergency medicine, it is the only open-access, peer-reviewed journal in our specialty following the Creative Commons Attribution-NonCommercial license agreement. Through the Creative Commons license, open access means that authors retain their copyright, and published material can be reused by its authors and others without permission, provided the author and original publication are credited. This sets WestJEM apart from other EM journals where authors are required to sign away their copyright and subsequently ask for permission to use their own work! Although its first issue was printed in July 2000, WestJEM has become the fastest growing journal in our specialty. WestJEM is indexed full-text in PubMed Central (www.pubmedcentral.gov) within the National Library of Medicine and is available for search through PubMed/Medline (www.pubmed.gov). We look forward to further database indexing in the near future and will continue to lend our steadfast support to the journal.

Just recently, we finalized an agreement with CAL/ACEP to co-sponsor WestJEM – a landmark example of how our two organizations can work together successfully. Although WestJEM has “Western” in its full title, this is in reference to Western (as opposed to Eastern) medicine. It does not have any geographic restrictions in its distribution or article selection. It is published both in print and electronic formats each quarter, which CAL/AAEM members receive as part of their membership. Several other state chapters (including the Florida Chapter of AAEM and the Uniformed Services Chapter of AAEM) and academic departments have signed up for electronic and print subscriptions for their members as well. If you are interested in obtaining a print or electronic subscription for your group, please contact the managing associate editor, Shahram Lotfipour (Shahram. Lotfipour@uci.edu). Your support is essential to the future of this great open-access emergency medicine journal.

In addition, reflecting the educational mission of AAEM, CAL/AAEM has been committed to providing high quality educational events to our members for free or nominal cost. When LLSA became mandatory, we provided online LLSA summaries exclusively to our members. Since 2005, we have sponsored and organized several pre-conference workshops at AAEM's Scientific Assembly. Most recently, we held a Pediatric Emergencies workshop with an impressive line-up of leading educators in pediatric EM. Additionally, through the support of CAL/AAEM, medical student symposia on emergency medicine at UCI and USC have grown from local conferences to become regional and statewide events.

CAL/AAEM has also established a legal advisory service that can be accessed by our members for free. We also offer an electronic news service, currently serving over 500 emergency physicians nationwide. The service provides news articles that are timely, pertinent and make it easy to be informed about both state and national issues that affect us now and in our future practice. To subscribe, please go to our web page at www.calaaem.org/news_service.php.

We have continued to foster our collaboration with CAL/ACEP and support their impressive advocacy efforts in Sacramento. CAL/AAEM has participated in discussion of important issues affecting emergency physicians in California and lent our support to legislative bills or statements championed by CAL/ACEP. We have even had one of our board members serve as a CAL/AAEM liaison to CAL/ACEP, attending their board meetings. We hope to serve as an example to other state chapters on how the two organizations can be partners in advancing our specialty.

Although CAL/AAEM is the largest state chapter, we are still a small organization, and we are working toward increasing our voting membership. With free membership for medical students and residents, we hope that membership early on during training stresses the importance of a fair and equitable practice to a younger generation of physicians before they enter the job market. We aim for 100% membership from all fourteen California residencies, who will hopefully become future voting members of CAL/AAEM.

Despite our successes, there is much work to be done. The state of emergency care in our state is abysmal. California's emergency health care system ranks last in the country for emergency care access. It has 7.1 emergency departments for every one million residents, compared to the national average of 20. It ranks 43rd in the country for Medicaid reimbursement. Our state has one of the top ten largest economies in the world, a GDP of \$1.7 trillion, yet we are in a financial Armageddon, with a debt growth of \$1.7 million per hour! Sacramento has proposed budget cuts with inevitable slashes to funding for health services. The current economic crisis, overcrowding, emergency department closures and increased volume in an already overburdened emergency safety net all translate to an unsafe work environment and patients not receiving the appropriate care they deserve. These problems are very real and, in large part, not unique to our state.

Our organization will continue to support our emergency physicians and help fight the good fight in any way we can! To find out more about our chapter, please visit our web page at www.calaaem.org.

Donate to the AAEM Foundation!

Visit www.aaem.org or call **800-884-AAEM**
to make your donation.



www.resus2010.com

All new content!
Plus...
over \$850 of FREE
Additional CME Materials
with
Registration!!

March 28-31, 2010
Planet Hollywood
Resort & Casino
Las Vegas, NV



Exclusive Award-Winning Film
Private Screening Included!

LIVING IN EMERGENCY
Stories of Doctors Without Borders

Brand New!
Resuscitation 2010
Certification Card



resuscitation 2010

A conference on care of the critically ill and injured patient
from the developers of Emergency Medical Abstracts and CMEDownload.com.



Need CME now?

Your favorite CME conferences.

Streaming video lectures.

iPod/iPhone versions.

Audio mp3s of every lecture.



Easy online CME.

CME tracker and reporting.

One low fee.

Subscribe now at
www.cmedownload.com!

AAEM Opposes Michigan Doctor Tax Bill

Mark Reiter, MD MBA FAAEM and
Larry D. Weiss, MD JD FAAEM
AAEM Board of Directors

Recently, Michigan Governor Jennifer Granholm proposed a 3% tax on physician revenues in Michigan as a means of raising funds for the state Medicaid program. The “doctor tax,” projected to raise \$300 million, passed the state House by a narrow margin in early October of 2009. The Michigan State Medical Society strongly opposed this tax.

However, AAEM members in Michigan became concerned when the Michigan College of Emergency Physicians (MCEP) publicly supported the tax. MCEP projected a net increase in income for emergency physicians because of improved reimbursement if the state increased Medicaid payments as promised. However, the MCEP calculations did not include the probability of further increases in the proposed tax. Certainly, once government obtains a new power to tax, it may later seek increases in that tax. Furthermore, AAEM considered the tax unfair and discriminatory. Physicians currently donate much of their time caring for Medicaid patients who receive medical care at steeply discounted rates. Moreover, society in general benefits from the Medicaid program, so society in general should share in the burden.

In an October 20, 2009, press release, AAEM outlined its staunch opposition to the “doctor tax.” The Academy noted the inherent unfairness of having physicians shoulder the tax burden to pay for indigent health care in Michigan, analogous to taxing teachers for their use of public schools or taxing public defenders for their use of the courts. Furthermore, the Academy stated its concern that the fallout from the “doctor tax” could lead to an exodus of Michigan physicians and create access problems for Michigan patients.

On October 28, 2009, after an active physician-led campaign, the State Senate had the wisdom to vote down this unfair tax by a 32-4 vote. Strong physician involvement and an education program focusing on how this bill would damage health care in Michigan, led to a decisive victory, thus preventing an unjust precedent. These events serve as another example of AAEM’s ability to quickly react to issues on a state level that profoundly affect the rights of our members.

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.

WMIG Update

Karen Serrano, MD
University of Wisconsin

As a second-year resident in emergency medicine and mother of three young children, balancing work and family has been an ever-present challenge in my medical career. While life can feel crazy at times, I think that having children has shaped the type of physician I have become. In fact, I would argue that motherhood has made me a better emergency physician.

There are actually many similarities between taking care of children and managing the flow of a busy emergency department. Multitasking is a reality both for moms and emergency physicians. At home, I must be vigilant, managing all three children simultaneously and knowing at which point to intervene. Similarly, in the emergency department, I must monitor multiple complicated patients at a time, keeping tabs on who needs interventions and prioritizing them. I love this aspect of emergency medicine, and the fact that I am always multitasking at home means these skills are continually being honed.

Motherhood has also prepared me to take care of pediatric patients and their families. Assessing children is much easier when I know from my own experience what a two-, four-, or six-month old should be able to do. I can also empathize with parents and enjoy being able to use my own parenting experience to counsel families, such as when I recently reassured a mother about her toddler’s nursemaid’s

elbow, explaining that it had happened to my own daughter twice. Sometimes it seems that the fact that I have three children carries more weight with parents than the medical degree emblazoned on my scrubs.

Finally, having kids helps keep me balanced. There is nothing more rejuvenating than coming home from a tiring shift and having an excited child greet me at the door with lots of hugs and kisses. Furthermore, my kids force me to leave my work at work. By virtue of their young ages, my children demand my full attention when I am home. I have learned to focus on my kids when I am home and schedule specific time for working on residency-related projects. Ironically, I think this forced balance helps me enjoy both of my roles more—that of a resident and as a mother.

In summary, I am grateful to be a resident, with all of the opportunities for learning and growth that it entails. I also love my children and am encouraged to see the ways that being a mom is helping me to become a better doctor.

Contact Dr. Lisa Mills (LMORR11@aol.com) or Kate Filipiak (kfilipiak@aaem.org) for more information or to join the Women in Medicine Interest Group.

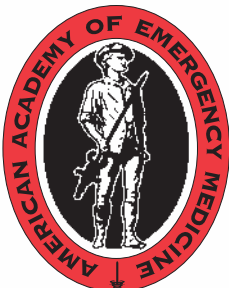
www.peercharts.com

Do you suffer from Documentation Syndrome?

Now there is help.

PeerCharts™

- ✓ **Comprehensive**
- ✓ **Affordable**
- ✓ **User-Friendly**
- ✓ **Customizable**



FAAEM
always means
board certified



*Don't forget! A portion of all proceeds supports the AAEM Foundation!

AAEM Young Physicians Section

Bringing CPR to the Masses

Michael Pulia, MD FAAEM
Young Physicians Section Board of Directors



You stand ready, blade in one hand, tube in the other. To your right, two techs are ready to spring into action with chest compressions. To your left, a pair of RNs stand with needles drawn waiting to access even the most difficult to find vein. The doors swing open and in rush the medics with a lifeless body in tow. The flurry of activity in the next few moments resembles a pit crew trying

desperately to get their driver back in the race. However, you are the leader of a team trying to bring someone back to life, and the stakes could not be higher. No other scenario in the ED commands this type of attention and resources. You run the algorithms, and despite everyone in the room giving it their all, this story does not have a happy ending. Aware of the grim odds, we know that too often this encounter ends with the words "time of death." As you leave the room and try to grasp the magnitude of the decision to call the code, you wonder if there was anything else you could have done. With increasing frequency, it is apparent to me that the outcome was likely determined well before the patient rolled into the ED and that I was not present for the most critical moments of their medical crisis.

This all too familiar story probably began something like this: an at home sudden cardiac arrest (SCA), no CPR until EMS arrived 8 minutes later, worked on in the field for another 5 minutes, a 10 minute ambulance ride and the patient arrives in your ED 20+ minutes after their arrest with little hope of recovery. Examining several major metropolitan areas, researchers have found that the survival to discharge rate for SCA is less than 2%.^{1,2} These dismal statistics are being challenged by new data from Europe and Seattle that suggest we can do much better. These locations saw survival to discharge rates improve to between 9-21% by implementing programs based on interventions in the first few moments following SCA, which are without question the most critical in determining the final outcome.^{3,4} Improved outcomes from early defibrillation and bystander CPR are well established.⁵⁻⁸ Despite efforts to educate the public about these benefits, bystander CPR rates remain at an unimpressive 30%.^{9,10}

It is with this exact dilemma in mind that the non-profit Ad Council, New York ad agency Gotham Inc., and the American Heart Association (AHA) have launched the massive new campaign entitled Hands-Only™ CPR. This program is based on the 2008 AHA science advisory published to amend and clarify the 2005 AHA Guidelines for CPR and Emergency Cardiovascular Care (ECC),¹¹ and it aims to dramatically change how bystander CPR is administered. The target audience is the majority of citizens who are either untrained or unwilling to participate in traditional CPR. As demonstrated by two large illustrations on the program's homepage, <http://handsonlycpr.org/>, the message is crystal clear: 1 - Dial 911 and 2 - Press hard and fast in the center of the chest.¹² That's it! So simple it's genius. No ratios to remember, no mouth to mouth, no lengthy training courses and no fear of making a mistake. By eliminating the hurdles that bystanders often cite when asked why they did not perform CPR,¹⁰ the campaign hopes to make CPR more accessible than ever. For those who are trained and comfortable

in providing the traditional 30:2 ratio CPR that includes mouth-to-mouth, the recommendation is to continue doing just that.

The 2008 advisory did not stem from the AHA giving up on this traditional CPR, but rather, new literature questioning the value of rescue breaths early after SCA and demonstrating that some CPR is better than no CPR. The origins of this paradigm shift can be traced back to the 2005 AHA Guidelines for CPR and ECC and its back to basics approach.¹³ Dr. Carl Ferraro, one of my mentors in residency, taught a simple but profound lesson about Basic Life Support (BLS); it is just doing for the patient what their body cannot. The 2005 guidelines took that same simplified approach; compressions were to be done before, after and in-between every intervention. Faster, more effective compressions with fewer interruptions would circulate the medications and improve chances for successful defibrillation. Shock-shock-shock was out and press-press-press was in. Since these guidelines were released, research continues to demonstrate the detrimental effects of any interruptions in compressions.¹⁴ Although chest compressions had been established as the cornerstone of all ECC, the exact role of early rescue breathing after SCA had yet to be elucidated.

Prior to 2005, only two human studies had demonstrated equivalent outcomes or no harm when comparing compressions only CPR (COCPR) versus traditional CPR.^{15,16} The future role of rescue breaths in CPR became more clear in 2007, when several nonrandomized observational studies were published that, again, demonstrated no improved benefit when rescue breaths were added to COCPR.^{9,17,18} One of these studies performed in Japan by Iwami et al. received significant media coverage in the U.S. The AHA took notice and made a statement saying it was not prepared to fully endorse COCPR for bystanders at that time. With the new Hands-Only™ CPR ad campaign featured prominently on the AHA homepage, www.americanheart.org/, it is safe to say they have now embraced COCPR as an alternative to traditional CPR that will improve outcomes in SCA by increasing bystander CPR rates.

According to media releases, the Hands-Only™ CPR campaign will employ a variety of ads, and the website features a bilingual video demonstration, real SCA success stories, links to free iPhone and Blackberry applications and a comprehensive FAQ page.¹² To complement the new simplified version of CPR, the AHA has also established short educational programs for those looking to be comfortable with CPR basics, such as the validated 22-minute CPR Anytime™ program. Data suggests these short, self-taught video courses can be widely disseminated and are often as effective as the traditional multi-hour instructor taught courses.¹⁹ While continued efforts to educate the public on early Automated External Defibrillator (AED) usage are important, the fact remains that most arrests occur in the home. COCPR can get family members involved early and buy patients time for EMS to arrive and defibrillate. As ED physicians, we can do our part to spread the word through community education, brief CPR updates to families of high-risk patients, or by simply referring people to the AHA or Hands-Only™ CPR websites.

continued on page 19

Attention YPS and Graduating Resident Members

CV & Cover Letter Review **Are you ready?**

Enhance your credentials. Increase your job opportunities.

The AAEM Young Physicians Section (YPS) is excited to offer a new curriculum vitae review service to YPS members and graduating residents.

The service is complimentary to all YPS members. If you are not a YPS member, visit us at www.ypsaaem.org to join and learn about the additional membership benefits.

For graduating residents, a \$25 Service Fee is required, which will be applied to your YPS dues if you join AAEM as an Associate or Full Voting Member. This offer is only valid for the year following your residency graduation.



FAAEM
always means
board certified



For more information about YPS or the CV Review service, please visit us at www.ypsaaem.org or contact us at info@ypsaaem.org.

The Young Physicians Section (YPS) presents

Rules of the Road for Young Emergency Physicians

- All YPS members receive a complimentary copy
- Sponsored by:
EMSeminars: www.emseminars.com
Emergency Excellence: www.emergencyexcellence.com
- For more information visit www.ypsaaem.org or contact us at info@ypsaaem.org.

INTRODUCTORY PRICE
\$25⁰⁰
for AAEM members
(plus shipping & handling)
\$50⁰⁰
for non-members
(plus shipping & handling)

Now Available!



FAAEM
always means
board certified

Rules of the Road

FOR YOUNG EMERGENCY PHYSICIANS

Chief Editors

David Vega, MD FAAEM
Tom Scaletta, MD FAAEM

Distributed by the Young Physicians Section of the American Academy of Emergency Medicine
Copyright © 2009 American Academy of Emergency Medicine. Send comments to AAEM YPS at info@ypsaaem.org

AAEM-0809-058

A potential unintended consequence of the increasing exposure to COCPR and an emphasis on the importance of uninterrupted compressions is renewed debate over the utility of advanced life support (ALS) for out-of-hospital SCA. The Ontario Prehospital Advanced Life Support (OPALS) study showed no improvement in survival to discharge rates when ALS was added to CPR and rapid defibrillation for SCA.²⁰ In light of this finding, the utility of any out-of-hospital intervention (advanced airway, IV access and medication delivery) should always be weighed against potential interruptions to or impaired quality of CPR. Running a code is challenging, even with a whole team performing assigned roles and switching out on compressions. One can imagine how difficult it is for two paramedics to run it alone while keeping up textbook CPR. Perhaps future revision to the AHA's guidelines for health care providers will move further away from recommending ALS in the field for patients with a witnessed SCA or short down/transport times. Obviously, the type of arrest, timing of response and time to nearest ED will influence the optimal type of care provided. Quality studies are still needed to clarify the optimal protocols and shared responsibilities between EMS and the ED in order to improve outcomes in SCA.

Even as we attempt to bring COCPR to the masses, a recently proposed experimental CPR technique could replace chest compressions all together. Named "only rhythmic abdominal compression" (OAC) CPR, this technique was developed by a team out of Purdue that included the late, renowned bioengineer Dr. Leslie Geddes. Published in 2007, this technique showed incredible promise in a swine model. By compressing the abdomen evenly with a wooden board shaped to fit under the costal margin, researchers were able to not only achieve higher coronary perfusion pressures than with standard chest compressions, they were also able to partially ventilate the test animals.²¹ The basis for these effects is that 25% of our circulation volume resides in abdominal organs and that compression of the abdomen moves the diaphragm enough to provide air exchange. This is a significant advantage over standard chest compressions which have been shown to provide no adequate ventilation in humans.²² Applied to a human model, AOCPR could potentially be developed into a one person CPR technique that would take care of both breathing and circulation. This might revolutionize how CPR is provided by lay persons, EMS providers and hospital resuscitation teams. Regarding complications, no broken ribs or abdominal organ injuries were noted in the test animals. To date, this technique has not been validated, and given the unanswered questions about its ability to provide adequate cerebral perfusion and a potential for increased aspiration of gastric contents, it is likely some time away from human trials.²³

With these ongoing advances in resuscitation science and ad campaigns like Hands-Only™ CPR, it is exciting to consider how many more success stories we will see in the ED as SCA outcomes improve. These changes promise to transform CPR from what some view as a modern day dying ritual into a public health and modern medicine success story. Calling a code after an unexpected sudden death is one of the hardest things we do as EPs and any reduction in how often we do so will feel like a tremendous victory. To truly help our future patients and save thousands of lives each year, we need to make an impact in those first few moments after SCA when we cannot be physically present. One way to achieve this goal is for our specialty to lead the charge in educating the public about the technique and benefits of COCPR. Looking back on our past achievements in public health issues such as seatbelts, child abuse, helmets and domestic violence, I know we will respond to this challenge and begin writing a new chapter in the story of SCA.

1. Eckstein M, Stratton SJ, Chan LS. Cardiac Arrest Resuscitation Evaluation in Los Angeles: CARE-LA. *Ann Emerg Med*. 2005;45:504–509.
2. Dunne RB, Compton S, Zalenski RJ, et al. Outcomes from out-of-hospital cardiac arrest in Detroit. *Resuscitation*. 2007;72:59–65.
3. Rea TD, Eisenberg MS, Culley LL, et al. Dispatcher-assisted cardiopulmonary resuscitation and survival in cardiac arrest. *Circulation*. 2001;104:2513–2516.
4. Waalewijn RA, de Vos R, Koster RW. Out-of-hospital cardiac arrests in Amsterdam and its surrounding areas: results from the Amsterdam resuscitation study (ARREST) in "Utstein" style. *Resuscitation*. 1998;38:157–167.
5. Gallagher EJ, Lombardi G, Gennis P. Effectiveness of bystander cardiopulmonary resuscitation and survival following out-of-hospital cardiac arrest. *JAMA*. 1995;274:1922–1925.
6. Wik L, Steen PA, Bircher NG. Quality of bystander cardiopulmonary resuscitation influences outcome after prehospital cardiac arrest. *Resuscitation*. 1994;28:195–203.
7. White RD, Hankins DG, Bugliosi TF. Seven years' experience with early defibrillation by police and paramedics in an emergency medical services system. *Resuscitation*. 1998;39:145–151.
8. Myerburg RJ, Fenster J, Velez M, et al. Impact of community-wide police car deployment of automated external defibrillators on survival from out-of-hospital cardiac arrest. *Circulation*. 2002; 106:1058–1064.
9. Cardiopulmonary resuscitation by bystanders with chest compression only (SOS-KANTO): an observational study. *Lancet*. 2007;369:920–926.
10. Swor R, Khan I, Domeier R, et al. CPR training and CPR performance: do CPR-trained bystanders perform CPR? *Acad Emerg Med*. 2006;13:596–601.
11. Sayre MR, Berg RA, Cave DM, et al. Hands-Only (Compression-Only) Cardiopulmonary Resuscitation: A Call to Action for Bystander Response to Adults Who Experience Out-of-Hospital Sudden Cardiac Arrest. A Science Advisory for the Public From the AHA ECC Committee. *Circulation*. 2008;117:2162–2167.
12. AHA Hands-Only™ CPR Web site. Available at: <<http://handsonlycpr.org/>>. Accessed Nov. 3, 2009.
13. 2005 American Heart Association Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care. *Circulation* 2005;112(24 Suppl):IV1–203.
14. Christenson J, Andrusiek D, Everson-Stewart S, et al. Chest compression fraction determines survival in patients with out-of-hospital ventricular fibrillation. *Circulation*. 2009;120(13):1241–7.
15. Hallstrom A, Cobb L, Johnson E, Copass M. Cardiopulmonary resuscitation by chest compression alone or with mouth-to-mouth ventilation. *N Engl J Med*. 2000;342:1546–1553.
16. Waalewijn RA, Tijssen JG, Koster RW. Bystander initiated actions in out-of-hospital cardiopulmonary resuscitation: results from the Amsterdam Resuscitation Study (ARREST). *Resuscitation*. 2001;50: 273–279.
17. Iwami T, Kawamura T, Hiraide A, et al. Effectiveness of bystander-initiated cardiac-only resuscitation for patients with out-of-hospital cardiac arrest. *Circulation*. 2007;116:2900–2907.
18. Bohm K, Rosenqvist M, Herlitz J, et al. Survival is similar after standard treatment and chest compression only in out-of hospital bystander cardiopulmonary resuscitation. *Circulation*. 2007;116:2908–2912.
19. Lynch B, Einspruch EL, Nichol G, et al. Effectiveness of a 30-min CPR self-instruction program for lay responders: a controlled randomized study. *Resuscitation*. 2005;67.
20. Steill IG, Wells GA, De Maio VJ, et al. Advanced cardiac life support in out-of-hospital cardiac arrest. *N Eng J Med* 351:647–656, 2004.
21. Geddes LA, Rundell A, Lottes A, et al. A new cardiopulmonary resuscitation method using only rhythmic abdominal compression: A preliminary report. *Am J Emerg Med* 2007; 25, 786–790.
22. Geddes LA, Rundell A, Otlewski M, et al. How much lung ventilation is obtained with only chest-compression CPR? *Cardiovascular Engineering: An International Journal*. 2008;8(3):145–8.
23. Tokuda AT, Ishimatsu S. A new cardiopulmonary resuscitation method using only rhythmic abdominal compression is hard. *Am J Emerg Med*. 2008;26(5):625.



Resident & Student Association



RESIDENT PRESIDENT'S MESSAGE

Health Care in America: A Liability Crisis?

Michael Ybarra, MD
AAEM/RSA President

The American Academy of Emergency Medicine (AAEM) has been hesitant to support current health care reform legislation under consideration by Congress because of the failure to address shortcomings that exist in the current tort system. Much has been said by advocates and policymakers on both sides of the aisle on this issue. Some argue the "crisis" that many physicians believe is a reality is overblown, and making substantial changes to the system will not help the bottom line. Others argue that medical liability contributes both directly to the cost of health care in America and indirectly in the form of "defensive medicine." The position of AAEM is that tort reform should be an important component of the legislation currently working its way through Congress. This next look at Health Care in America focuses on the current tort system – where we are and where we are headed.

Though the Federal Government has the authority to make significant changes to the tort system, currently, most malpractice law has been determined by the individual states. In fact, most malpractice law has not been written by the state legislatures but instead determined by courts establishing legal precedent.¹ The terms "malpractice" and "tort" are often used interchangeably, when in actuality, medical malpractice is a piece of the broader body of tort law which deals with injuries sustained by individuals. Tort law is divided into three categories: intentional torts (such as assault), negligence (for example, medical malpractice), and strict liability (damages suffered from hazardous products).

To successfully bring a medical malpractice case under the tort of negligence, the plaintiff must prove five elements²:

1. Factual causation – the "cause and effect" linkage
2. Legal causation – in other words, the remoteness of the injury to the negligence of the physician (this is to prevent liability for consequences not foreseen by any reasonable person)
3. Duty – meaning, a doctor-patient relationship or, in the ED, anyone who registers seeking care
4. Breach of duty – for example, not meeting the standard of care
5. Damages – such as physical loss of function, emotional loss, or monetary loss

As opposed to in a criminal trial where the plaintiff must establish proof beyond a reasonable doubt, cases in the tort system must prove these five elements with a preponderance of evidence.

If the plaintiff is successful in a malpractice case against a physician, the jury may award both compensatory and punitive damages. Compensatory damages are economic (such as the cost of medical care and lost wages) and non-economic (such as emotional or psychological harm). Punitive damages are awarded in cases where the jury believes the physician acted recklessly.

With this backdrop of the current system of medical malpractice, in the context of broader health care reform, many have wondered what significant changes can do to change the bottom line. The non-partisan Congressional Budget Office (CBO) released an analysis of the economic effects of a tort reform package consisting of a \$250,000 cap on non-economic damages and a \$500,000 cap for punitive damages. They estimated these changes would reduce the total cost of U.S. health care spending by 0.5% yearly and reduce the federal budget deficit by approximately \$54 billion over the next ten years. The savings would come roughly equally from savings in malpractice premiums and indirectly from savings on defensive medical practices.³

The Federal Government stands to gain from medical malpractice reform because of the amount of money spent on Medicare, Medicaid and the Children's Health Insurance Program. Additionally, the CBO concluded private health care premiums would decrease slightly, and because health care benefits are paid with pre-tax dollars, the government would collect more tax revenue from higher taxable wages.

Despite the CBO's research, some key Senators and advocacy organizations argue the data is flawed and the government stands to save much less. Outspoken critics of the legislation such as Rep. John Boehner of Ohio argue the CBO data is conservative and the country can save much more. Prior CBO reports (including the frequently cited 2004 study) failed to find significant savings. However, the 2009 report included new data from academic studies as well as evidence from states such as Texas and California, which adopted the caps listed above. The major unknown in the debate is the extent to which malpractice reform will impact physician practice patterns. Will doctors order fewer tests? The CBO cited a 2007 study that found states with higher malpractice costs had physicians that ordered more lab studies and imaging tests when compared to doctors practicing in states with a friendlier malpractice climate.

The Congressional Budget Office report released in October is an important tool physicians can use to urge lawmakers to

continued on page 22



We Need Your Expertise: Participate in the AAEM Career Network!

Career Network is a network of physicians, available to AAEM members only, who have volunteered to talk about the EM job climate in their area. It is helpful to graduating residents and those who are considering relocating. Did you know that approximately 10% of physicians change jobs annually? The average emergency physician will do so five to six times during their career. You can help your fellow AAEM members by participating in this nationwide network of AAEM physicians. Career Network was started by AAEM/RSA and needs your participation. There are still many areas that are underrepresented, including some states that have no representation!!



Take a look at our website; you can enter through links on

the AAEM website – www.aaem.org,
the AAEM/RSA website – www.aaemrsa.org,
or directly link to Career Network at <https://ssl18.pair.com/aaemorg/members/aaemcareer/network/>

What We Ask For:

1. Full Name
2. City, State (in which you can discuss the local EM practice environment - maximum of two areas)
3. Preferred method of contact: pager, email, etc.
4. Employer type: independent group, large corporate group, academic, hospital employee, etc.
5. Military affiliation: past or present

Go online and sign up to represent your area. If you have questions, please direct them to info@aaemrsa.org.

Thank you for your help.





RESIDENT EDITOR'S LETTER

Balance Billing

Ryan Shanahan, MD
AAEM/RSA Resident Editor



It was roughly one year ago that the California Supreme Court ruled in *Prospect Medical Group Inc. v. Northridge Emergency Medical Group* that physicians in California could not bill patients directly for the balance due after insurance reimbursement.¹ In a decision cheered by patient advocates and derided by most physicians (most of all those involved in the care of patients seeking emergency treatment),

doctors were left to battle it out with insurance companies if they felt that reimbursements were unfairly low.

First, let's start with a formal definition of balance billing. When anyone receives care, no matter how minor, a bill is generated – usually multiple bills – to account for hospital charges, equipment used and physician services. Typically, the charges represented in these bills are significant overestimates of what the hospital or physician group expects to collect. Insurance companies negotiate discounts of the charged amount and agree, or contract, with a hospital or physician to provide services at that discounted rate. If the hospital or physician were to then bill the patient directly for the difference between what the insurance company paid and what was initially billed, this would be balance billing.

Medicare and most insurance companies prohibit balance billing for elective services.² Part of the rationale is that a hospital or physician always has the option of refusing to accept the negotiated rate by refusing to see patients with a particular kind of insurance. In emergency care, however, the luxury of prescreening patients based on insurance does not exist. Emergency care must be provided under federal law – specifically the Emergency Medical Treatment and Active Labor Act (EMTALA).

What happens then, when insurance companies reimburse providers for emergency care at a rate that the providers deem unfair? In the past, emergency departments that were unsatisfied with the reimbursements provided by a particular insurance company would bill the patient directly for the difference. Because the bill generated by the emergency department was designed in anticipation of insurance discounting, collection of the balance from the patient could be viewed as a significant overpayment. Under the California ruling, the practice of balance billing for emergency services was forbidden. Doctors were entitled to a "fair" reimbursement for their services and could appeal to the insurance company but ultimately had to accept what was paid or pursue legal recourse. Theoretically, an insurance company could drop reimbursements to one cent on the dollar, and emergency providers would have to accept this or sue the insurance company (some would argue that MediCal already does this).³

Obviously, this is an unfair position in which to place California emergency providers. Our system of billing has not helped, though. If the amount the physician or hospital charged reflected a value closer to the cost of providing the services plus a reasonable profit rather than the current practice of charging based on expected reimbursements, then billing for the balance might be far less aggravating for patient advocacy organizations.

1. <<http://www.ama-assn.org/amednews/2009/01/26/prsa0126.htm#s1>>
2. <http://www.businessweek.com/magazine/content/08_36/b4098040915634.htm>
3. <http://www.foley.com/publications/pub_detail.aspx?pubid=5590>

Resident President's Message - continued from page 20

take malpractice reform seriously. Despite strong data from a non-partisan source, most political analysts believe it is unlikely that the current Congress will act. We are our best advocates, and many surveys of physicians suggest this is an issue we care about most. AAEM has voiced strong opinions on the importance of tort reform and in 2006 published a White Paper in the *Journal of Emergency Medicine*. The AAEM/RSA board will work with our committees and members to spread the word and advocate for this important issue. For more information, visit the AAEM/RSA website or read the White Paper at http://www.aaem.org/positionstatements/tortreform_whitepaper.php.

1. <<http://www.kff.org/insurance/7328.cfm>>
2. <http://info.med.yale.edu/caim/risk/malpractice/malpractice_2.html>
3. <<http://cboblog.cbo.gov/?p=389>>

**Welcome to our newest
100% Residency Program**

**University
of Toledo**

*To sign your program up for 100% membership,
please email info@aaemrsa.org*



Resident Journal Review: January-February 2010

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

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 from September and October 2009.

Viccellio A, Santora C, Singer AJ. The association between transfer of emergency department boarders to inpatient hallways and mortality: a 4-year experience. Ann Emerg Med. Oct 2009;54(4):487-491.

Emergency department boarding remains one of the most significant impediments to the provision of emergency care and one of the most important issues affecting the field of emergency medicine. The boarding of admitted patients is recognized as a major determinant of emergency department overcrowding. To address this problem, many have advocated that some admitted patients board in inpatient hallways. Indeed, others have found that patients prefer to board on inpatient services and may move into beds faster than if they were waiting in the emergency department. Opponents often relay concern over potential poor outcomes of hallway boarding. The authors of this study sought to examine the safety of moving admitted patients to inpatient hallways.

In this retrospective cohort study, the charts of all patients admitted via the emergency department between 2004 and 2008 were included. The hospital instituted an interdepartmental collaborative full capacity protocol in 2001, in which the ED treating physicians identified patients suitable for inpatient hallway boarding during times of full capacity. Patients were excluded from hallway boarding if they were admitted to an ICU or step down unit or they required high flow oxygen or frequent suctioning, or needed isolation due to diarrhea, neutropenia or respiratory causes, or were at risk for elopement. Patients with seizures or chest pain with positive troponin were also excluded. Other monitored patients were included. The primary outcome was mortality, and the secondary outcome was transfer to ICU.

Of the 55,062 admissions, 4% went to a hallway bed. Mortality was lower for patients admitted to hallways (1.1%) than for those admitted to standard beds (2.6%). Transfers to the ICU were also lower for patients initially placed in hallways than for those admitted to standard beds (2.5% compared to 6.7%). Anecdotally, monitoring failed to identify any increased or direct harm to patients.

Noticeably, this study has important limitations – namely the fact that the inpatient hallway admissions group was pre-selected to be a lower risk group by the exclusion of high severity of illness patients. Despite this acuity difference, the study suggests that boarding of patients in inpatient hallways does not result in an overt increase in harm. Furthermore, it lays the foundation for prospective, controlled trials to evaluate this potentially ground-breaking practice that addresses the problem of overcrowding on an institutional and interdepartmental manner.

Bektas F, Eken C, Karadeniz O. Intravenous paracetamol or morphine for the treatment of renal colic: a randomized, placebo-controlled trial. Ann Emerg Med. Oct 2009;54(4):568-574.

Acetaminophen has long been considered an effective oral or rectal treatment for acute pain. Additionally, at therapeutic doses, it may be associated with fewer side effects than many other analgesics, including opioids and non-steroidal anti-inflammatory drugs. Recently, intravenous formulations of acetaminophen (paracetamol) have become available in several European countries. In the U.S., intravenous acetaminophen was submitted for FDA in May of 2009 and is undergoing priority review. The authors of this study sought to evaluate the efficacy and safety of intravenous paracetamol compared to morphine and placebo.

In this prospective, randomized, double-blind, placebo-controlled trial, 146 subjects with renal colic were available for analysis after exclusions and randomization to receive 1 gram intravenous paracetamol, 0.1 mg/kg intravenous morphine or placebo. Rescue fentanyl 0.75 mcg/kg was provided at 30 minutes for treatment failures. The primary outcome was reduction in visual analog pain intensity score at 30 minutes. Secondary outcomes were need for rescue analgesics and adverse effects.

The mean reduction in pain intensity score at 30 minutes was equivalent for paracetamol (43mm, 95% CI 35-51mm) and morphine (40mm, 95% CI 29-51mm), and both were significantly greater than placebo (27mm, CI 95% 19-34). Use of rescue analgesics and combined adverse events were not significantly different among the groups. Among the paracetamol group, 11 patients (24%) had at least one side effect, most commonly nausea/vomiting (15%), versus the placebo group with eight patients (16%) with at least one adverse event. No serious adverse events were reported among any group.

This study adds to a small but increasing body of evidence to support the use of intravenous acetaminophen for acute pain. In this study, intravenous acetaminophen was as efficacious as intravenous morphine and without major adverse effects in the treatment of renal colic. Larger studies are required to validate these results; however, emergency physicians may have an additional, safe, intravenous analgesic agent available to treat pain found in emergency department patients.

Pines JM, Isserman JA, Hinfey PB. The measurement of time to first antibiotic dose for pneumonia in the emergency department: a white paper and position statement prepared for the American Academy of Emergency Medicine. J Emerg Med. Oct 2009;37(3):335-340.

The use of time to first antibiotic dose (TFAD) in community acquired pneumonia (CAP) as a performance measure of emergency

continued on page 24



department care has been highly controversial. Much of the debate revolves around concerns about the validity of data in the original studies, recommendations that were based on conflicting data regarding outcome benefit, and potential unintended consequences when such standards are practically applied. The authors of this study reviewed the literature regarding this topic in an attempt to address the two following questions: (1) Is measurement of TFAD associated with improved outcomes in CAP? (2) Is the measurement of TFAD associated with antibiotic overuse or interventions that could result in overuse in non-CAP conditions? This review was initiated by the Clinical Practice Committee of the American Academy of Emergency Medicine (AAEM).

After applying defined search criteria in PubMed, eight relevant articles were reviewed. Articles were assessed by separate reviewers and graded according to study quality and categorized with regard to direction of evidence. Two articles provided support for the use of TFAD protocols, one study was neutral, and five did not support the practice. Of the two supporting articles, one showed a mortality benefit while the other did not, after risk adjustment. Both studies showed significant decreases in length of stay. Importantly, both studies were before and after studies in which a complete pneumonia pathway protocol was initiated and included an early antibiotic administration component. Two of the other included studies did not show any mortality benefit.

Other studies showed some concerning consequences of instituting TFAD reduction methods: protocols prioritizing possible pneumonia patients over others, policies to give antibiotics before obtaining chest X-ray results, decreased accuracy of diagnosis of CAP (in two studies), and increased use of antibiotics in similarly presenting conditions (asthma, heart failure, COPD).

Importantly, the lead author of this study was also the lead author of an included study that questioned early TFAD measures and highlighted potential harms of these practices. Thus, the bias of the authors must be considered. Yet, given conflicting reports of benefits of this practice and lack of convincing evidence, combined with numerous studies showing unintended consequences, the authors of the study concluded that "it is difficult to support the continued measure of TFAD in the ED as a quality measure." The AAEM board unanimously approved a Class C recommendation (not acceptable or not appropriate) for the measurement of TFAD in the ED.

Hwang SO, Zhao PG, Choi HJ. Compression of the left ventricular outflow tract during cardiopulmonary resuscitation. Acad Emerg Med. Oct 2009; 16(10):928-933.

Since the 1960's, closed chest CPR has been used to provide artificial circulation via external compressions when rescuing patients from cardiac arrest. Recommendations from the 2005 International Consensus Conference on Cardiopulmonary Resuscitation and Emergency Cardiac Care Services state that rescuers should place their hands on the lower half of the sternum at the center of the chest between the nipples, depressing the chest 4-5cm. To date, little is known about which region of the heart is actually compressed. In

this single center prospective observational study, the authors sought to elucidate the morphological changes of the heart during chest compressions.

The study involved 34 patients over the age of 18 who presented with non-traumatic cardiac arrest or who developed cardiac arrest during their ED stay. CPR was performed by ED residents according to the American Heart Association (AHA) guidelines. Following endotracheal intubation and the first dose of epinephrine, transesophageal echocardiography was performed to monitor the heart during compressions.

Images that were captured during CPR showed there was significant narrowing of either the aortic root or the left ventricular outflow tract (LVOT) during chest compressions from 2.1cm to 1.0cm ($p < 0.001$). The area of maximum compression (AMC) was found to be at the aorta in 59% of patients and at the LVOT in 41%. On linear regression, calculated left ventricular stroke volume increased as AMC moved closer to the left ventricle.

With recent literature emphasizing the importance of effective uninterrupted chest compressions on patient survival, this novel study shows that the current guidelines on hand position for CPR are not the most effective for generating forward blood flow. The authors suggest that the hands should be placed more caudal on the sternum in order to prevent compression of the aortic root or the LVOT.

Kupperman N, Holmes JF, Dayan PS. Identification of children at very low risk of clinically-important brain injuries after head trauma: a prospective cohort study. Lancet. 2009; 374: 1160-1170.

Children who sustain minor head trauma infrequently have clinically important traumatic brain injuries (ciTBI) and rarely need neurosurgical intervention. Now that accessibility to CT scans has increased, close to 50% of children who are seen in North American emergency departments for head trauma undergo CT scanning. The vast majority have no significant findings. The unnecessary radiation exposure to this most vulnerable of populations has prompted researchers to seek criteria to risk-stratify those patients who are at very low risk for ciTBIs.

This multicenter prospective cohort study studied children under 18 years of age in 25 emergency departments in the U.S. who presented to the ED within 24 hours of head trauma. Exclusion criteria were trivial injury, defined as a ground-level fall or running into a stationary object, presence of ventricular shunt, GCS less than 14, and history of a bleeding diathesis. The outcome measure for the 42,414 patients in the study was the development of ciTBI (death, neurosurgical intervention, intubation for more than 24 hours or hospital admission for more than 24 hours due to brain injury). The decision for the patient to undergo CT scanning or to be admitted was at the discretion of the ED physician. Those who were discharged were followed up 7 to 90 days after the initial ED visit to identify missed injuries.

continued on page 25



Resident Journal Review - continued from page 24

The data showed that 14,969 (35.3%) patients had head CTs performed, and 5.2% had traumatic brain injuries on CT (defined as intracranial hemorrhage or contusion, cerebral edema, infarction, diffuse axonal injury, shearing injury, midline shift, herniation, diathesis of the skull, pneumocephalus, sinus thrombosis or depressed skull fracture). Prediction criteria for children under age two who developed ciTBI included altered mental status, non-frontal scalp hematoma, loss of consciousness for more than five seconds, severe injury mechanism, palpable skull fracture and abnormal behavior. For children aged two years and older, predictors include altered mental status, loss of consciousness, vomiting, severe injury mechanism, signs of basilar skull fracture and severe headache. Severe injury mechanism was defined as motor vehicle crash with rollover or patient ejection, death of another passenger, pedestrian or unhelmeted bicyclist struck by a motor vehicle, fall more than three feet in those less than two years old, fall more than five feet in those two years of age or older or head struck by high-impact object. If all of the criteria are negative, then the negative predictive value and sensitivity for predicting ciTBIs in those under two years of age were 100% and 100%, respectively; and for those two years of age and older, they were 99.5% and 96.8%, respectively.

The authors state that if the rules had been applied to the patients in this study, 25% of the head CTs would have been avoided. Interestingly enough, for those under two years old with altered mental status or palpable skull fracture, the risk of ciTBI was as high as 4.4%. Although these prediction criteria are helpful to risk-stratify patients, this study must be reproduced and validated in different populations. As with all clinical prediction rules, the purpose is not to replace clinical decision-making but to inform the clinician.

Tauber M, Koller H, Moroder P. Secondary intracranial hemorrhage after mild head injury in patients with low-dose acetylsalicylate acid prophylaxis. J Trauma. 2009; 67(2):521-525.

Low dose acetylsalicylic acid (LDA) prophylaxis is commonly used for

patients with ischemic heart disease, cerebrovascular disease and peripheral vascular disease, among other reasons. The relationship between the use of LDA and the risk for intracranial bleeding after head trauma has not been clearly defined. This study sought to evaluate the prevalence of secondary intracranial hemorrhage after head trauma in patients taking LDA.

This was a single-center prospective study at a level one trauma center in Austria. One hundred consecutive subjects were enrolled who met the inclusion criteria of age over 65, taking regular LDA-prophylaxis (100mg/d), isolated mild head injury with a GCS of 15, preliminarily negative head CT, and no hypertensive irregularities (systolic blood pressure over 150 mmHg). Exclusion criteria included use of clopidogrel, warfarin or NSAIDs, hematologic or oncologic disease, and moderate or severe head injuries. Regular repeat head CT (RRHCT) were done for all patients within 12-24 hours.

Results of the RRHCT showed that four patients developed a secondary intracranial hemorrhagic event (SIHE), one of which was a large intraparenchymal hemorrhage with midline shift resulting in death, and one other who required neurosurgical drainage of a subdural hematoma. The other two patients required no interventions and did well. Initial coagulation profiles were similar among those who had SIHE and those who did not. Based on these results, the authors support the decision to have all patients over age 65 on LDA prophylaxis with mild head trauma admitted for observation and have a RRHCT in 12 to 24 hours. If RRHCT is not done, then the patient should be observed for more than 48 hours.

There were many limitations to this study. First, this small prospective study did not have a matched control group not taking LDA for comparison. Also, mild head injury was never defined. In addition, patients were included if they were admitted to the hospital, and this may represent a selection bias, studying a more acute subset of patients. Finally, other co-morbidities were not considered in the study. Before the recommendation can be made to admit all patients over age 65, further studies must be done.

Washington Watch - continued from page 7

malpractice statute...[and] relief for Christopher Torretti's traumatic brain injuries may be available in other forms, but is not provided under EMTALA."

In affirming the trial court's ruling, the appellate court reviewed EMTALA, as well as the Department of Health and Human Services' Centers for Medicare and Medicaid Services (CMS) regulations promulgated to interpret and apply EMTALA. Turning to the regulation's interpretation of the statute, the court wrote: "EMTALA's requirements are triggered when an 'individual' comes to the emergency department. An 'individual' only 'comes to the emergency department' if that person is not already a 'patient'... The Regulation defines 'patient'...as '[a]n individual who has begun to receive outpatient services as part of an encounter... CMS explains that EMTALA does not apply to outpatients, even if during an outpatient encounter 'they are later found to have an emergency medical condition...[and] are transported to the hospital's dedicated emergency department.'" The court then

iterated the fact that Torretti "came to Paoli for her scheduled appointment involving routine monitoring of her high-risk pregnancy and did not present as an emergency to the Paoli medical staff; thus concluding that "Torretti's circumstances are not those contemplated by EMTALA coverage."

As to the Torrettis' stabilization claim that defendants violated EMTALA because they did not stabilize her emergency condition and inappropriately transferred her, the appeals court concurred with the district court's dismissal of the claim on summary judgment because the Torrettis could not show that defendants had actual knowledge of an emergency medical condition, and "the requirement of actual knowledge is the key to this [EMTALA] issue." This court conformed with all its sister circuit courts of appeals that have addressed this issue under EMTALA and have determined that "Congress did not intend EMTALA to serve as a federal malpractice statute or cover cases of hospital negligence."

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



MEDICAL STUDENT COUNCIL PRESIDENT'S MESSAGE

It's VEGAS BABY!!!

Jamie "Akiva" Kahn

President, AAEM/RSA Medical Student Council



Happy New Year - I hope your 2010 is off to a wonderful start!! 2009 was filled with wonderful experiences for me: SAEM in New Orleans, ACEP in Boston, applying for a residency position, finishing up my clerkships, traveling around the country to interview...it has been quite the year! During my journey, I have met some wonderful and inspirational people and have enjoyed the huge variety of experiences. 2010 holds just as much potential. For those of us finishing up, we are looking forward to futures we have been envisioning since we first received our short white coats. Match Day, graduation (longer coats!), saying goodbye to the friends that got us through some of the tough times and celebrated with us after exams, and meeting our new colleagues when we start our first days of residency. For the third years in the crowd, you are halfway done! Almost "old pros," there is no question that you will survive this challenging year and emerge at the end stronger and wiser...and hopefully more certain that emergency medicine is the right specialty for you. First and second years, I am glad you're taking the time to take a break from the anatomy lab and pathology textbook to read this article. While what I am about to say applies to all medical students, you have the most to gain from it:

**AAEM Scientific Assembly in Las Vegas.
Vegas Baby!!**

What happens in Vegas...at least when it comes to your experiences at this conference...doesn't exactly stay in Vegas. Nor do you want them to. These events are an incredible chance to meet people: medical students, residents, mentors, faculty and program directors.

Sure, everyone will say it is important that you show up at a conference here and there. But without taking full advantage of them, without putting yourself out there and using these incredible opportunities to learn more about emergency medicine, about the issues in our field, about your potential future residency program...you're just another face in the crowd. So I challenge you to come and GO ALL IN!

So here is the deal. I am inviting you to be AAEM/RSA's Valentine's date on February 14th at the Medical Student Track in Las Vegas. I think you should court emergency medicine, take it out for a spin on the dance floor, and see if you feel any sparks. Or, for those students out there who are already in love, come and renew your vows. We will plan it all and ensure there is something for everyone. We will congratulate the schools that have achieved the status of EMIG Select by having 20 or more AAEM/RSA members and encourage you all to become more involved in leadership; either in your school's interest group or nationally with AAEM/RSA and the Medical Student Council! Check out the AAEM/RSA website, Facebook page and emails for more details about scheduled events.

The Next Generation of Board Review—

"This book is amazing; it's really helping my in-service review."



"AAEM and Dr. Schofer have done an outstanding job preparing a comprehensive and succinct review of emergency medicine designed to prepare you for the qualifying exam in emergency medicine. With the review chapters and test questions, I would not need any other resource to prepare for this exam."

AAEM Resident and Student Association's:

Emergency Medicine: A Focused Review of the Core Curriculum

Editor-in-Chief: Joel Schofer, MD FAAEM

Senior Associate Editor: Amal Mattu, MD FAAEM

Associate Editors: James Colletti, MD FAAEM

Elizabeth A. Gray, MD

Robert Rogers, MD FAAEM

Richard Shih, MD FAAEM

"A Focused Review of the Core Curriculum has found the perfect balance of depth and brevity to match my test anxiety and short attention span."

This is a 22 chapter text based on the contents of the national AAEM Written Board Review Course, and written to prepare you for the:

- Emergency medicine qualifying exam (formerly the "written boards")
- Emergency medicine annual resident in-service exam
- ConCert Exam
 - 79 color images
 - 225 question practice in-service examination
 - 22 chapters written by experts in the field

This text also serves as a comprehensive review of emergency medicine for the motivated medical student.

INTRODUCTORY PRICE:

\$49⁹⁵

for AAEM members
(plus shipping & handling)

\$79⁹⁵

for non-members
(plus shipping & handling)

15% discount for 100% residency programs
Buy a set of board review books
for your graduating seniors or
incoming interns and save 10%!

To purchase your copy, go to www.aaemrsa.org or call 800-884-2236.

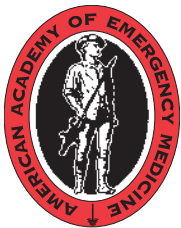
AAEM introduces the new members only area of the website.

- 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.



FAAEM
always means
board certified

common **SENSE**

555 East Wells Street / Suite 1100
Milwaukee, WI 53202-3823

Pre-Sorted
Standard Mail
US Postage
PAID
Milwaukee, WI
Permit No. 1310



PRE-CONFERENCE COURSES

- Advanced Ultrasound
- Coming to an ED Near You – Bringing Military Medical Advancements to the Civilian Emergency System
- LLSA Review 2009
- Pediatric Emergencies
- Presentation and PowerPoint® Skills for Emergency Physicians
- Regional Anesthesia Skills Lab
- Resuscitation for Emergency Physicians: The AAEM Course (2 day course)

Remember, in today's economy, every dollar counts. Scientific Assembly registration is always **FREE** for AAEM members (registration fee is refundable). Prices for the pre-conference courses vary but are well worth the investment!

Registration now open!
Go to www.aaem.org