common SENSE

~ELECTION~ ISSUE

VOLUME 16, ISSUE 1
JANUARY/FEBRUARY 2009

THE NEWSLETTER OF THE AMERICAN ACADEMY OF EMERGENCY MEDICINE

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PRESIDENT'S MESSAGE

Join the AMA Now!

Larry D. Weiss, MD JD FAAEM

Recent decisions by the American Medical Association (AMA) reinforce the need for more AAEM members to join "the house of medicine." Despite relatively few emergency physicians who belong to the AMA, the Texas Medical Association and the AMA recently submitted an amicus curiae brief on our behalf in our Texas cases against TeamHealth. They made this decision because the issues in our cases may ultimately affect all physicians. I also firmly believe they provided the amicus brief because they just wanted to do the right thing.

In recent years, the AMA intensely lobbied for tort reform, EMTALA reform and many economic issues that benefit physicians. In 2006, the AMA issued a Board of Trustees (BOT) report on the corporate practice of medicine (CPOM), offering to provide assistance to state medical societies to encourage legislatures to strengthen legislation regarding the lay corporate practice of medicine.

The AMA has steadily increased its efforts to advocate for our patients. Nearly three years before the Institute of Medicine published its book *To Err is Human*, the AMA founded its National Patient Safety Foundation dedicated to decreasing the clinical rate of error. The AMA strongly advocates against the abuse of alcohol, tobacco and illegal drugs. Currently, the AMA has an organized campaign to extend health insurance coverage to all patients.

On many issues regarding physician practice rights, emergency physicians receive a great deal of support from the AMA. As noted above, the AMA currently has a strong interest in the problem of lay corporate control of medical practices. An author of the BOT report on CPOM, AMA President-Elect J. James Rohack, MD, will address this issue at our Scientific Assembly, where he will deliver the keynote address on March 2, 2009.

Specialty societies alone cannot resolve some of medicine's most intractable problems, such as the liability crisis and the CPOM issue. Having the support of physicians from many specialties can help us resolve some of emergency medicine's most important problems. In turn, our role as good citizens in the house of medicine will require us to help resolve problems affecting other specialties. This will make us all stronger and will allow us to improve the medical care received by all patients.

Currently, AAEM has no seats in the AMA House of Delegates (HOD) because too few of our members belong to the AMA. AAEM attends sessions of the AMA's Specialty and Service Society, but we can only stand in the back of the room and observe HOD deliberations without the right to participate. The time has come for us to mature as a society and take our place in the AMA HOD. The AMA currently has a moratorium on admitting new specialty societies to the HOD until it works out new conditions on participation. In all probability, the modified rules will not change significantly. More AAEM members must join the AMA for us to have a voice in the HOD.

By joining the AMA, you will get the personal satisfaction of directly working with a wide variety of physicians in your county and state. In many localities, we get overlooked because we simply have not been involved. Your membership in the AMA will also give AAEM a voice in the AMA HOD. Help advocate for the medical profession, your specialty and your patients by joining the AMA. You may easily find membership information on their website at www.ama-assn.org.

To sign up for
AAEM or **AAEM/RSA**
membership, go to
www.aaem.org/membership
or call 800-884-2236.

INSIDE THIS ISSUE

EDITOR'S Letter

Thank You

EDITOR'S LETTER

David Kramer, MD FAAEM

As many of you know, my term on the board of directors (BOD) will end at our 15th Annual Scientific Assembly. Also, this is my last issue as editor of *Common Sense*. I have enjoyed both roles immensely, and it has been both an honor and a privilege to serve both AAEM and you over the last three years. I have learned a lot and hopefully have contributed in some small way to our overall organizational wisdom.

Since I am stepping down as editor, the position is open and the BOD invites any interested parties to please notify the home office so that your name can be added to the list of potential editors. This is a wonderful opportunity to contribute to your organization while simultaneously having a regular forum for expressing your own ideas and opinions on many of the issues facing our specialty.

Next, I'd like to remind everyone that your vote for our new directors on the board is very important. The people on the BOD are your representatives and speak for you. This alone should stimulate you to take advantage of your opportunity to help determine who takes on such an important role.

Finally, I'd like to remind everyone that it is not too late to register to attend the upcoming AAEM Scientific Assembly. I look forward to seeing everyone there.

Thank you again.
Dave Kramer, MD FAAEM

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 quallity 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 (Associate-voting status)
Emeritus Member: $250 (Must be 65 years old and a full voting member in good standing for 3 years)
Affiliate Member: $365 (Non-voting status; must have been, but are no longer ABEM or AOBEM certified in EM)
International Member: $125 (Non-voting status)
AAEM/RSA Member: $50 (voting in AAEM/RSA elections only)
Student Member: $50 (voting in AAEM/RSA elections only)
*Associate membership is limited to graduates of an ACGME or AOA approved Emergency Medicine Program.

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.

Recognition Given to Foundation Donors

The information below includes a list of the different levels of contributions to the AAEM Foundation. The Foundation would like to thank the individuals below that contributed in 2008.

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

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

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The AAEM Foundation thanks

William T. Durkin, Jr., MD MBA FAAEM

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

The AAEM Foundation thanks

Samuel H. Glassner, MD FAAEM

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

Donate to the AAEM Foundation!

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

Recognition Given to Foundation Donors

The AAEM Foundation thanks

David W. Lawhorn, MD FAAEM

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

Candidate Platform Statements

AAEM does not endorse any statement made by candidates and specifically rejects anticompetitive statements.

The nomination period for AAEM's upcoming elections has ended. All individuals running for an open seat on the board of directors have been identified, and the race has begun. Presented here for the benefit of all full voting, emeritus and Young Physician Section (YPS) members of AAEM are the formal platform statements of each of the candidates.

The elections will be held immediately following the Candidates Forum scheduled during AAEM's 15th Annual Scientific Assembly, March 2-4, 2009, at the Sheraton Phoenix Downtown Hotel in Phoenix, AZ. Although balloting arrangements will be made available for those unable to attend the Assembly, all voting members are encouraged to hold their ballots until the time of the meeting. The forum will allow members the opportunity to question candidates directly about their vision of the association and its place in the specialty of emergency medicine. The responses offered in this session, in addition to the platform statements offered here, will provide members with the information they need to make intelligent and informed decisions.

AAEM's democratic election process is just one of the many things that make our organization unique among medical specialty societies. Please carefully review the information presented here, and then make your arrangements to join us in Phoenix for the Forum and final elections.

Full voting, emeritus and YPS members not planning to attend the Scientific Assembly should return their completed ballot to the AAEM office in the enclosed envelope. Those attending the Phoenix conference should remember to bring their ballots with them for voting after the special Candidates Forum to be held on Tuesday, March 3rd, 2009, from 12:00 p.m. to 2:30 p.m.

Kevin H. Beier, MD FAAEM

Candidate for At-Large Board Member

Nominated by Andy Walker, MD FAAEM, and Larry Weiss, MD JD FAAEM

I am honored to have been nominated for this position and would like to thank Andy Walker and Larry Weiss for their confidence in considering me for the AAEM board.

The growth of the American Academy of Emergency Medicine over the last 10 years has been exceptional, and if the Academy continues to grow, our ability to argue on behalf of our specialty and our patients will similarly strengthen. The Academy has matured in parallel with our specialty and has taken the correct position in defending the working emergency physician and our patients without equivocation.

As a long-standing member of AAEM, I will continue to fight against corporate and other abuses of emergency physicians and to defend our patients. I have practiced community-based emergency medicine since completing residency 13 years ago, and I am thus well aware of the turmoil and challenges we and our patients face in this rapidly evolving healthcare climate.

I was fortunate enough to receive an excellent medical education at the University of Virginia and outstanding residency training in emergency medicine at Hennepin County Medical Center in Minneapolis. I am indebted to those institutions and the quiet titans of emergency medicine who taught me the art of medicine. I believe strongly in ABEM board certification as the best means to ensure both good patient care and the continued health of our specialty. I will fight for this principle as a board member.

I am one of the founders of the Tennessee Chapter of AAEM and served TNAAEM as its first president. During our first two years as a fledging chapter, we successfully fought what seemed to be overwhelming forces in their attempt to bring back restrictive covenants for emergency physicians in the State of TN. We also worked with the state government to reduce ED over-utilization, while at the same time protecting both patients and emergency physicians. Under my leadership, TNAAEM proved to be an effective lobby despite its small size, and has been a consistent voice in the state legislature for individual emergency physicians. At the national level, I serve as Chairman of Government Affairs for the Academy, and I have a particular interest in driving malpractice tort reform. I intend to pursue this passionately at both the state and federal levels.

I take the opportunity to serve AAEM as a board member very seriously, and if elected, I will strive to make emergency medicine better for the working emergency physician and our patients. Thanks for your consideration.

Candidate Platform Statements

Patrick Connor, MD FAAEM

Candidate for At-Large Board Member

Nominated by Tom Scaletta, MD FAAEM, and Robert McNamara, MD FAAEM

Why I seek your vote?

In a word "PASSION:" For our craft and for our need to work in a fair and equitable environment. Passion: For fairness, honesty and positive changes in our working environment. My background in emergency medicine is deep and varied. I helped establish two emergency medicine practices. The basis of my second practice, the one I founded, was guided by the principles as established by AAEM: A fair and equitable working environment, involving open books, equal shifts, equal pay, the elimination of non-competes and restrictive covenants.

Over my 18 year career, I have honed my leadership skills in both the academic and community working environments. I have also have been privy to the pitfalls of corporate emergency medicine. Much like the practice of emergency medicine, I have experienced it – as both employee and owner – from many angles. The experience and knowledge that I have acquired over the years, the experience that I can offer as an at-large board member of AAEM, cannot be replicated by reading manuals or texts. The insights that I have gained from my experiences, past and present, will be an asset to the AAEM board and its membership.

I would like to thank Drs. Tom Scaletta, MD FAAEM, and Robert McNamara, MD FAAEM for nominating me.

Vote for courage and reason.

Mark Foppe, DO FAAEM

Candidate for At-Large Board Member

Nominated by William Durkin, MD MBA FAAEM, Robert McNamara, MD FAAEM, and Larry Weiss, MD JD FAAEM

Many thanks to Bill Durkin, Bob McNamara and Larry Weiss for the nomination. I am grateful to have further opportunity to serve AAEM. I was "turned on" to AAEM when Bob McNamara, MD, lectured to my residency. I joined the next day as a resident member and have been active and supportive since, giving annually to the AAEM Foundation and the PAC. It is with great pride that I place FAAEM behind my degree.

Through the years, I have served on the EM Practice, Government Affairs, Membership and OMC committees. I have chaired the Task Force protecting the integrity of our board certifications against AAPS/BCEM. I currently serve as a sub-committee chair to OMC, and this year, I was named chair of the Membership Committee.

I was board certified by AOBEM in 2002, receiving fellowship by the ACOEP in 2004. For the ACOEP, I serve on the Board of Directors for the Foundation of Osteopathic Emergency Medicine (FOEM), chair the Academic Awards Committee and am vice-chair of the Research Committee. I moderate and organize the Resident Research Award Competitions (posters, research papers and oral abstracts) and have served as moderator/organizer for the Clinical Pathology Competition (CPC) for the past four years.

On the state level, I currently serve as president of the Florida Chapter of AAEM (FLAAEM). Please see our website at www.FLAAEM.org to review our activities. I also sit on the Board of Trustees for the Florida Osteopathic Medical Association (FOMA).

I work in the adult and pediatric emergency departments at Lakeland Regional Medical Center in Lakeland, Florida. The annual volume is 136,000+ patients. I love emergency medicine and pride myself on being a "pit doc." I work 20 nine hour shifts each month.

If elected, I promise to serve the Academy and its membership with diligence and dedication. I will focus on promoting sovereign immunity for EMTALA based care providers, supporting due process rights for the EM physician and continuing to oppose the recognition of BCEM as equivalent to ABEM/AOBEM.

Candidate Platform Statements

John Levin, MD FAAEM

Candidate for At-Large Board Member

Self-Nomination

I would like to help all members (and nonmembers, if asked) navigate the waters of any medical malpractice case with which they become involved. I have been an emergency medical defense expert for 22 years and have defended – successfully – many ER physicians across the country. I understand the stress that is incurred when a physician is sued and know how to assist both the attorney and the doctor. I would like to evaluate any medical malpractice that a member requires. I have worked with many attorney firms across the country and am very comfortable at trial and deposition defending emergency physicians.

Lisa Mills, MD FAAEM

Candidate for At-Large Board Member

Nominated by Trevor Mills, MD FAAEM

One foot in academia, one foot in the community. Like many emergency physicians, I wear a number of different "hats." I spend half my life on the west coast working in a busy community ED. Here, I routinely deal with the issues that face many emergency physicians: overcrowding, diversion, lack of consultants, irritable specialists, financial pressure and loads of paperwork. During the other half of my career, I work on the "third coast," in academia, teaching residents, students and faculty in the ways of ultrasound. Here, I promote EM in the political battles over performance, credentialing and billing for ultrasound. In either setting, the position statements of AAEM guide my course.

Open books, non-discrimination, fairness in the workplace – these are real issues that significantly affect job satisfaction and physician wellness. Each is an issue where AAEM has paved the way for every emergency physician. As Chair of the AAEM Women's Interest Group, I bring these same issues to light for women emergency physicians who face additional barriers to fair practice based upon gender.

In the realm of clinical practice, from the use of tPA, treatment of VT/VF, to the use of ultrasound, AAEM has put itself on the line to protect the emergency physician's clinical judgment. Likewise, as a member of the AAEM Clinical Guidelines Committee, I have developed statements promoting the use of evidence-based medicine in everyday practice.

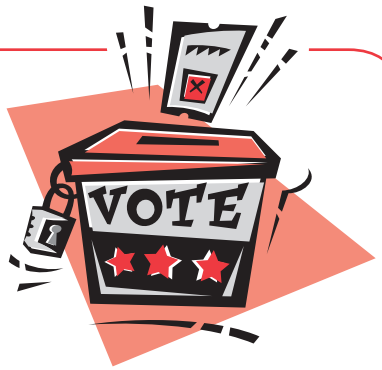
During my term on the board of directors for the Louisiana Chapter of AAEM, I renewed my belief in the mission of AAEM. At this time, Hurricane Katrina flooded my city and devastated my hospital. After the storm, I worked side by side with fellow emergency physicians in a sweltering parking lot without electricity, side by side with physicians whose families were evacuated, whose homes were destroyed, whose careers were in jeopardy and whose lives were in shambles. These physicians stayed to help and to heal when their own lives were in a state of upheaval. These physicians exemplified emergency medicine, the practice of caring for people. AAEM supported and acknowledged the work of the physicians of the gulf coast. AAEM defends the rights of all emergency physicians every day.

Advocacy, equality and common sense – these are the traits that AAEM has helped install in my career; these are the traits that I will apply while serving on the board of directors. One foot in the community, one foot in academia, one physician dedicated to AAEM.

Don't forget to vote!

If you are unable to attend the 15th Annual Scientific Assembly in Phoenix, make sure to send in your ballot in the envelope provided.

See instructions and ballot after page 18 inside this issue.



Candidate Platform Statements

Mark Reiter, MD MBA FAAEM

Candidate for At-Large Board Member

Nominated by Howard Blumstein, MD FAAEM, Tom Scaletta, MD FAAEM, and Larry Weiss, MD JD FAAEM

I am pleased to accept a nomination for the AAEM board of directors. Over my past four years on the AAEM board, I have worked hard to promote AAEM's mission for our members. I also serve on the AAEM Services Board, helping to oversee business activities such as AAEM's relationship with PEPID, as well as EvolveMed (our partner for AAEM PeerCharts). I am well-prepared for this role, having earned an MBA with concentration in Health Care Policy, and through my prior experiences on the board of trustees of the Medical Society of New Jersey, the AMA Council on Legislation, and leadership roles in many other organizations, including past president of the AAEM Resident and Student Association (AAEM/RSA).

I promise to keep our membership well-informed of the great work being done by the Academy. I will continue to strongly advocate for you on core issues such as defending the value of board certification and combating corporate practice of medicine abuses. I am committed to developing new opportunities for our membership, such as the new Young Physician Section (YPS). As a member since 2001, I firmly believe in the AAEM mission and hope to have the opportunity to continue to serve you, our membership. I'm asking for your vote, as I have the experience, skills and enthusiasm to help AAEM continue to thrive.

American Academy of Emergency Medicine involvement (2001 to present)

- Board of Directors, AAEM
- Board of Directors, AAEM Services
- Board of Directors, AAEM Resident and Student Association
- President, AAEM Resident and Student Association
- Vice President, AAEM Resident and Student Association
- Chair, AAEM Board Certification Task Force
- Chair, AAEM/RSA Communications Committee
- AAEM Committees: Operations Management, EM Practice, Corporate Practice of Medicine, EMTALA
- Liaison to AAEM Young Physician Section
- Liaison to AMA Resident/Fellow Section

David D. Vega, MD FAAEM

Candidate for YPS Director

Nominated by David Kramer, MD FAAEM, Mark Reiter, MD FAAEM, and Larry Weiss, MD JD FAAEM

I am happy to accept the nomination for YPS Director on AAEM's board of directors. I am an active clinician and Associate Program Director at York Hospital, a community teaching center in York, Pennsylvania. I have served AAEM through many activities aimed at providing improved resources for younger physicians within the organization and would like to continue these efforts as the YPS Director.

As an associate member of AAEM, I petitioned for the formation of the Young Physicians Section (YPS) taskforce and then led this group as its chairperson. I played a key role in developing the AAEM bylaw changes that allowed for the creation of Sections within AAEM, thereby allowing the Young Physicians Section to be established. I then led the team that developed the YPS bylaws and structure, subsequently serving as the founding president of the Section. I was re-elected as president for a second term and now serve on the YPS board of directors as the immediate past president. This experience in founding and leading the Young Physicians Section has prepared me well to serve as the YPS Director.

Along with Tom Scaletta, I am a chief editor and contributing author for *Rules of the Road for Young Emergency Physicians*, which we plan to begin distributing through the YPS in early 2009. One of my goals is to help the YPS develop a library of publications such as this one, to be used as a resource for members and for recruiting (and retaining) graduating residents and practicing young emergency physicians into the Academy. It is critical to the future of our specialty that we continue to educate younger emergency physicians about the issues that threaten the safe and fair practice of emergency medicine by board certified specialists.

Outside of the Young Physicians Section, I also serve the Academy as the series editor for AAEM's "Ask the Experts in Emergency Medicine" series on Medscape. I have also enjoyed volunteering with AAEM's oral board review course and plan to continue with this as often as possible. I look forward to working with the YPS and the board of directors in encouraging existing young members to increase their own involvement within AAEM.

I am grateful for the leadership opportunities that AAEM has provided me so far, and would be proud to continue serving the academy through a position on the board of directors. With this in mind, I would ask you to vote for me as the next YPS Director.

MedPAC to Recommend Broad Disclosure of Industry's Financial Ties to Doctors

Kathleen Ream
Director of Government Affairs

In its report to Congress in March 2009, the Medicare Payment Advisory Commission (MedPAC) will recommend that drug and medical device makers, as well as hospitals, be required to publicly report details about their financial relationships with doctors and other healthcare providers and groups. On November 6, 2008, the commissioners approved a package of five such disclosure and reporting recommendations that are intended to discourage inappropriate deals among healthcare institutions, companies and practitioners. Another intent is for researchers to use the publicly reported information to study how financial ties among healthcare providers affect practice patterns.

MedPAC Chair, Glenn Hackbarth, said the recommendations were aimed at transparency, not condemnation, of financial arrangements in the healthcare industry. He added that if all financial links were inappropriate, MedPAC would urge their elimination.

While state disclosure laws have centered on drug company payments in the form of cash, food and gifts to doctors, MedPAC's recommendations go far beyond that. The first of the five recommendations the panel adopted calls for broad disclosure of payments that drug and device manufacturers make to doctors, pharmacists, health plans, organizations that sponsor continuing medical education, hospitals and medical schools, patient organizations and professional organizations. The second recommendation urges Congress to direct the Department of Health and Human Services (HHS) Secretary to report that information on a public website searchable by manufacturer, doctor name, type of payment and other factors.

The third recommendation addresses the free drug samples drug companies widely distribute to doctors, a tactic critics say leads to unjustified prescribing of costly brand-name drugs. It urges Congress to require drug manufacturers and distributors to report to the HHS Secretary specific information about free drug samples given to physicians and physician groups. MedPAC did not recommend that a value on the free samples be reported or that the data be reported publicly, but it did recommend that the data be made available to researchers to study the impact of samples on prescribing decisions.

The last two recommendations deal with financial relationships between hospitals and doctors, and concerns that giving doctors an ownership stake in hospitals can lead to inappropriate referrals to the facility. Recommendation four calls on Congress to require hospitals and other entities that bill the Medicare program to annually report specific data on physician ownership in their businesses, except where the businesses are publicly traded organizations and to post the data on a public website. The fifth recommendation urges Congress to require that HHS submit a report on "the types and prevalence of the financial relationships between hospitals and physicians."

While MedPAC's recommendations and possible design features for a public disclosure law have manufacturers reporting on a host of financial relationships ranging from consultant payments to medical education grants, rebates and discounts given to health plans and pharmacy benefit managers were considered proprietary data not to be included for competitive reasons. MedPAC Commissioner, Thomas Dean, disagreed and called the omission "unfortunate." Also, a number of commissioners emphasized that financial ties between doctors and drug and device companies can improve healthcare by promoting product development, for example, and that these beneficial links should not be discouraged by a disclosure law.

EMTALA Screening Examination Case Proceeds in Virginia

On September 5, 2008, the U.S. District Court for the Western District of Virginia denied defendant Danville Regional Medical Center of Virginia LLC's (DRMC) motion to dismiss a lawsuit claiming the hospital violated EMTALA by not providing an appropriate medical screening examination for plaintiff, who suffered a heart attack and a stroke at DRMC after being left untreated in the hospital's emergency department for more than 11 hours. (Scruggs v. Danville Regional Medical Center of Virginia LLC, W.D. Va., No. 4:08CV00005, 9/5/08).

The Facts

On September 3, 2006, Everett Wayne Scruggs (plaintiff) arrived at the DRMC ED complaining of "prolonged dry heaves over the past two days." An ED registered nurse conducted a triage screening examination, prioritized Scruggs as a "non-urgent" patient, but did not include in the triage report Scruggs's "diabetic ketoacidosis condition or his history of diabetes."

Approximately 11.5 hours after the plaintiff arrived at DRMC's ED, Dr. Ramon Gomez took a medical history and performed a medical examination, after which Gomez ordered intravenous fluids, oxygen, cardiac monitor, cardiac labs and a blood sugar test. Nearly 40 minutes later, a nurse found plaintiff "unresponsive and in cardiac and respiratory arrest." Plaintiff was successfully resuscitated with his cardiac status improving within 15 minutes. Plaintiff "was treated at DRMC until September 18, 2006, and was never transferred to another facility."

Seventeen months later in February 2008, plaintiff filed suit alleging an EMTALA violation that DRMC failed to provide an appropriate and prompt medical screening examination (MSE). Defendant moved to dismiss arguing that the complaint fails to set forth facts as required under EMTALA. Plaintiff responded that triaging alone is not equivalent to an appropriate MSE. Defendant replied by asserting that the claim is one for "negligent triage and that EMTALA is not a substitute for state law medical negligence claims."

The Ruling

The district court found that triage is not equivalent to an EMTALA-required MSE, because triage "merely determines the order by which patients are seen in the emergency department." "Plaintiff clearly has outlined a claim within the realm of EMTALA," the court continued, "by asserting he did not receive an 'adequate' medical screening examination based on the eleven and one-half hour time period prior to receiving medical treatment. This is clearly more than a claim for negligent triage as proposed by Defendant at oral argument."

For these reasons, the court determined that the plaintiff's claim was sufficient under EMTALA and that the defendant's motion to dismiss was denied.

The opinion can be obtained at http://www.vawd.uscourts.gov/opinions/kiser/8-5memoopinion.pdf

continued on page 23

Upcoming AAEM–Endorsed or AAEM–Sponsored Conferences for 2009

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

February 28 – March 1, 2009
- Resuscitation Course for Emergency Physicians: The AAEM Course
  Held at the 15th Annual Scientific Assembly
  Phoenix, AZ
  www.aaem.org

March 1, 2009
- Pre-conference Workshop at the 15th Annual Scientific Assembly include:
  Advanced Ultrasound
  Children Are Not Little Adults! – Pediatric Emergencies
  LLSA Workshop
  Simulation Workshop
  USAAEM Course
  Phoenix, AZ
  www.aaem.org

March 2-4, 2009
- 15th Annual AAEM Scientific Assembly
  Phoenix, AZ
  aaem.org

April 1-2, 2009
- AAEM Pearls of Wisdom Oral Board Review Course
  Las Vegas
  aaem.org

April 25-26, 2009
- AAEM Pearls of Wisdom Oral Board Review Course
  Chicago, Dallas, Los Angeles, Orlando, Philadelphia
  aaem.org

September 14-17, 2009
- The Fifth Mediterranean Emergency Medicine Congress (MEMC V)
  Valencia, Spain
  emcongress.org/2009

October 14-15, 2009
- AAEM Pearls of Wisdom Oral Board Review Course
  Las Vegas
  aaem.org

October 17-18, 2009
- AAEM Pearls of Wisdom Oral Board Review Course
  Chicago, Dallas, Los Angeles, Orlando, Philadelphia
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January 25-29, 2009
- 7th Annual Western States Winter Conference on Emergency Medicine
  Park City, UT
  wswcem.com

January 26-28, 2009
- SkiBEEM (The Best Evidence in Emergency Medicine)
  Silver Star Ski Resort, BC, Canada
  beemcourse.com

February 7-11, 2009
- Rocky Mountain Conference in Emergency Medicine
  Copper Mountain, CO
  coppercme.com

February 20-22, 2009
- The Difficult Airway Course-Emergency™
  Huntington Beach, CA
  theairwaysite.com

March 13-15, 2009
- The Difficult Airway Course-Emergency™
  Miami, FL
  theairwaysite.com

March 15-18, 2009
- Emergency Medicine 2009 – Moving Forward
  Scottsdale, AZ
  mayo.edu/cme/

March 17-19, 2009
- Second International Emergency Medicine and Disaster Management Conference
  Muscat, Oman
  omanemergency2009.com

March 27-29, 2009
- The Heart Course-Emergency
  Atlanta, GA
  theheartcourse.com

May 14-17, 2009
- Public Health in the ED: Surveillance, Screening and Intervention (SAEM Consensus Conference)
  New Orleans, LA
  saem.org

May 21-23, 2009
- High Risk Emergency Medicine
  San Francisco, CA
  highriskem.com

June 5-7, 2009
- The Difficult Airway Course-Emergency™
  Boston, MA
  theairwaysite.com

June 8-10, 2009
- The Heart Course-Emergency
  Cambridge, MA
  theheartcourse.com

June 13-25, 2009
- Expedition Medicine 2009
  Kilimanjaro
  expedmed.org

July 21-24, 2009
- High Altitude Medicine 2009
  Ashford, WA
  mmmedicine.com

August 17-21, 2009
- Expedition Medicine 2009
  Washington, D.C.
  expedmed.org

September 18-20, 2009
- The Difficult Airway Course-Emergency™
  Chicago, IL
  theairwaysite.com

October 23-25, 2009
- The Difficult Airway Course-Emergency™
  Las Vegas, NV
  theairwaysite.com

October 26-28, 2009
- The Heart Course-Emergency
  Las Vegas, NV
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November 13-15, 2009
- The Difficult Airway Course-Emergency™
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Do you have an upcoming educational conference or activity you would like listed in *Common Sense* and on the AAEM website? Please contact Kate Filipiak to learn more about the AAEM endorsement approval process: kfilipiak@aaem.org.

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

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Emergency Medicine in Madagascar

Author: Dr. Ramalanjaona is a U.S. trained attending physician and Clinical Associate Professor of Emergency Medicine at North Shore University Hospital in Plainview, NY, and is ACEP Lead Ambassador to Madagascar.

Editors: Christopher Doty, MD FAAEM, and Andrew C. Miller, MD, are both from State University of New York (SUNY) Downstate Medical Center and Kings County Hospital Center in Brooklyn, NY. Dr. Miller is a resident in the Combined EM/IM Residency at Kings County Hospital.

Author's Introduction

Dr. Ramalanjaona serves as the ACEP Lead Ambassador to Madagascar and successfully introduced EM as a specialty in Madagascar in the summer of 1999.

Brief History/Social Context of the Country

The Democratic Republic of Madagascar lies off the southeastern cost of Africa and is the fourth largest island in the world. It became independent from France in June 1960 and enjoys a stable political democracy. It has an estimated population of 18 million with an average per capita income of $400 (U.S.) per year. The Malagasy people are a mixture of Indo-Malaysian and African descent, and all the major religious affiliations are represented including Christianity, Islam and Hinduism. Education is modeled after the French system, and the official languages of instruction are French and Malagasy. Knowledge of the English language is a requirement in secondary education and medical schools.

Traditional Medicine

The practice of traditional medicine, handed down through generations, such as folk remedies and herbal medicine, remains popular for those unable or unwilling to seek western treatment. Also, the rainforests of the island are reservoirs of local traditional plants used for medicinal purposes, including the raraha plant which has anesthetic qualities. Furthermore, these traditional healers, or Ombiasy, perform the duties of both spiritual guides and physical healers. One becomes an Ombiasy by an informal training passed along through generations, and they gather and formulate their own medications.

General Overview of Healthcare System

The island is divided into six provinces each with its own provincial hospital that is supplemented by several local hospitals, dispensaries, maternal centers and mobile health units. The main hospitals are the University of Antananarivo (1,300 beds) and the University of Mahajanga (400 beds) which host the two schools of medicine on the island. There is one hospital bed for every 586 people and one physician per 8,300 inhabitants. The island has a high birth rate of 45.8 per 1,000 and low death rate of 14 per 1,000 with 50% of population under the age of 15 years. The overall literacy rate is 80% and average life expectancy is 57.5 years. The main causes of death are infectious diseases (tuberculosis and infectious gastroenteritis), malnutrition and cardiovascular events.

Pre-Hospital Care

A single 911 dispatch system does not exist; police, fire and medical emergencies are handled by three different communication systems. There is no uniform training or certification of emergency medical technicians (EMT's) on the island. There are two emergency medical services (EMS) systems, urban and rural, sharing common characteristics: each consists of two major divisions (pre-hospital and hospital), offers primarily transport services in 90% of runs and are equipped with rudimentary instruments for transport and stabilization (oxygen tank, stretcher, splint and first aid kits). They only differ by the average of radius covered (100 km for urban vs. 25 km for rural) and number of EMT's available (0.13 per 1,000 people for urban vs. 0.001 per 1,000 for rural).

Emergency Medicine

EM is an integral part of the Malagasy healthcare system. The Ministry of Health sets the guidelines and manages the leadership role for EM care. The scope and pattern of EM practice varies according to the type, location and hospital affiliation. In rural and private clinics, the ED is staffed by a nurse, a PA (physician assistant) onsite, and one on-call physician; at the provincial hospital, it is staffed by trained and certified EPs and ED house staff. The latter is composed of one senior resident who is in charge of trauma resuscitation, one senior and junior medical student all under the supervision of an attending emergency physician (EP). Emergency physicians are trained for an average of two to three years after their internship and are paid government employees. Provincial ED's have onsite labs and x-rays including a CT scanner and ultrasound capabilities. They also have on-call specialists who perform abdominal and thoracic surgical procedures emergently if needed.

EM Education

The University of Antananarivo has one of the only two existing EM residency programs in Africa (apart from the University of Capetown, South Africa). The training lasts between two and three years after internship with sub-specialization in anesthesiology where available. The program uses BLS and ACLS with simulator and manikin training. In 2005, the University of Antananarivo graduated its first residency class of EPs, and since then, six EPs per year have completed their training. In 2007, the EM Malagasy Professional Society successfully applied as a member of IFEM (International Federation of Emergency Medicine).

Future of EM

The government plans to establish an academic department within the two existing schools of medicine including implementing a faculty development program, opening of another EM residency program at the University of Mahajanga, expanding the number of graduates at the University of Antananarivo and development of a regional affiliation with other sub-Saharan countries (i.e. South Africa) to facilitate the acceptance of EM as a primary specialty.

References:

1. Ramalanjaona, GR. EM in Madagascar. Annals of Emergency Medicine 1998; 31(6):766-8
2. Ramalanjaona, GR. Profile of pre-hospital system in Madagascar 2001; July1-Sept 1; 5(3):317-21

RESIDENT PRESIDENT'S MESSAGE

Scientific Assembly 2009: Phoenix, March 2-4

Megan Boysen, MD
AAEM/RSA President

What I love most about the AAEM Scientific Assembly is its size. It's large enough to provide a forum for outstanding, internationally recognized speakers in the field of emergency medicine. Yet, it's small enough to make connections, talk to presenters and speakers, socialize with residents and other medical students and meet fellowship and program directors. This year, especially, shouldn't be missed. The preliminary program is available at: http://www.aaem.org/education/scientificassembly/.

Also this year, like every year, registration is free to all AAEM members. The deposit for residents and medical students is refunded, unless you choose to donate it to the AAEM Foundation. The AAEM Foundation is a fund established for education and advocacy of physician practice rights in support of their patients.

For residents, there are several must-attend events. If your schedule doesn't allow you to be there for the entire conference, one particular high-yield day is Tuesday, March 3rd. The resident track will be held Tuesday morning, with several excellent speakers in the main forum Tuesday afternoon. Tuesday will also feature an "open mic" session throughout the day, in which new speakers have the opportunity to present a 25 minute lecture on the topic of their choosing. Two of these slots will be reserved for resident speakers. The resident social event will be held Tuesday evening.

Other important events at the assembly include the opening reception and the AAEM/JEM Research Competition on Monday, March 2nd, and the medical student track on Sunday, March 1st.

If you want one more reason to go: Phoenix is probably warmer than wherever you are right now.

RSA Updates

Shortly after the Scientific Assembly, the AAEM/RSA board of director elections will be held. There are positions for both residents and medical students. The resident positions include AAEM/RSA president, vice president, secretary/treasurer and five at-large board member positions. The Medical Student Council has the president, vice president and regional representative positions open (two from each region – northeast, midwest, south and west). I encourage you to become involved in AAEM/RSA and run for one of these positions for the coming year. Graduating medical students may run for resident positions.

Recently, AAEM/RSA has published a review book for the emergency medicine qualifying examination ("written boards"). *Emergency Medicine – A Focused Review of the Core Curriculum* is a 22 chapter text with color images and a 225 question practice in-service examination created by Drs. Joel Schofer, Amal Mattu, James Colletti, Elizabeth Gray, Robert Rogers and Richard Shih. AAEM/RSA has sponsored this book so that it can be available at a reduced rate to our members. More information about this textbook can be found at www.aaemrsa.org

I look forward to seeing you at the Scientific Assembly, and I look forward to your involvement in AAEM/RSA next year.

Welcome to our newest 100% Residency Program!

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

Adopt-A-Program & Adopt-A-Resident

Are you interested in furthering the careers of future emergency medicine residents? "Adopt" an emergency medicine residency program or an individual resident, by paying their AAEM/RSA dues. A membership in AAEM/RSA will provide residents with the opportunities to network with physicians, residents and students interested in emergency medicine. Each resident will receive the membership benefits listed at www.aaemrsa.org/membership/benefits.php.

An individual who decides to Adopt-A-Program or Adopt-A-Resident will automatically be entered into a drawing to receive two nights at the Sheraton Hotel in Phoenix, AZ, for AAEM's 15th Annual Scientific Assembly. This gift is valued at $500!

Membership for a resident costs just $50 per year, or $120 for three years. However, by signing up a residency program as a group, a 10% discount will be applied. This is a great opportunity to further the careers of emergency medicine residents across the country! Please contact info@aaemrsa.org if you are interested in our Adopt-A-Program offer.

Brian Ostick, MD
Chair, AAEM/RSA Membership Committee

Student Track at the Scientific Assembly

MEDICAL STUDENT COUNCIL PRESIDENT'S MESSAGE

Greg Casey
AAEM/RSA Medical Student Council President

The 15th Annual Scientific Assembly is coming up quicker than you think, and guess what? You're invited! At first, it seems a bit intimidating to attend a national assembly as a medical student, but the experience is well worth your time. The Student Council of AAEM/RSA is planning an exciting pre-conference student track on March 1st, 2009. While we continue to work out some of the details, our tentative schedule includes a Program Director Panel, a presentation by a nationally recognized resuscitation researcher and a talk from a leader in the field of emergency medicine education.

Attending at least one national conference as a medical student with aspirations of pursuing emergency medicine is a wise choice. Whether you choose to attend ACEP, SAEM, ACOEP or AAEM, you will be exposed to a variety of educational and social events which will surely add to your career development and understanding of emergency medicine. AAEM encourages students to attend the assembly and welcomes you to enjoy your time in Arizona. During your stay, you will have the opportunity to network with attending physicians, residents, other students, academic faculty members and even program directors. While at the Assembly, you will also have time to discover the answers to some of the following questions: Is emergency medicine right for me? What are my interests? What current research is going to change the practice of emergency medicine? How can I strengthen my residency application? How can I get involved in AAEM/RSA leadership?

I'll help you answer the last question! The student track is a perfect time to learn more about the Student Council of AAEM/RSA and how you can get involved. As the Student Council of AAEM/RSA continues to grow and prosper, we are looking for ways to improve our organization, and finding student leaders interested in taking on leadership roles is paramount. Our growth has led to the expansion of the Student Council in order to manage our emergency medicine interest group network (EMIG). For the first time, our EMIG group includes international medical students, and we hope to continue our growth. Elections are held in the spring, but it's not too early to start thinking about running now.

The 15th Annual Scientific Assembly is a great place to get involved with AAEM/RSA, and we hope to see you during our student track on Sunday, March 1st, 2009, from 1-5 p.m. Good luck with your classes and rotations, and I look forward to meeting you in March!

Healthcare in America: Medicaid, SCHIP, and Why There are Still Uninsured

RESIDENT EDITOR'S LETTER

Michael Ybarra, MD
AAEM/RSA Resident Editor

With as many programs as there are in the United States to help individuals obtain health insurance, it is surprising that there is still a large group of people who lack coverage. Over the last two issues, we've discussed Medicare, the largest social program in the United States, the broad groups of health coverage and who pays for them. Medicaid and SCHIP have been mentioned in passing, but not given the attention they deserve. What follows is part three of a series on healthcare in America – facts and figures, so you can decide what the future should look like.

Medicaid

Medicaid is a federal and state government partnership that works to provide a safety net for individuals and families with low incomes. It was established in 1965 as Title XIX of the Social Security Act. According to the Centers for Medicare and Medicaid Services (CMS), the state "(1) establishes its own eligibility standards; (2) determines the type, amount, duration and scope of services; (3) sets the rate of payment for services; and (4) administers its own program." As would be expected, there is tremendous variation in eligibility, services and payment from state-to-state. A person eligible in California may not be eligible in the District of Columbia. Additionally, a service covered in the District of Columbia may not be covered in California.

The federal government does require states to have some minimum criteria for coverage. For example, children and pregnant women whose families make at or below 133% of the federal poverty line (which for a family of four is approximately $28,000) must be eligible for coverage. The government also requires certain services such as inpatient hospitalization and childhood vaccinations be covered by the state in order to receive the federal subsidy. However, the state is allowed to determine the amount and duration of Medicaid services. While a state must pay for inpatient hospitalization, they can set a limit for the number of days covered. In terms of physician reimbursement, states have broad rights to determine how and how much they pay. Some states pay on a fee-for-service basis, while others enroll beneficiaries in HMO-type organizations.

Medicaid beneficiaries receive health insurance at a relatively low cost, but they are required to participate in "cost sharing" through deductibles, co-insurance and co-payments. Here again, the federal government does restrict states by requiring pregnant women and children under age 18 be excluded from cost sharing.

The federal government pays a percentage of costs for each state's Medicaid program. This percentage, known as Federal Medical Assistant Program (FMAP) is determined every year by a complicated formula, but is required by law to be between 50% and 83% of the total costs. Based on 2003 data from CMS, the cost of Medicaid to the federal and state governments is upwards of $300 billion annually, providing healthcare to 46 million individuals (approximately $6,500 per person). CMS estimates the cost to be $445 billion in 2009.

SCHIP

The State Children's Health Insurance Program (SCHIP) is a relatively young program, established in 1997 as Title XXI of the Social Security Act, but is the largest expansion of publicly funded healthcare since 1960. The original program provided $24 billion in additional federal funds over ten years to insure children whose families are below 200% of the federal poverty line (for a family of four, roughly $42,400 – just slightly below the average intern salary).

SCHIP and Medicaid are very similar in that the states have broad rights to define and enact the program. Additionally, federal matching dollars are provided in much the same way as they are in Medicaid, but at a slightly higher rate. Both the federal and state governments pay for the services, but the program is administered by the states. In 2007, there were 7.1 million individuals who received health insurance through SCHIP.

SCHIP made national headlines in 2006, because the original charter, which provided funding through 2007, was about to expire. President Bush and Congress came to an agreement in late 2007, after the president vetoed two earlier attempts at reauthorization that would have expanded coverage. The current SCHIP legislation is essentially identical to the original program until February 2009, when the Obama administration, and presumably future Secretary of Health and Human Services, Tom Dashle (D), South Dakota, will decide with a Democratic Congress where to take the program.

Who are the Uninsured?

Despite a vast (and expensive) safety net enacted by the federal and state governments, there are still roughly 45 million uninsured, many of them children. Because Medicaid covers individuals who make up to 133% of the poverty line, and SCHIP covers children whose families make 200% of the poverty line, the uninsured in America quite often are middle class families. Data from the Robert Wood Johnson Foundation suggests that 46% of uninsured make above 200% of the federal poverty line. And despite the safety net that Medicaid and SCHIP provide for the poor, 25% of uninsured individuals make less than the federal poverty line.

The Robert Wood Johnson Foundation addresses some of the most common myths about the uninsured in America on their website. One of the most common is that the uninsured are also unemployed. The fact is that "80% of non-elderly uninsured live in families where the head of the family works." The Employee Benefit Research Institute estimates that 28% of the uninsured are age 25-34 (nearly one in three), 20% are children, and 35.7% are Hispanics (the largest uninsured racial or ethnic group).

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Resident Journal Review: January-February 2009

David Wallace, MD MPH; Dana Sajed, MD; Christopher Doty, MD and Amal Mattu, MD

This is a continuing column providing journal article summaries 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 in September and October 2008.

Awasthi S, Mao A, Wooton-Gorges SL, Wisner DH, Kuppermann N, Holmes JF. Is hospital admission and observation required after a normal abdominal computed tomography scan in children with blunt abdominal trauma? Acad Emerg Med 2008;15:895-9

Children who have sustained blunt abdominal trauma are frequently admitted to the hospital for observation despite having a normal abdominal computed tomography (CT) scan. This study aimed to quantify the risk of intraabdominal injury (IAI) after having a normal abdominal CT in the emergency department (ED).

1,085 patients under 18 years of age comprised the cohort with abdominal trauma and normal CT scans. None of the 348 patients who were sent home were later determined to have IAI, and only two of the 737 that were hospitalized were later found to have an IAI. The negative predictive value of a negative abdominal CT scan for IAI was 99.8% in this study. No oral contrast was used in the scans; weight-based intravenous contrast was used in the scans. All studies were interpreted by a board certified or board eligible faculty radiologist.

In this cohort, the incidence of IAI was very low. As such, admission for serial abdominal exams and repeat laboratory measurements may be unwarranted in a majority of patients. These findings will need to be validated in other centers prior to a widespread change in practice; however, they raise interesting questions about the incidence of occult IAI in pediatric trauma.

Holcomb JB, Wade CE, Michalek JE, et al. Increased plasma and platelet to red blood cell ratios improves outcome in 466 massively transfused civilian trauma patients. Annals of surgery 2008;248:447-58

The ideal ratio of blood products to be administered in massive transfusion is unclear. Traditionally, the use of plasma and platelets has been reserved for patients with persistently low blood pressure unresponsive to saline administration, those who have received more than six units of packed red blood cells, abnormal coagulation laboratory findings or obvious microvascular bleeding. The investigators examined outcomes in 467 massive transfusions (≥ 10 units packed red blood cells) at sixteen level 1 trauma centers. Patients were stratified into one of four groups, based on high or low plasma and platelet to red blood cell ratios. Patients who died within 30 minutes of arriving to the hospital were excluded.

The plasma:RBC ratio ranged from 0 to 2.89, and the platelet:RBC ratio ranged from 0 to 2.5. A plasma:RBC ratio ≥ 1:2 was associated with an improved 30-day survival (40% vs. 60%, $p<0.01$). The same was true for a platelet:RBC ratio ≥ 1:2 (40% vs. 60%, $p<0.01$). The injury severity score and maximal regional abbreviated injury scores were not different between groups.

This study challenges current recommendations regarding the administration of platelets and plasma in the setting of massive transfusion. Expect more discussions on this topic as attention shifts to this interesting question.

Scalea TM, Bochicchio KM, Lumpkins K, et al. Early aggressive use of fresh frozen plasma does not improve outcome in critically injured trauma patients. Annals of surgery 2008;248:578-84

Scalea et. al report on their experience with 806 patients admitted to the intensive care unit of the R Adams Cowley Shock Trauma Center over a two year period. In this cohort, 365 patients (45%) were transfused during the first 24 hours, with 250 patients receiving both packed red blood cells (PRBCs) and fresh frozen plasma. After controlling for injury severity, there was no association between mortality and transfusion of plasma products either overall or in a 1:1 ratio with PRBCs. Furthermore, subgroup analysis of those requiring at least 10 units of PRBCs did not find a mortality benefit for the 1:1 ratio of PRBCs to FFPs.

The investigators acknowledge the difference in their population compared to the Holcomb et. al. study. Specifically, the patients in the Scalea investigation were those who survived to be admitted to the intensive care unit. For the group who received a blood transfusion, the 24 hour mortality was 14%. The Holcomb study had a sicker population overall, with 24 hour mortality of 31%. Kaplan-Meier survival plots reported in the Holcomb paper showed that an early transfusion strategy could have a sustained mortality impact at both 24 hours and 30 days. These differences prevent direct comparisons between the papers and partially explain their findings.

These studies highlight the need for further investigation in the best transfusion strategy for trauma patients. While new insights are becoming available from military experience with platelets, FFP and RBCs, the translation of these findings into an older civilian population with higher ISSs needs to be better defined.

Kemp AM, Dunstan F, Harrison S, et al. Patterns of skeletal fractures in child abuse: systematic review. BMJ 2008;337:a1518

This systematic review sought to identify characteristics of fractures that distinguished child abuse from benign causes. In addition, the investigators sought to calculate the probability of abuse for individual fracture types.

Thirty-two studies were included in their review. Fractures attributable to abuse were found throughout the skeletal system, but were most commonly found in infants and toddlers. After exclusion of major trauma as a cause, rib fractures had the highest likelihood of abuse (71%), followed by humeral fractures (66%). Despite historical associations between metaphyseal fractures and abuse,

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Financial Stewardship

Brian Ostick, MD
AAEM/RSA Board of Directors
AAEM/RSA Membership Committee Chair

Growing up the son of an economics teacher wasn't always easy. When I was a kid in the 1980s my dad beat me at the game Monopoly, made me cry, then wrote an article about it in the *Wall Street Journal*. Nevertheless, I grew up interested in economics, finance and investing. Recently, the world's financial markets have been turned upside down, and many people are panicking about the health of their portfolios and their retirement options.

As residents, we work hard for our paychecks. Paying a little attention to your finances at home now, at a young age, will pay off in the long run. Below is a top ten list for financial stewardship. These are basic principles that will not make you rich quick, but may build the foundation for sound investment practices in the future.

#10 Pay Yourself First

The most important bill you have to pay with every paycheck is towards your future. PAY YOURSELF FIRST means that every paycheck, you put a set amount of money into savings or investments. For example, you may decide to pay yourself 20% of each paycheck. That money is for savings only; don't even consider it part of your disposable income. If you made $50,000 a year, you set aside $10,000 for savings and live off of $40,000.

Most people who have extra money lying around let that money burn a hole in their pocket, and they will find a way to spend it. By paying yourself first, you start your retirement fund now and will contribute to it until you need that money in the future. Many experts say in order to keep the same lifestyle in retirement you had while working, you will need 85% of your salary every year. With people retiring earlier and living longer, the total retirement fund needed can be large. Start early, and start now!

#9 If your employer will match contributions to a 401K, take advantage!

Many companies will allow their employees to contribute to a 401K or 403B program, which essentially are retirement funds. Many times, these companies will match the contribution their employees make to their retirement funds, up to a certain limit. The money they contribute to your retirement is FREE MONEY! If you don't contribute to your 401K, they won't contribute either. Many financial experts say to contribute at least up to the amount your employer will match, to take advantage of the free money.

#8 Make sure your credit reports are accurate.

The government introduced a law a few years ago stating you can receive your credit report from three major credit agencies for free once per year. This can be done online from websites such as annualcreditreport.com. This free offer does not include your FICO score (a number that estimates your credit worthiness). FICO scores can be obtained for a small fee. Look through each credit report thoroughly, and make sure your report is ACCURATE. Errors on your credit report are more common than you might expect, and this can damage your credit score significantly. A low credit score affects your bottom line and impacts your rates when you apply for a mortgage, loan, etc.

#7 Pay off your credit card debt.

Credit card debt is the worst kind of debt, because credit card interest rates range from about 7% to 27% or even higher! Get rid of credit card debt if you can. Set up a budget for yourself, and include credit card payments as part of the budget. Pay off more than the minimum amount each month so you can reduce the debt faster. Call your credit card company, and ask for a lower rate. Many companies will give you a lower rate just for asking, especially if you have a good credit history.

#6 Make a budget, and stick to it.

Everyone makes a set amount of money each month and spends variable amounts each month. If you spend more than you make, you will increase your debt. Make a budget, and stick to that budget each month. This can be difficult, but it will keep you from spending money you don't have.

#5 Build an emergency fund.

Emergencies happen when you least expect it. If your roof leaks, you need to fix it. Think about keeping a few months worth of your salary within close reach in case you need cash fast. This money may be kept in a savings account such as an online account, which generally gives higher interest rates than a standard checking account, and allows you to access money quickly. It doesn't matter where you keep the money, but have access to a few thousand dollars in case of an emergency.

#4 Don't default on your loans.

This sounds simple, but missing a loan payment can negatively affect your credit report for years. You don't want to have negatives on your credit report, since they bring down your credit score. If you are having trouble paying back loans or getting a deferment, call your loan provider. Many will work with you to come up with a payment you can afford.

#3 Invest in a ROTH IRA if you have the funds.

This is one of the best investment vehicles for a single person making under $99,000 or a married couple making less than $156,000. After you cross that threshold, you will no longer be able to invest in the ROTH IRA. Most residents will qualify for contribution to a ROTH IRA, but won't be eligible on an attending salary. If you have extra cash left over at the end of each month, consider a ROTH IRA.

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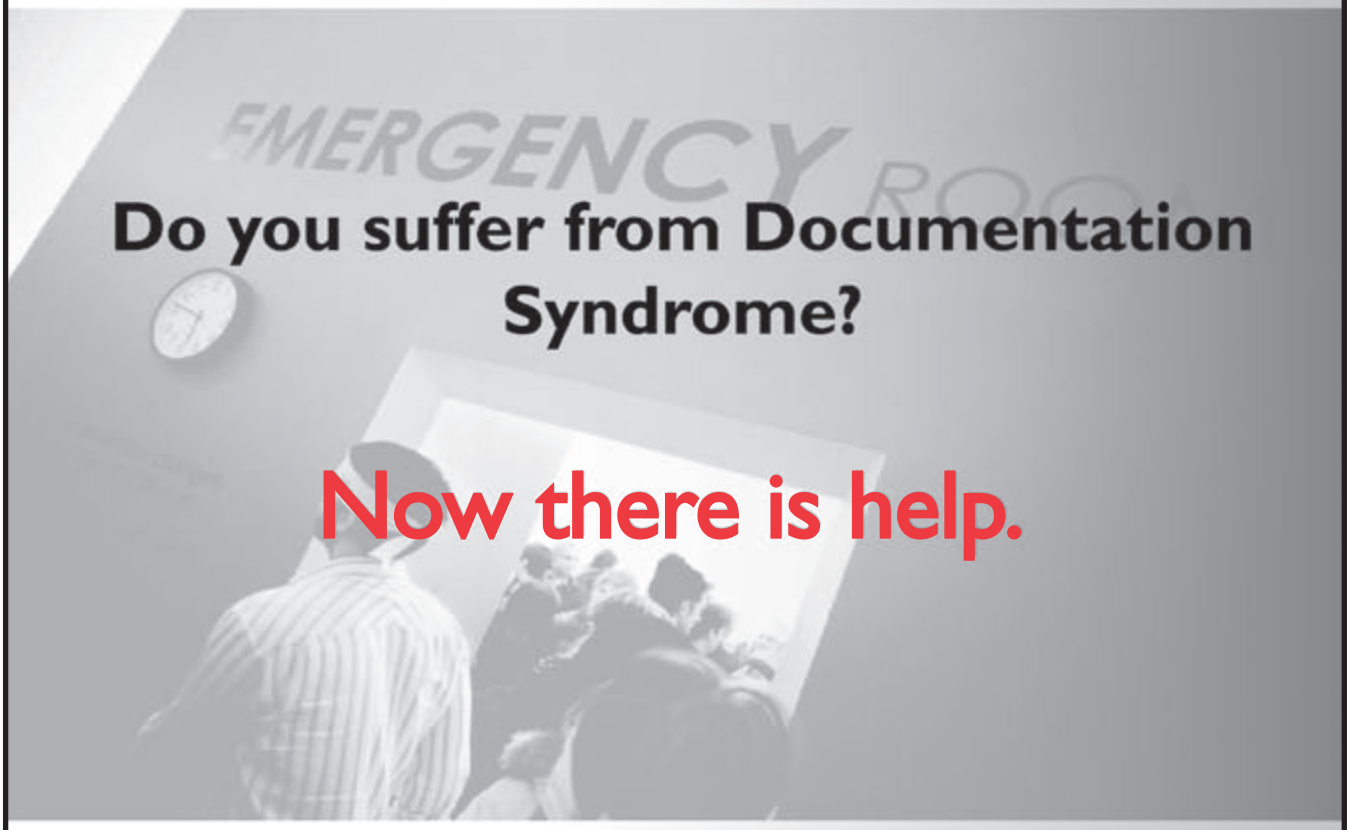

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A Case of Ascending Paralysis: the Signs and Symptoms of Tick Paralysis

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Summary:

Tick paralysis (TP), a response to the neurotoxic effects of the salivary secretions produced by attached hard ticks (Ixodidae), is a syndrome that mimics a large number of better known neurological disorders. TP is a sporadic, seasonal, rural disorder in which acute ataxia often develops five to six days following a history of walking in grass or low brush, followed by ascending flaccid paralysis. Recognition and timely removal of the tick usually leads to complete resolution of symptoms, whereas continued feeding can lead to respiratory arrest and death. Follow-up includes species determination and patient surveillance for tick-borne infectious disease.

Case:

A 42 year-old man was hiking in Colorado for one week in July. Upon returning to his home in Tampa, Florida, he felt flu-like symptoms and fatigue but no fever or rash was noted. Two days later, he developed global muscle weakness and presented to the emergency room. Upon physical exam, a tick was found under the hair of the right occipital area.

Question: The patient likely has which of the following diagnoses:

a) Lyme Disease
b) Guillain-Barre Syndrome (GBS)
c) Colorado Tick Fever
d) Tick Paralysis
e) Babesiosis

Further Case History:

The patient underwent extensive workup. All laboratory testing including CBC, CMP and Lyme titers were within normal limits. Neurology was consulted given the concern of possible Guillan-Barre Syndrome (GBS). After the tick was removed, the patient improved, indicating a diagnosis of tick paralysis (TP).

Discussion:

TP is a worldwide disease, occurring in Australia, Europe, South Africa and throughout North America. In the United States, most cases occur in the Rocky Mountain states and the Pacific Northwest, including Washington, Montana, Oregon, Idaho, Wyoming, Nevada, Utah, Colorado and the northern parts of Arizona, New Mexico and California. However, cases have also been reported in central, southern and eastern states, including Texas, Oklahoma, Mississippi, Florida, Georgia, North Carolina, South Carolina, Virginia, Washington, D.C., Pennsylvania and New York. In Canada, most cases are encountered in the western part of the country, primarily southern British Columbia[1,2].

More than 60 species of ticks are known to cause paralysis, but only a handful are responsible for most cases. In North America, the disease is associated primarily with six species: *Dermacentor andersoni* ("Rocky Mountain wood tick"), *D. variabilis* ("American dog tick"), *Amblyomma americanum* ("Lone Star tick"), *A. maculatum* (Gulf Coast tick), *Ixodes scapularis* (formerly *I. dammini*, "Black-legged tick") and *I. pacificus* ("Western Black-legged tick"). Peak incidence occurs between April and June when nymphs and mature adults abound in low vegetation and climb upward, questing for their next host by extending their anterior pairs of legs[1,3,4]. Paralysis is a response to a neurotoxin secreted by the salivary glands of the arachnid[1,5]. The biochemistry and pharmacology of the specific paralysis-inducing toxins produced in North American ticks are yet to be fully elucidated, but current evidence points to a mechanism by which the toxins inhibit presynaptic acetylcholine release at the neuromuscular junction[1,3,6]. TP presents more often and more severely in children, suggesting a concentration-dependent relationship between toxin levels and symptom expression[1,4].

Signs and symptoms of TP begin about five to six days after the parasite has attached, when neurotoxin is secreted at its peak levels. These prodromal symptoms include restlessness, irritability, fatigue, nausea, paresthesias and possibly ataxia. Over the next 24-48 hours, the patient develops ascending symmetrical flaccid paralysis and weakness in the lower extremities. Over the course of the next day or two, paralysis and weakness may ascend to involve the trunk, axial and upper limb muscles. Cranial nerves may also become involved in an ascending pattern, resulting in bulbar, facial and/or extraocular paralysis. Patients demonstrate diminished or absent deep tendon and superficial reflexes while, aside from occasional paresthesias, their sensory exam remains normal. Pain and fever are absent. Death ensues following paralysis of the respiratory muscles[1,5,7,8,9].

Atypical presentations reflect variations in the site of tick attachment. There may be ataxia and associated cerebellar deficits without accompanying muscle weakness. The disorder may also present as an isolated facial paralysis without trunk or limb involvement. Another group of atypical presentations is unilateral paralysis and/or weakness, including isolated unilateral facial paralysis[1,8].

Tick paralysis is treated by removal of the tick. Although the site of attachment is most often the head and neck region, the entire body should be scrutinized, including ear canals, nostrils and genitalia. Multiple ticks should be suspected, and all must be removed[1,4,7,10]. Applications of petroleum jelly, nail polish, alcohol, a needle and heat are inappropriate. These measures may result in infection and cause the parasite to salivate or regurgitate more of its bodily fluids.

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Déjà vu: Eye Injury Case in Louisiana

The November/December issue of *Common Sense* had an article titled "EMTALA Eye Injury Case Dismissed by Federal District Court" (see page 6). The article described an EMTALA case with an interesting procedural history, which in sum is the following:

On August 3, 2007, Vincent Smithson brought suit in the federal district court for the Eastern District of Louisiana against NorthShore Regional Medical Center, Inc. and NorthShore Regional Medical Center, LLC (known collectively as "NorthShore") for alleged violations of EMTALA, that NorthShore improperly transferred Smithson, an uninsured patient, before stabilizing his eye injury. On July 30, 2008, the court denied defendant and plaintiff cross-motions for summary judgment, and in so doing returned the case for a jury trial. On August 4-6, 2008, the court held a jury trial, where at the close of Smithson's evidence, the court denied as a matter of law plaintiff's motion for judgment. The jury found that defendant did not violate EMTALA, and the claim was dismissed.

In the latest turn on this case, plaintiff moved for judgment as a matter of law, or in the alternative, for a new trial to overturn the jury verdict. On October 10, 2008, the federal district court for the Eastern District of Louisiana denied both of Smithson's motions (Smithson v. Tenet Health System Hospitals Inc., E.D. La., No. 07-3953, 10/10/08).

The Facts

On August 4, 2005, at about 7:15a.m., Smithson arrived at the NorthShore ED, complaining that a foreign object had entered his left eye while using a weed eater just 15 minutes earlier on the lawn of NorthShore Regional Medical Center. He was seen immediately by the ED physician, who diagnosed an "open globe injury." Within five minutes of seeing the patient, the ED physician consulted the on-call ophthalmologist via telephone, who ordered a CAT scan to determine if a foreign body was in Smithson's globe. After the CAT scan, at around 9:45a.m., the ED physician phoned the ophthalmologist with the results. The ophthalmologist said to prepare the preoperative lab work as he would be in for surgery around noon. Upon arrival, the ophthalmologist told plaintiff he needed surgery for urgent repair, but around 2:30p.m., Smithson was transferred via ambulance to the Medical Center of Louisiana at New Orleans (Charity Hospital).

On the transfer form, Smithson was certified as "stable for transfer." Smithson arrived at Charity Hospital at 4:55p.m. and waited in the ED until 7:30p.m. before being examined. He underwent surgery at 10:30p.m. The court documents indicate that the "next morning, the doctors detected an infection in Smithson's eye, and three days later, his eye was removed."

The Ruling

The court noted that plaintiff asserted that the jury verdict went against the great weight of the evidence, which he contended established NorthShore was in violation of the relevant EMTALA provision providing that "a hospital must provide an appropriate medical screening examination within the capabilities of the hospital's emergency department." The district court noted that this EMTALA provision is interpreted as requiring the screening to be "performed equitably in comparison to other patients with similar symptoms." After reviewing the evidence, the court determined that "there is ample evidence to support the jury's finding that the hospital did not screen the plaintiff disparately and thus did not violate the screening requirement of EMTALA."

Plaintiff also argued that the great weight of the evidence established that he was not provided stabilizing treatment before his transfer. Finding that the jury was presented with contradictory evidence with regard to plaintiff's stability and to transfer of plaintiff, the court determined that the jury's verdict was not against the great weight of the evidence. Moreover, since the jury found that NorthShore did not violate EMTALA, the court would not consider plaintiff's causation issue, nor would it find any evidence of comparative fault as not prejudicial. For these reasons, the federal district court for the Eastern District of Louisiana, denied Smithson's motion for judgment as a matter of law or, alternatively, as a motion for a new trial.

The October 10, 2008, opinion can be accessed at http://op.bna.com/hl.nsf/r?Open=mapi-7kgpex.

Recovery in EMTALA Screening Claim Not Bound by California Damages Cap

On October 10, 2008, the U.S. District Court for the Eastern District of California determined that the $250,000 non-economic damages limitation of the California Medical Injury Compensation Reform Act (MICRA) does not apply to a claim alleging violations of the Emergency Medical Treatment and Active Labor Act's (EMTALA) screening provision (Romar v. Fresno Community Hospital and Medical Center, E.D. Cal., No. 1:03-cv-6668, 10/10/08).

The Facts

Minor Christina Romar made three presentations to Fresno Community Hospital and Medical Center's (FCH) ED in December 2002. She is suing FCH claiming that she was disparately screened in violation of EMTALA. EMTALA imposes a duty on a hospital to provide a patient with an "appropriate medical screening" designed to determine if an emergency medical condition exists. A hospital meets its obligation when it "provides a patient with an examination comparable to the one offered to other patients presenting similar symptoms." Plaintiff identified 30 individuals she contended presented to FCH with the same key symptoms that she herself had. Plaintiff stated that each of the 30 patients received a superior screening in that they each received various diagnostic tests, but she received none. Since plaintiff did not receive FCH's "standard screening," Romar argued that she was disparately screened.

The test determining whether a plaintiff may recover for a disparate screening "is whether the challenged procedure was identical to that provided [to] similarly situated patients as opposed to whether the procedure was adequate as judged by the medical profession." EMTALA and MICRA have damages provisions: In EMTALA, "Congress explicitly directed federal courts to look to state law… to determine both the type and amount of damages available, which may include medical malpractice damages caps." And the California law has a damages cap on non-economic damages of $250,000 for claims constituting "professional negligence." At issue is a cause of action asserted against a healthcare provider on a legal theory other than medical malpractice (e.g., an EMTALA screening claim), and the courts determine whether it is nevertheless based on the 'professional negligence' of the healthcare provider so as to trigger MICRA.

The Ruling

The parties did not dispute that screening is a professional medical service, or that the provision of a medical screening is within the scope of services for which FCH is licensed. However, the court found that a "disparate screening claim is not a negligence claim because it is based on disparate treatment and does not involve the

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there was insufficient evidence to support or refute this observation. Similarly, the location of rib fracture was not found to correlate with abuse, despite the widely held belief that posterior fractures indicate abuse. In fact, no fracture on its own was able to conclusively distinguish abuse from non-abuse, although some should raise serious concerns (such as femoral shaft fractures in children that are not yet walking). The authors offer a radiographic strategy to identify fractures in cases of suspected abuse: skeletal survey with oblique view of the chest (for improved identification of rib fractures).

Seamon MJ, Medina CR, Pieri PG, et al. Follow-up after asymptomatic penetrating thoracic injury: 3 hours is enough. J Trauma. 2008 Sep;65(3):549-53

Patients with asymptomatic penetrating thoracic trauma are typically managed with an initial chest X-ray (CXR) then followed up with a second CXR six hours later to exclude the development of delayed pneumothorax (PTX) or hemothorax (HTX). Over a 30 month period, the authors of this study screened 648 patients who presented with penetrating thoracic injury, of whom 127 had no initial findings and were asymptomatic. Of these 127 cases, 100 completed the study protocol which included an initial supine anteroposterior CXR, continuous pulse oximetry, hourly blood pressure monitoring and upright posteroanterior and lateral radiographs at three and six hour intervals. Of these patients, two developed delayed PTX between arrival and three hours. No patient developed PTX or HTX between three and six hours. The two with delayed injury were admitted and received tube thoracostomy.

The study authors conclude that three hours is a safe amount of observation time for asymptomatic penetrating chest wounds. In addition, the cost efficiency of the potentially shorter emergency department stay is also calculated, and as expected, three hour observation is less expensive to both patient and hospital when compared to six hour observation.

Two limitations of this study are the low incidence of delayed injury when compared to prior published reports and the very low follow up rate for patients in their group (only 17 returned to their trauma clinic). However, the timing of delayed insult in their cohort is consistent with two prior studies1,2 which indicate the same thing – that delayed injuries typically occur within a three hour window, and patients may be safely discharged after a brief period of observation and serial CXR. It appears that a shortened stay in the emergency department is not only safe, but would be beneficial to alleviate overcrowding and is cost-effective as well.

1. Kiev J, Kerstein MD. Role of the three hour roentgenogram of the chest in penetrating and nonpenetrating injuries of the chest. Surg Gynecol Obstet. 1992;175:249–253
2. Shatz DV, Pedraja J, Erbella J, Hameed M, Vail SJ. Efficacy of follow-up evaluation in penetrating thoracic injuries: 3- vs. 6-hour radiographs of the chest. J Emerg Med. 2001;20:281–284

Newton MF, Keirns CC, Cunningham R, et al. Uninsured adults presenting to US emergency departments: assumptions vs. data. JAMA. 2008 Oct 22;300(16):1914-24

The authors of this paper review the existing data regarding emergency department utilization by uninsured patients in the U.S. to examine certain assumptions found in both medical literature and lay media regarding the potential strain placed on emergency care. After an extensive literature search for articles dealing with medical, surgical or trauma care for uninsured patients in an emergency setting, they identified 127 relevant studies. After careful review, the most commonly held perceptions from these articles were analyzed.

Interestingly, the authors found that some commonly held assumptions are not necessarily true:

1. Uninsured patients use the ED for nonurgent care. This assumption does not necessarily hold true, although it is difficult to clearly define what constitutes urgent versus nonurgent conditions. Often times, this data is based on a triage-based definition of urgency and nonurgency, although many supposed nonurgent conditions can be appropriately managed in an ED (e.g. orthopedic injuries, lacerations).
2. Uninsured patients are a leading cause of ED overcrowding. Again, this is not clearly supported by available data. What is known is that ED overcrowding is multifactorial and likely due to a lack of inpatient bed availability, ED closings and an aging population with increasing prevalence of chronic illnesses. Additionally, overcrowded emergency departments are a challenge in many countries with universal healthcare coverage, which goes against this assumption.

Some commonly held notions about access to care for the uninsured and ED use were supported by the available literature: the uninsured lack access to primary care, the uninsured pay more to use emergency resources than they would pay elsewhere and the uninsured present with higher acuity of illness. Additionally, it is noted that uninsured patients are more likely to delay getting care for their illnesses and once in the healthcare environment, receive less care than their insured counterparts.

While this study is not likely to change patient management on a day-to-day clinical shift, it is important to understand this data, because if solutions to ED overcrowding are designed based on false assumptions, these efforts will waste resources on unnecessary issues and will fail to fix the true problems.

Body R, McDowell G, Carley S, Mackway-Jones K. Do risk factors for chronic coronary heart disease help diagnose acute myocardial infarction in the Emergency Department? Resuscitation 2008;79:41-5

The Thrombolysis In Myocardial Infarction score (TIMI) assigns one point for the presence of three or more cardiac risk factors. Incremental TIMI points correlate with risk of death, myocardial infarction or need for urgent revascularization at 14 days. The score is used to risk stratify patients presenting with unstable angina or non-ST elevation myocardial infarction. In consideration of this use, the study authors conducted an emergency department based cohort study of traditional risk factors for the diagnosis or exclusion of acute myocardial infarction.

Consecutive patients older than twenty-five years of age presenting to the emergency department with a complaint of chest pain within

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Healthcare in America: Medicaid, SCHIP, and Why There are Still Uninsured - continued from page 18

The uninsured in America are a diverse group, with varying income levels, racial and ethnic backgrounds and education levels. More information about Medicaid, SCHIP and the uninsured in America can be found at the Centers for Medicare and Medicaid Services website, the Robert Wood Johnson Foundation and the U.S. Census Bureau.

Learn more by reading these primary sources:

Employee Benefit Research Institute estimates from the March Current Population Survey, 2007 Supplement.

"Income, Poverty, and Health Insurance Coverage in the United States: 2006." U.S. Census Bureau, August 2007, table 6, p. 21.

Cover the Uninsured, a Project of the Robert Wood Johnson Foundation: http://covertheuninsured.org/.

The Centers for Medicare and Medicaid Services: http://www.cms.hhs.gov/.

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the prior 24 hours that was felt to be cardiac in origin were included. All patients were followed up six months after presentation. The primary outcome of interest was acute myocardial infarction, as defined by the American Heart Association and European Society of Cardiology. Logistic regression was used to evaluate individual risk factors for the diagnosis of acute myocardial infarction.

796 patients were included in the final analysis; 148 patients were diagnosed with acute myocardial infarction. There was no trend towards increasing incidence of AMI with increasing number of risk factors. In addition, 12% of patients who ultimately ruled in for AMI had no traditional risk factors.

Management of patients presenting to the emergency department with a complaint of chest pain remains challenging. Traditional risk factors may not be useful for predicting who is currently having an acute myocardial infarction – careful scrutiny of the patient's EKG, attention to history of present illness and management including provocative testing when indicated remain cornerstones of optimal care.

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A Case of Ascending Paralysis: the Signs and Symptoms of Tick Paralysis - continued from page 22

The tick should be grasped with blunt, angled forceps as close as possible to the skin and to the embedded mouthparts (hypostome). Wearing protective gloves, slowly pull the organism straight outward with a gentle and steady traction, without twisting its body. Do not burst the tick. The hypostome is usually deeply and firmly embedded and should be removed surgically should it come detached. Antiseptic solution is then applied to the wound, and the recovered tick and severed mouthparts may be preserved in 75% ethanol for identification. The patient should be instructed to return in the event of additional illness and educated on protective measures against ticks.

The symptoms of TP, at least those caused by North American species, typically resolve rapidly following removal of all ticks from the patient. Improvement in the condition of the patient subsequent to tick removal is confirmatory for the diagnosis. Species found in some other parts of the world, notably *Ixodes holocyclus* of Australia, produce a very potent neurotoxin and symptoms may not subside as quickly, even worsening after removal[5]. The prognosis depends on clinical presentation prior to removal. If all ticks were removed prior to the onset of bulbar weakness, the patient often makes a full recovery within the first 24 hours. However, if onset of bulbar symptoms occurs during continued feeding, the likelihood of fatal respiratory paralysis increases to 10%. Therefore, prompt of diagnosis and tick removal are paramount[1,5,7,8].

Because ticks are both vectors and reservoirs for various infectious diseases, it is important to educate the patient about this added risk for possible concurrent illnesses. Table 1 displays the geographical location and infectious diseases associated with North American tick species which are also known to cause TP[1,8,11,12].

The list of differential diagnoses for ascending flaccid paralysis and acute ataxia is extensive: 1) neuropathies such as Guillain-Barre syndrome, diptheric polyneuropathy, porphyrias and meningoradiculopathies, 2) neuromuscular junction disorders such as botulism and myasthenia gravis, 3) myopathies due to electrolyte imbalance such as hypokalemia, hypophosphatemia, hypomagnesemia, 4) heavy metal intoxication, 5) spinal cord disease and 6) various CNS disorders such as rabies and poliomyelitis[1,5,8,13]. In addition to the previously described symptoms of TP and the recent history of exposure to rural tick-inhabited areas, there are other distinguishing clinical features of tick paralysis. Neurophysiological studies reveal diminished compound muscle action potential (CMAP) amplitudes, normal nerve conduction velocities and normal response to repetitive stimulation. There are normal CSF findings and but an absence of response to cholinergic drugs. Table 2 compares several of the major differential diagnoses with hallmarks of TP[1,5,6,13].

TABLE 1

Tick Species	Geographical Location	Infectious Diseases
D. andersoni	Rocky Mountain states, western Canada	Tularemia, Rocky Mountain spotted fever, Colorado tick fever
D. variabilis	Eastern 2/3 of U.S., southern Canada	Tularemia, Rocky Mountain spotted fever, Ehrlichiosis
A. americanum	South central and south eastern U.S.	Tularemia, Ehrlichiosis, Lyme disease
I. scapularis	North central and north eastern U.S.	Lyme disease, Babesiosis
I. pacificus	Pacific coast from California to British Columbia	Lyme disease, Babesiosis

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MedPAC to Recommend Broad Disclosure of Industry's Financial Ties to Doctors - continued from page 23

professional medical standard of care/how a reasonable hospital in FCH's position would act." Furthermore, the court reasoned that the MICRA cap has been applied to conduct that may not necessarily be viewed as traditional medical malpractice, but since "the professional standard of care is not incorporated into the duty to provide materially similar screenings, the professional standard of care is not inextricably intertwined."

"If anything," wrote the court, "disparate screening may be a 'malpractice' action brought on a… 'non-negligence theory,' which is outside 'the ambit of [MICRA].' Because FCH has not sufficiently shown in this case that plaintiff's EMTALA disparate screen ing claim is one 'based on professional negligence,' the MICRA damages cap does not apply." This California federal district court did recognize that other federal cases that applied other states' damages caps (e.g., Michigan, Indiana, Virginia) "are distinguishable… [and the] malpractice damages cap are all broader in scope than MICRA."

The opinion for the Romar case is available at http://op.bna.com/hl.nsf/r?Open=mapi-7klqr4.

Financial Stewardship - continued from page 20

#2 Don't panic in times of financial trouble.

Warren Buffet, one of the most well known investors of our time said, "When everyone is greedy, be fearful… When everyone is fearful, be greedy." Investing should be a long-term process; contribute to your savings and retirement continually throughout your career. Don't try to "time" the market – even professional fund managers have not been successful trying.

#1 ENJOY YOURSELF!

Life isn't all about making money. Make su re you enjoy your money and have fun. Make time for family, friends and yourself. Don't worry too much over the state of the current financial markets; we're in it for the long run! Take a look at your personal finances, and make sure you are financially sound. Don't worry, last week I bankrupted my dad with four houses on Park Place!

A Case of Ascending Paralysis: the Signs and Symptoms of Tick Paralysis - continued from page 26

TABLE 2

	GBS	Botulism	MG	Poliomyelitis	Spinal Cord Compression
Ascending paralysis		X (descending)	X	X	
Symmetrical weakness				X	
Diminished/absent DTR's			X		
Normal sensory exam	X				X
Bulbar involvement	X		X		X
No bladder/bowel dysfunction		X		X	X
Normal CSF	X*			X	X
Diminished CMAP amplitudes					
Normal nerve conduction velocity	X*				
Normal response to repetitive stimulation		X	X (muscles show more fatigability)		
No response to acetyl cholinesterase inhibitors			X		
Rapid disease progression (hours to days)	X (days to weeks)		X (symptoms tend to fluctuate)		
Symptom improvement following tick removal	X	X	X	X	X
Other distinguishing disease features	History of recent illness/infection	Toxin detection	AchR antibody detection, positive Tensilon test	History of fever, virus detection, virus antibody detection	Positive MRI, Babinski sign

*may be normal early on in disease course

It is important for clinicians to include TP in the differential diagnosis of ascending, flaccid paralysis with ataxia. The disease should be strongly suspected when confronted by a bilateral ascending paralysis following a one week history of hiking in tick-infested grasslands or brush during the spring or summer. The entire skin should be scrutinized for embedded hard ticks, and all must be promptly extracted by the appropriate technique to avoid potential respiratory failure. Recovered specimens should be preserved in 75% ethanol for identification*. The patient should be instructed to return in the event of additional illness that may indicate a tick-borne infectious disease.

Species identification is offered by co-author
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AAEM Young Physicians Section

Wellness

Kevin Noreika, MD
Young Physicians Section (YPS) Board of Directors

As we begin this new year, it is important to take a minute to consider wellness. While it is very common for people to make New Year's resolutions to lose weight, stop smoking and begin an exercise program, commonly, these well-intentioned plans do not come to fruition. Likewise, as emergency physicians, we work in a very fast-paced and stressful environment, and yet despite this, we typically do not spend enough time contemplating issues such as lifestyle considerations. However, if we do not take the time to ensure that we are balancing the stress of our jobs with our family life and personal goals it can lead to significant challenges. Job wellness can encompass many aspects including scheduling and shift distribution, time away from the ED and financial security. As the senior EM residents finish their final year of training, it is important that these aspects are given serious consideration.

Emergency physicians provide care to the public 24 hours a day, seven days a week without regards to the financial status of the patient—often being the only facility in an area to do so. This is an aspect of the job which is very gratifying, but also leads to a significant amount of stress during shifts. Although you may be accustomed to working frequent long shifts as a resident, upon reaching the level of attending, you will soon realize that this is not an ideal schedule to allow for a balanced lifestyle. There are numerous studies that indicate shift work can have a direct impact on our lives; it is even being considered by some as a risk factor for heart disease. In this regard, it is very important to carefully consider the number of shifts, as well as the distribution of day and night shifts per month. There are some groups which have dedicated night shift physicians and others that allow for fewer night shifts as you gain seniority over time. These aspects of your job are very important to consider when searching for a long-term position.

Sleep hygiene is also an important factor. Sleep debt is additive, and unfortunately, unless adequate consideration is made for time to sleep this will lead to increased stress, risk for depression and potential for errors at work. It is important to ensure that the room in which you sleep is consistently quiet, cool and dark. Make sure to turn off your phones, and try to avoid making appointments during the days after night shifts when you should be sleeping. For those that need to complete tasks during the day, try to get anchor sleep which entails spending a few hours before and after work sleeping. Your group can also help by scheduling on a circadian friendly progression and by grouping together your night shifts. There are ever-growing resources available on the subject as research continues.

Another appealing aspect of our profession is the lack of on-call time. This allows for time to recover from the stress of the ED and to engage in enjoyed activities. Adequate days off and vacation time are essential to allow for a balanced lifestyle. Spending time with family and friends and pursuing hobbies are invaluable both physically and mentally. Money is, of course, an important factor, and often in our profession the more shifts worked equals a higher income. As your income increases dramatically after residency, it is tempting to increase spending in accordance. However, overspending can necessitate working more shifts than is comfortable which places you at higher risk of burnout. Many young physicians accept these high paying positions and then subsequently change jobs within the first few years of practice. Keeping a careful balance of work load and debt will help you to maintain an enjoyable lifestyle.

Considering a long-term financial plan at the beginning of your practice is also a very important step in providing for overall wellness. Unfortunately, there is not a great deal of time available during our residency training to develop our foundation in financial planning. As physicians, we are sometimes not as knowledgeable regarding financial management, and therefore, finding a professional who is trustworthy and understands your goals will make this much easier. The importance of life and disability insurance is also a crucial part of this plan. It is best to consider this as a senior resident because of potential discounts for disability insurance that can be applied before you graduate. Developing a plan that provides for continued financial stability throughout your career and security into retirement will also help to reduce stress for both you and your family.

Emergency medicine can be a very rewarding career, but if you do not take time to reflect on balancing your work with your overall life goals, it can lead to significant stress. Wellness encompasses many different aspects of your life and always needs to be an integral factor when evaluating your current and future positions in relation to your ultimate goals.

(For more information, the Young Physician Section will soon be releasing a publication called *Rules of the Road for the Young Emergency Physician* which provides a more in-depth exploration of this and many other topics which are essential to the new EM physician).

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