

common SENSE

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THE NEWSLETTER OF THE AMERICAN ACADEMY OF EMERGENCY MEDICINE



PRESIDENT'S MESSAGE

Leadership in Emergency Medicine

Larry D. Weiss, MD JD FAAEM

Emergency medicine's growing list of significant problems requires many more emergency physicians to take an active role in advocacy. AAEM remains active in a wide variety of issues despite our limited resources. Further increasing our membership will give us additional resources to pursue our agenda, but we also need a larger core of committed advocates to improve the productivity of our committees.

Our board still spends much of its time performing committee work. Over the past year, we strengthened our committee structure, resulting in devolution of some activities to appropriate committees. I hope to accelerate this process, improving our productivity and broadening the scope of our activities.

We offered a leadership development track at our Scientific Assembly in Phoenix as part of an effort to significantly increase the number of AAEM members directly involved in national advocacy. We invited members who already showed leadership potential by their activity in our committees and who otherwise served AAEM through their past involvement.

Unfortunately, we had to limit the size of our leadership track. This generated complaints from other attendees.

We limited the size of this program to minimize any interference with the rest of the educational programs. We also wanted to limit the size of the audience to facilitate discussion.

Our board felt gratified to know our members had a strong interest in the leadership track. We hope you will channel that interest toward a greater involvement in our advocacy efforts. Joining a committee is an easy way to begin advocating for your specialty. You may easily find a list of our committees by going to our website at www.aaem.org/committees/. Perhaps we will host another leadership program when we have a sizeable number of new committee members.

In my opinion, maintaining your AAEM membership makes you a leader in emergency medicine. Furthermore, the title "FAAEM" identifies you as a board certified specialist at the top of your profession. Taking the extra step of direct involvement in AAEM will give you the satisfaction of making a significant contribution to your specialty, advancing our mission and helping emergency physicians and our patients. I hope you will make that important decision and get involved.

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Editor's Letter

David D. Vega, MD FAAEM

It is that time of year when more than 1,500 residency-trained physicians are added to the emergency medicine workforce. Congratulations to those who are starting out on this exciting new stage of their careers. This is also a great time for all of us to reflect a bit on the important role that board certification plays in protecting our patients and our specialty. Most of us are already well-versed in the issues surrounding board certification, but we must be careful not to let our guard down. This can be dangerous, as exemplified by the stealthy establishment and acceptance of alternative board certification in some areas. The need for vigilance continues.

Most emergency physicians are well aware of the critical role that board certification plays in ensuring that patients receive the best possible care. However, many of our patients, colleagues in other specialties and politicians are probably not aware of this or, quite frankly, do not really care. At a recent meeting of my county medical society, I had the opportunity to speak with several state representatives, of whom none had a clear understanding of board certification and its importance to patient care in the emergency department. We must continue to take every opportunity to educate the public on the importance of board certification.

Residency training is now required by both the American Board of Emergency Medicine (ABEM) and the American Osteopathic Board of Emergency Medicine (AOBEM), to be eligible for certification in emergency medicine. In the early development of our specialty, it was necessary and appropriate to have practical experience serve as a substitute for formal training in emergency medicine. Incredible advances have been made since that time, and "on the job training" can no longer be accepted as the standard for delivering the best in emergency patient care. It is only through structured, closely supervised and standardized training that a physician can be guaranteed to attain the expert level of knowledge and abilities required for the safe and effective delivery of emergency medical care.

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AAEM Mission Statement

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

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

Membership Information

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

*Associate Member: \$250

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

International Member: \$125 (Non-voting status)

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

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

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

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Recent Court Cases Involving EMTALA

Kathleen Ream, Director of Government Affairs

Estate of Murdered Woman Allowed to Pursue EMTALA Claims

On April 6, 2009, the US Court of Appeals for the Sixth Circuit ruled that a third party (i.e., the estate of a patient's wife) may pursue claims under EMTALA against a hospital that released a patient with a mental illness who, ten days after discharge from the hospital, murdered his wife. In this case, a representative of the estate of Marie Moses-Irons, the plaintiff, appealed the district court's decision to grant the motion of Providence Hospital and Medical Centers, Inc. and Dr. Paul Lessem, the defendants, for summary judgment and dismissal of the plaintiff's claims (*Moses v. Providence Hospital and Medical Centers Inc.*, 6th Cir., No. 07-2111, 4/6/09).

The Facts

On December 13, 2002, Moses-Irons took her husband, Christopher Howard, to the Providence Hospital emergency department in Southfield, Michigan, because Howard had severe headaches, muscle soreness and high blood pressure. He was also vomiting, slurring his speech, hallucinating, delusional and making threatening statements, including telling his wife that he had "bought caskets." Moses-Irons reported these symptoms to the ED staff and also informed staff that she feared for her safety. Physicians at the hospital admitted Howard for further testing, including an MRI, a lumbar puncture and a psychiatric evaluation. Evaluating Howard during his stay at the hospital were several physicians, including Dr. Lessem, a psychiatrist.

Lessem examined Howard several times during Howard's hospital stay. On December 17, 2002, Lessem determined that Howard was not "medically stable from a psychiatric standpoint," and decided that Howard should be transferred to the hospital's psychiatric unit for patients "who are expected to be hospitalized and stabilized and who are acutely mentally ill." Lessem's notes state, "will accept [patient]...if [patient]'s insurance will accept criteria" and "please observe carefully for any indications of suicidal ideation or behavior." The notes also indicate that Lessem believed Howard had "atypical psychosis" and "depression."

Howard was never transferred to the psychiatric unit. Instead, Howard was informed that he would be released. A hospital clinical progress report stated that "[patient]...wants to go home. His affect is brighter. No physical symptoms now. [Patient] wishes to go home, wife fears him. Denies any suicidality." Howard stated in a deposition that he never declined going to the psychiatric unit. In Howard's discharge summary form of December 18, 2002, a resident wrote that Howard had a "migraine headache" and an "atypical psychosis [with] delusional disorder." Howard was released on December 19, 2002, and on December 29, 2002, Howard murdered Moses-Irons.

On December 14, 2004, the plaintiff filed a federal suit against the hospital and Lessem, alleging a violation of EMTALA and various negligence claims. On May 14, 2007, the defendants filed a motion for summary judgment, raising these arguments: 1) that the plaintiff does not have standing to sue, because only the individual patient who seeks treatment at the hospital has standing under EMTALA; 2) EMTALA's requirements were satisfied when the hospital admitted Howard on December 13, 2002; and 3) because Howard was indisputably screened and diagnosed as not having an emergency medical condition, EMTALA did not apply. Following oral argument on July 30, 2007, the district court granted the defendants' summary judgment motion from the bench, dismissing the EMTALA claim and

choosing not to exercise jurisdiction over the negligence claims. The plaintiff appealed.

The Ruling

Because any one of the grounds would have been sufficient for the district court to grant summary judgment to the defendants, the federal appellate court addressed each argument.

- 1) **Standing** – The court determined that "the civil enforcement provision, read in the context of the statute as a whole, plainly does not limit its reach to the patients treated at the hospital... [and that] EMTALA's plain language belies defendants' argument that Congress intended to deny non-patients the right to sue in every circumstance." Using this reasoning, the federal court concluded that the plaintiff had standing to sue pursuant to EMTALA.
- 2) **Hospital's Obligations Upon Finding an Emergency Medical Condition** – According to the federal court, EMTALA imposes an obligation on a hospital beyond simply admitting a patient to an inpatient care unit. The statute requires "such treatment as may be required to stabilize the medical condition," forbidding the patient's release unless his condition has "been stabilized," "as defined when "no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during" the patient's release from the hospital. The defendants pointed to a rule, promulgated by the Centers for Medicare and Medicaid Services (CMS), that effectively ends a hospital's EMTALA obligations upon admitting an individual as an inpatient. But the court stated that "[e]ven if the CMS regulation could somehow be deemed consistent with the statute, its promulgation in 2003, after Howard's stay in the hospital ended, would preclude this Court from applying it to this case." Determining that the hospital was required under EMTALA to admit Howard into the inpatient psychiatric unit and to treat him in order to stabilize him, the court concluded that the defendants were not entitled to summary judgment on these grounds.
- 3) **Existence of an Emergency Medical Condition** – The US Court of Appeals held that a mental health emergency could qualify as an "emergency medical condition" under the plain language of the EMTALA statute and noted that "there is plenty of evidence in the record to create an issue of fact with respect to whether Howard's condition was a mental health emergency."

However, in order to trigger further EMTALA obligations, hospital physicians must actually recognize that a patient has an emergency medical condition. If they do not believe an emergency medical condition exists because they wrongly diagnose the patient, EMTALA does not apply. In its review of this question, the court determined "because issues of fact exist relating to Howard's medical condition – upon his initial screening as well as prior to his release – the district court erred in granting summary judgment on this ground."

Regarding the plaintiff's suit against Lessem, the court pointed to EMTALA's provision for private suits "against the participating hospital." The court agreed with its sister circuits, noting that "EMTALA does not authorize a private right of action against individuals." Thus, the district court's grant of summary judgment dismissing the plaintiff's claim against Dr. Lessem pursuant to EMTALA was affirmed, while the judgment of the district court with respect to the plaintiff's claims against the hospital was reversed and remanded for further proceedings.

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Physician Claim of Retaliation under EMTALA Allowed to Proceed

On March 11, 2009, the US District Court for the Eastern District of Michigan ruled that a physician may pursue a claim of retaliation under EMTALA for the suspension of his clinical privileges when he refused to authorize the transfer of a woman who he believed was in labor and had an emergency medical condition (*Ritten v. Lapeer Regional Medical Center*, E.D. Mich., No. 2:07-cv-10265, 3/11/09).

The Facts

Plaintiff Gary M. Ritten, a board certified obstetrician/gynecologist licensed to practice medicine in Michigan since 1988, initially was granted medical staff privileges at Lapeer Regional Medical Center (LRMC), defendant, in 1999. Ritten was reappointed to the LRMC medical staff in 2001 and again in 2003. He was due to go through the reappointment process again in September of 2005.

In the summer of 2005, the reappointment process was revised so that the Credentials Committee would be given additional historical data for each physician being considered for reappointment. This added data consisted of a summary of all the "occurrence" and "incident" reports made about a given physician over the previous five years. The summary for Ritten showed that he was the subject of three times as many reports as any other physician under review. In addition, a chart of "patient safety indicators" for each physician scheduled for review revealed a trauma rate of 47.46% for Ritten when he delivered babies using a vacuum extractor, versus a national trauma rate of 21.9% and a trauma rate for other LRMC obstetricians of 22.9%.

Approximately two weeks before these materials were to be presented to the Credentials Committee, an outside obstetrician was invited to review the materials concerning Ritten. The reviewer reported to the hospital CEO, Burton P. Buxton, that the trauma rate on the "patient safety indicators" chart was too high and that Ritten's rate of vacuum delivery appeared to be high, as well. On Friday, September 2, 2005, Buxton summarily suspended Ritten's privileges at LRMC.

The Medical Executive Committee convened on September 6, 2005, to address the suspension of Ritten's privileges, and voted to rescind the summary suspension. Although Ritten's privileges were reinstated the next day, Buxton brought this matter to the LRMC's Board of Trustees at a special meeting called on September 9, 2005. The board voted to reinstate the summary suspension of Ritten as initially imposed by Buxton.

Ritten requested a hearing. The hearing on Ritten's suspension of privileges resulted in a "majority vote" that the suspension of staff privileges should be continued. This decision was affirmed by an appellate review committee, and the Board of Trustees voted on September 21, 2005, to make the suspension of Ritten's privileges permanent.

Preceding all of these events, an incident had arisen concerning the care of a patient identified as Patient L. This patient arrived at LRMC's emergency department around 11:00pm on August 8, 2005, and was promptly sent to the hospital's labor and delivery unit in light of her 20-week pregnancy and her complaints of vaginal bleeding and cramping. Patient L was evaluated by a nurse, who then paged Ritten and described to him the results of her examination. Based on this initial screening, Ritten formed the "impression that the patient was in labor," and determined that Patient L should be admitted to

labor and delivery for observation until he could examine her the following morning.

Ritten examined Patient L the next morning and determined that the appropriate course of action was "to rupture the for[e]bag and augment labor in order to evacuate the uterus", in light of the "non-viability of the fetus...and out of concern for the mother's safety." Another physician who was asked to examine Patient L disagreed with Ritten's evaluation. CEO Buxton became aware of this matter and spoke to Ritten about his plan for treating Patient L. When Buxton noted that it was against hospital policy to "perform an abortion," Ritten responded that an abortion was "inevitable" because "[t]he baby's not viable" and the patient's membranes were "already ruptured." Buxton explained that another physician's evaluation determined that her membranes were not ruptured, suggesting the possibility that the fetus "potentially could become viable."

Ritten claims that Buxton told him that he "want[ed] that patient... transferred out of the hospital," and that he threatened "if you don't transfer that patient out of here, you may lose your job." Ritten protested against a transfer of Patient L, advising Buxton that "she's not stable for transfer" and could "deliver at any point in time." Nonetheless, Ritten contacted another hospital and was told that Patient L would not be accepted in her present condition as described by Ritten. Buxton followed up with his own phone call, and "the physician on the other end of the phone indicated that if this was ...an inevitable abortion as Dr. Ritten ha[d] told him it was and that the membranes were ruptured...that there was nothing they could do for the patient." During this call, Patient L went into active labor. The baby did not survive.

This incident formed the basis for the EMTALA claim asserted in Ritten's complaint, alleging that the loss of his staff privileges was attributable, at least in part, to Buxton's effort to get back at him for disobeying Buxton's order to transfer Patient L and for engaging in practices that Buxton viewed as tantamount to performing elective abortions.

The Ruling

In a threshold challenge to Ritten's claim of retaliation, the defendant argued that the terms of EMTALA ceased to apply to LRMC's care and treatment of Patient L once this patient had been admitted to the hospital's labor and delivery unit. In the defendant's view, the admission of Patient L triggered the application of EMTALA's implementing regulation, which provides that a hospital satisfies its obligations under the statute once it has "screened an individual... and found the individual to have an emergency medical condition, and admits that individual as an inpatient in good faith in order to stabilize the emergency medical condition."

For a number of reasons, the Court could not conclude as a matter of law that the admission of Patient L to LRMC's labor and delivery unit defeated the plaintiff's appeal to EMTALA's protection against retaliation. The Court noted that the Department of Health and Human Services issued clarifying policies that "caution against treating pregnant women as inpatients – and, hence, generally beyond the reach of EMTALA – merely because they are routinely sent from the emergency room to the labor and delivery unit for admission, evaluation, and treatment...Under these circumstances, the Court is reluctant to find as a matter of law that Patient "L" had been admitted for inpatient care, such that the terms of EMTALA were no longer applicable."

Likewise, the court found that in sharp contrast to the defendant's

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documents, there was ample evidence that the plaintiff believed Patient L to be suffering from an emergency medical condition that required stabilization. The court found that the record seemingly proved the plaintiff's assessment of Patient L's condition when the patient delivered a baby without any apparent medical intervention, and when the hospital to which Buxton sought to transfer Patient L was found to share the plaintiff's belief that a transfer was inappropriate. The court also determined there was sufficient evidence that Buxton may have initiated the summary suspension of privileges in retaliation to Ritten's refusal to transfer the patient.

Rejecting the defendant's arguments, the court refused to dismiss the plaintiff's claim citing that "EMTALA prohibits a hospital from 'penaliz[ing] or tak[ing] adverse action against...a physician because the...physician refuses to authorize the transfer of an individual with an emergency medical condition that has not been stabilized.'"

The court also concluded that immunity from liability, conferred for actions under the Health Care Quality Improvement Act (HCQIA), may apply to the 2006 hearing committee decision to continue the suspension. However, the hospital's prior suspension actions on which Ritten sought reinstatement via his EMTALA claim were found not to meet the HCQIA immunity standard.

Inadequate Screening Claim May Proceed

On March 23, 2009, the US District Court for the Northern District of Indiana allowed the parents of their deceased son, who was examined in and discharged from a hospital ED, to pursue their claim that the hospital did not perform an appropriate medical screening as required under EMTALA (*Bode v. Parkview Health System Inc.*, N.D. Ind., No. 07-cv-324, 3/23/09).

The Facts

Makota Z. Norris, born in 1999, had multiple health and developmental problems, resulting in difficulty gaining weight and numerous respiratory and sinus infections that often brought him to the hospital. By age six, Makota was not talking and he used a walker to walk. He needed help with bathing, dressing and eating. On December 26, 2005, Makota's mother, Laurie Bode, brought him to the ED at Parkview Whitley Hospital for vomiting and diarrhea.

In the ED, Makota's medical history and information were taken by a nurse, while a paramedic measured Makota's vital signs. Parkview's written ED nursing policies stated that a patient's blood pressure must be measured and documented as one of the vital signs during the initial assessment, unless the patient is less than six years of age. The nursing policies also required a patient's vital signs to be reassessed at least every two hours prior to discharge. The nurse did not take Makota's blood pressure, contending that he appeared to be less than six years old. However, Makota's birth date was reported on each page of the primary ED records.

When the nurse completed the initial assessment, Dr. David Hurley took his own history from Makota's mother and conducted his own examination of Makota. Following his examination, Hurley ordered blood tests and a chest x-ray. Before the test results were completed, Hurley's shift ended, and he was relieved by Dr. Joachin Okafor. In transferring Makota's care, Hurley advised Okafor of the history, examination and the tests he had ordered for Makota. Okafor then reviewed Makota's chart and examined him.

While in the ED, Makota vomited and had a single episode of diarrhea. The diarrhea appeared to have blood in it, so Okafor ordered a stool culture to test for infection, but the results of that test would not be back until the following day. When the results of

the x-ray and blood tests came back, Okafor assigned Makota with a diagnosis of acute gastroenteritis, which did not constitute an emergency medical condition.

Before deciding on a plan of care, Okafor talked with Makota's primary care physician. Following the discussion with the primary care physician, Makota was discharged with instructions to begin taking certain prescriptions and to see the primary care physician in the morning. Makota's mother also was instructed to return Makota to the ED immediately if there were any problems.

Early the next morning, Bode was unable to wake Makota, so she phoned 911. Upon arrival of the paramedics, CPR began, but resuscitation efforts were stopped at 7:04am at the Parkview ED. When Makota's stool results came back, it was determined that Makota had died of dehydration due to vomiting and diarrhea caused by *Clostridium difficile* infection.

Makota's parents, the plaintiffs, filed suit claiming that Parkview violated its duties under EMTALA, including the failure to afford Makota an appropriate medical screening and releasing him in an unstable condition. The plaintiffs argued that the defendant violated EMTALA because it deviated from its standard screening procedures, and those deviations were not *de minimis* (minimal, or insignificant). While defendant Parkview admitted these deviations, it maintained that they were *de minimis* because they were committed by the nursing staff, and the deviations had no bearing on the testing that the physicians determined was necessary to complete an appropriate medical screening examination. The defendant filed a motion for summary judgment claiming there is no genuine issue of material fact, and they are entitled to judgment as a matter of law.

The Ruling

To comply with the screening requirement, hospitals must perform an "appropriate medical screening." There is no national "appropriate medical screening" standard; a hospital can define which procedures are within its capabilities when it establishes a standard screening policy for patients entering the ED. However, when a departure from the standard screening procedures is only a slight deviation – *de minimis* – there is no violation of EMTALA.

Contending that Parkview's failure to take Makota's blood pressure and reassess his vital statistics are not *de minimis* deviations as a matter of law, the court cited a Tenth Circuit opinion as the seminal case constituting *de minimis* deviation. The court noted that in that case, "The Tenth Circuit explained that because the policy of documenting the patient's medical history and list of medications had been effectuated, the deviation of how that information was received was merely formalistic. The court went on to hold that such formalistic deviations are *de minimis* and not actionable." Here, Parkview never determined what Makota's blood pressure was, although it was required to do so because he was six years old. The federal district court found the fact that Makota's blood pressure was not taken was a deviation because similar patients with similar symptoms would have had their blood pressure taken. The court determined that this finding is not a *de minimis* deviation as a matter of law.

The court clarified that the quality of the screening is not what is being questioned to decide whether Parkview performed an appropriate medical screening under EMTALA. Rather, the material question of fact is if there is uniformity in the screenings. The district court stated that the physicians' "professional medical opinions as to what they believed was or was not necessary for them to perform an emergency medical screening of Makota is not enough

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Accomplishments: Profiles of Academic and Professional Excellence

As a younger specialty in the house of medicine, emergency medicine sometimes finds itself underrepresented within academic circles. The selection of emergency physicians to prominent academic appointments helps better our positions for political advocacy, promotion of fair practice environments, support of residency training programs, and involvement with other issues critical to the safe and effective delivery of emergency care. Below we profile two fellows of the Academy who have been selected for prominent positions in academic emergency medicine.

Robert Barish Selected as Chancellor of LSU Health Sciences Center at Shreveport

Robert Barish, MD FAAEM, Vice Dean for Clinical Affairs and Professor of Emergency Medicine at the University of Maryland School of Medicine in Baltimore, has been selected as the new Chancellor of the LSU Health Sciences Center at Shreveport.

Dr. Barish graduated from New York Medical College in 1979. He completed an internal medicine residency in 1983 and an emergency medicine residency in 1985. After residency, he was appointed head of the emergency medicine program at the University of Maryland Medical Center.

Dr. Barish earned an MBA from Loyola College in 1995 and served as the CEO of UniversityCARE, a network of family-oriented health centers in Baltimore-area neighborhoods, between 1996 and 1998. In 1998, he was named Associate Dean for Clinical Affairs at the University of Maryland School of Medicine, and he became Vice Dean in 2005.

He is the recipient of six awards for outstanding teaching. In 2008, Dr. Barish was awarded the University System of Maryland Board of Regents Faculty Award for Public Service, the highest honor bestowed on a faculty member there.

A former lieutenant colonel and flight surgeon in the Maryland Air National Guard, Dr. Barish was among a select group of candidates invited to become a NASA astronaut at the Johnson Space Center in 1992. As part of the Maryland Defense Force, Dr. Barish helped lead a medical regiment that delivered emergency care services to more than 6,000 Hurricane Katrina victims in Jefferson Parish as part of the State of Maryland's Operation Life Line relief efforts.

Shahram Lotfipour appointed Associate Dean at UC Irvine

Shahram Lotfipour, MD MPH FAAEM, has been appointed as Associate Dean for Clinical Science Education at the University of California, Irvine. Dr. Lotfipour attended medical school at the University of Iowa College of Medicine. He completed his emergency medicine residency training at Henry Ford Hospital and obtained a Masters in Public Health from the University of California, Los Angeles.

Dr. Lotfipour served as Assistant Dean for Clinical Science Education since 2008. He also served as Director of EM Education, EM Clerkship Director and advisor for the EM interest group.

Dr. Lotfipour received several awards at UC Irvine including Excellence in Teaching Awards, the Outstanding Medical Student Clerkship Award, the ARISE Award for Academic Achievement and the Most Valuable Player Service Award. He was also inducted into the Zeta Chapter of the Alpha Omega Alpha Honors Medical Society.

Dr. Lotfipour is the Managing Associate Editor of the *Western Journal of Emergency Medicine*, one of the only open-access EM journals in the world. He is also the current treasurer and a past president of the California chapter of the American Academy of Emergency Medicine.

Other Announcements:

Joel T. Levis, MD PhD FAAEM, and Gus M. Garmel, MD FAAEM, both AAEM members from Northern California, published a new textbook, *Clinical Emergency Medicine Casebook* (Cambridge Univ Press, 2009). The book features over 110 challenging and interesting cases from the Stanford/Kaiser EM Residency Program with discussions, key teaching points, color photographs and more. Dr. Garmel received AAEM's Program Director of the Year award in 2008.

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

The American Academy of Emergency Medicine

Presents The

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FALL DATES

October 14-15, 2009 – Las Vegas

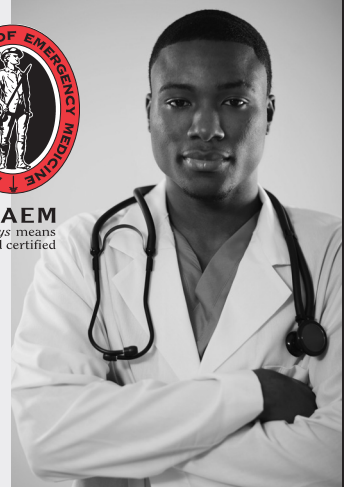
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Announcing the AAEM Women in Medicine Interest Group

Lisa Mills, MD FAAEM
WMIG Chair

I am very proud to introduce AAEM's Women in Medicine Interest Group (WMIG). This group strives to take the tenets of AAEM and apply them to women working in emergency medicine. Our mission includes promoting the personal and professional welfare of the woman specialist in emergency medicine and advocating for gender equality with particular interest in fair and equitable practice for women. Through the activities of this group, we also hope to project a positive face of women in emergency medicine.

This is an unprecedented time for women in the house of emergency medicine. There are more board certified woman emergency physicians than at any time in history. Woman physicians are presidents of major bodies of emergency medicine. EM sisters unite and join the latest interest group of AAEM! Resident members are valued, active members of the group.

Contact AAEM staff member Kate Filipiak (kfilipiak@aaem.org) for more information. To join the Women in Medicine Interest Group, go to www.aaem.org/committees/.

Mission Statement of the AAEM Women in Medicine Interest Group

The AAEM Women in Medicine Interest Group, a section of AAEM, a democratic organization, is committed to the following principles:

1. The personal and professional welfare of the woman specialist in emergency medicine.
2. Projecting a positive face of women in emergency medicine.
3. Co-advocating with AAEM on legal issues, with particular interest in fair and equitable practice for women in emergency medicine.
4. Promoting women in emergency medicine.
5. Functioning as a resource for women in emergency medicine and women who are considering a career in emergency medicine.

The **Western Journal of Emergency Medicine**, the official journal of the California State Chapter of the American Academy of Emergency Medicine, is now listed in PubMed Central.

Mark I. Langdorf, MD MHPE, Editor-in-Chief of the *Western Journal of Emergency Medicine* (WestJEM), is pleased to announce that WestJEM, the official journal of the California Chapter of the American Academy of Emergency Medicine (CAL/AAEM), is now listed in PubMed Central with full-text manuscripts and high quality images, within the US National Library of Medicine. Journal abstracts can be searched through PubMed (www.pubmed.gov). WestJEM is co-sponsored by the Department of Emergency Medicine from the University of California, Irvine. Due to the generous support of CAL/AAEM and the Department of EM at UC Irvine, WestJEM does not charge authors for open-access publication.

The journal is the premier open-access, peer-reviewed emergency medicine journal, drawing submissions from the Western Hemisphere and providing an English language forum for developing emergency care systems throughout the world. WestJEM, currently in its tenth volume, is published quarterly, both in print and electronically, and focuses on the roles of technology and public health in providing efficient and optimal emergency care.

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Washington Watch - continued from page 5

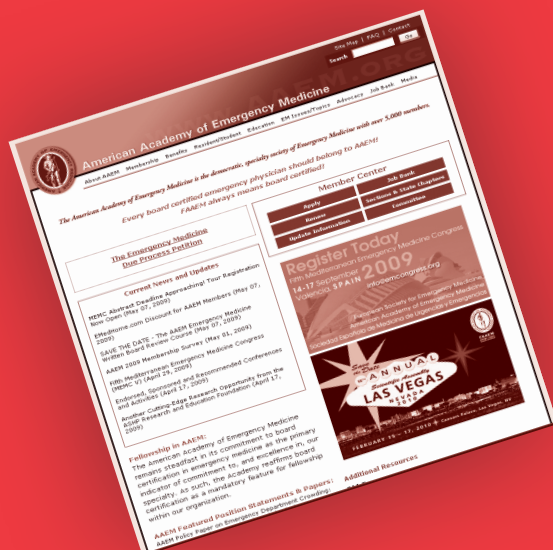
to alleviate the need for Parkview to comply with its own standard procedures as a matter of law....To accept Parkview's position would essentially negate the approach courts have adopted to examine EMTALA claims: uniformity of policy. This would, in effect, allow physicians to override standard hospital policies in exchange for their professional opinion. Such a proposition is contrary to the EMTALA framework and, instead, more appropriately considered in the medical malpractice context." Thus, the court denied the defendant's summary judgment motion on the inadequate screening charge, allowing the claim to proceed.

As to the stabilization charge, the court determined that Parkview was not required by EMTALA to stabilize Makota before releasing

him because "[t]here is nothing in the record to support the allegation that Parkview had actual knowledge that Makota had an emergency medical condition... [and as] a result, there has been no violation of EMTALA for failure to stabilize." A diagnosis does not have to be correct for a hospital to be in compliance with EMTALA, and so the court granted the defendant the motion for summary judgment on this claim.

Editor's note: These cases exemplify the critical importance of understanding EMTALA and its implications on your practice as an emergency physician. Additional information and resources can be found on AAEM's website at www.aaem.org/emtala.

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Editor's Letter - continued from page 2

This is not to say that there is no role for the non-specialist in emergency medicine. Clearly there are not enough emergency medicine specialists to cover every emergency department in the United States. Until there are enough specialists to cover every emergency department, we have to accept that some departments will be staffed by non-specialists. This does not change the fact that emergency care is best delivered by the board certified specialist. Board certification must remain the mark of someone who has attained an expert level of training and subsequent verification through the processes of initial certification and maintenance of certification. Along the same lines, offering fellow status in specialty organizations to non-certified physicians serves only to diminish the value of board certification.

AAEM has a strong record of supporting residency training in emergency medicine as a prerequisite of board certification. Fellow status in AAEM requires board certification in emergency medicine. Each one of us must continue to support AAEM's efforts in promoting the importance of board certification. We also must watch carefully for attempts, particularly with our own state medical boards, to accept certification in emergency medicine by organizations that do not currently require residency training in emergency medicine. Anything that diminishes the value of residency training and legitimate board certification leads toward less than ideal care of patients in emergency departments.

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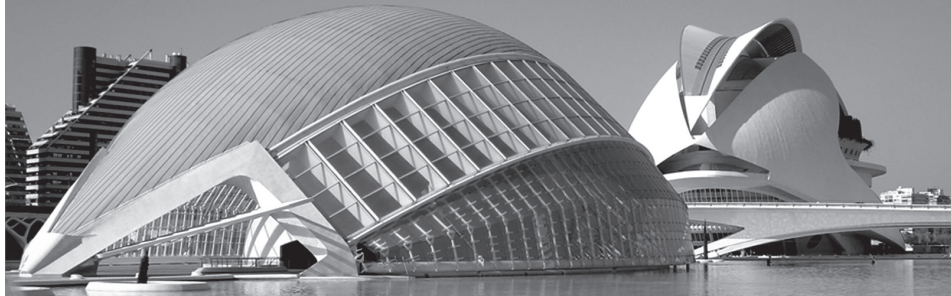
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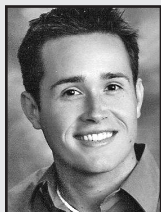
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Resident & Student Association



RESIDENT PRESIDENT'S MESSAGE

Healthcare in America: The True Value of Residency Education

Michael Ybarra, MD
AAEM/RSA President

As we begin a new membership year with the incoming team of leadership for AAEM/RSA, we have the opportunity to build on our past successes and implement exciting new ideas. I cannot stress enough the importance of every member to our organization – we benefit from your ideas and contributions, and your membership adds to the growing voice that AAEM/RSA has in the house of medicine and in national policy debates. You, as a resident, are extremely important to us, to your residency program, to the hospital at which you work, to the local communities you serve and to the healthcare system as a whole. The next installment in a continuing series on Healthcare in America is about you: how residency education is funded and your true value to the system!

Through college and medical school, we have already invested a tremendous amount of money in ourselves, but the government also knows the value and importance of medical education and has invested even more. The government sees a value in ensuring that our country has a steady stream of well-trained physicians and is, therefore, the primary sponsor of Graduate Medical Education.

The federal government pays for our positions as residents by reimbursing hospitals through Medicare. Additional money is available through Medicaid, but varies widely by state and is under tremendous financial pressure, as most Medicaid programs are well over budget. Medicare, which is housed in the Department of Health and Human Services, pays for costs in two categories: Direct Graduate Medical Education (D-GME) and Indirect Medical Education (IME) costing over five billion dollars annually.¹

D-GME payments help to cover resident salaries, benefits and teaching attending physician compensation, among other costs related to resident training. IME costs are also reimbursed and include payments for extra tests that residents may order, longer patient stays and technological investments that enhance resident education. The IME is controversial; some economists argue that IME payments simply add to hospitals' revenues unjustly while others argue that residents truly add indirect costs. One study whose author argued against IME attempted to quantify the true value of a resident and argued that resident salaries are well below fair market value.²

The Balanced Budget Act of 1997 capped the number of funded residency training spots giving Medicare most of the power to control the number and distribution of residency programs.³ If a hospital decides to start an emergency medicine residency program to meet the growing population demands, it has to reduce the number of residents in another specialty or fund the

program without additional Medicare funds. Of note, podiatry and dentistry residency programs are not included in this cap.

Changes to these rules have occurred since 1997. For example, in 1999, rural hospitals were given the option to increase their resident cap by 30% with the hope that more rural trained residents would mean more physicians working in rural areas.

Medicare has created additional incentives to encourage growth of certain specialties. For example, reimbursement to hospitals for fellowship programs is typically half of the full-time equivalent salary for a resident, except for geriatrics and preventive medicine. This means a hospital will receive more reimbursement from Medicare for a geriatric fellow than an endocrinology fellow.⁴

D-GME payments are calculated based on a moderately complicated formula that includes variables such as number of Medicare inpatient days, the total number of inpatient days, the number of residents at the teaching hospital and an amount known as the Per Resident Amount (PRA). The PRA is a fixed annual dollar amount, unique to each hospital depending on location and local wage indices and based on a 1984 number that is increased every year to reflect inflation. The PRA is slightly higher for primary care residents to encourage hospitals to train more primary care physicians.⁵

IME costs are reimbursed to the hospital based on an adjustment percentage (again determined by a complicated formula!). For example, if Medicare typically reimburses a hospital \$3,000 for a laparoscopic cholecystectomy, and the procedure is performed on a Medicare patient at a teaching hospital whose adjustment percentage is 5%, then that hospital will actually receive \$3,150. The reimbursement to hospitals for Indirect Medical Education decreased sharply from 1997 to 2007, but began to increase again in 2008 after intense lobbying from hospitals. Even so, hospitals receive a lower adjustment percentage today than they did ten years ago.⁶

These reimbursements are for teaching hospitals up to their allowed number of residents. If a hospital has more residents than allotted by the Medicare cap, the additional residents must be fully funded by the institution. This sets the stage for intense debates within hospitals as to how to distribute and prioritize residency programs.

Residency education is a national priority reflected by the tremendous investment that the federal government has made. Your true value as a resident is important not only in the patient

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Resident & Student Association

Resident President's Message - continued from page 14

care and community service that you provide, but also the funding that you contribute to your hospital's bottom line.

Editor's Note: At the time of publication of this article, there are bills in the US Senate (S.973) and House of Representatives (H.R.2251), both titled "Resident Physician Shortage Reduction Act of 2009," proposing an increase in the current GME funding caps, potentially increasing the number of residents and future workforce of emergency physicians. The Association of American Medical Colleges has a very easy website portal that automates the process of sending emails supporting the bill to your representatives: <http://capwiz.com/aamc/home>. Show your support for increasing the Medicare caps by emailing your representatives today!

1. Bruccoleri, R, Hexom, B. "Graduate Medical Education Funding." American Medical Student Association. 10 June 2009. <http://www.amsa.org/pdf/Medicare_GME.pdf>.
2. Nicholson and Song (2001). "The incentive effects of the Medicare indirect medical education policy." *Journal of Health Economics*. 20: 909-933.
3. Balanced Budget Act of 1997, H.R.2015, 105th Cong., 1st Sess. (1997).
4. "Medicare Payments for Graduate Medical Education: What Every Medical Student, Resident, and Advisor Needs to Know." American Association of Medical Colleges. 10 June 2009. <<http://www.aamc.org/advocacy/library/gme/dgmebroc.pdf>>.
5. Mitchell, Christianne. "Medicare Direct Graduate Medical Education (D-GME) Payments." American Association of Medical Colleges. 10 June 2009. <<http://www.aamc.org/advocacy/library/gme/gme0001.htm>>.
6. Dalton K, Norton EC, Slifkin R, Kilpatrick K. "The influence of Medicare's indirect medical education adjustment on hospital sponsorship of graduate medical education (GME)." *Abstr Book Assoc Health Serv Res Meet*. 1999; 16: 413.

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Washington Update

RESIDENT EDITOR'S LETTER

Ryan Shanahan, MD
AAEM/RSA Resident Editor



As a new academic year begins, roles change at AAEM/RSA. I will be taking over the role of *Common Sense* resident editor, as Dr. Michael Ybarra serves as the AAEM/RSA president this year. With my introductory column, I wanted to discuss the 'Public Plan,' one of the more contentious issues facing Congress this session as they work on health reform.

A 'Public Plan' option would allow anyone, regardless of age, to purchase a Medicare-like health insurance plan directly from the Federal Government. It would be available to those who are currently uninsured or lack secure health insurance coverage through their employer. A public plan would compete with private plans in the health insurance marketplace.

To its supporters, a public plan is the best way to provide guaranteed access to millions of uninsured and underinsured Americans. By providing a plan that anyone can join, a public plan would eliminate the unfortunate fact that many individuals cannot afford insurance. This plan is seen as simple – a standard benefit package, defined premium and easy enrollment. A public plan can take advantage of Medicare's economies of scale as well as the reduced administrative overhead that Medicare enjoys over private plans. In a Lewin Group¹ study on the issue, they estimated the average family premium for a public plan would be \$761 vs. \$970 for a private plan. It would also have the clout to mandate quality improvement, much like Medicare has already done with the treatment of pneumonia. The main academic supporters of the public plan option are Dr. Jacob Hacker of UC Berkeley and Dr. Len Nichols of the New America Foundation; their proposals differ in minutia, but overall paint the same picture.

To its detractors, this plan is concerning both for the increased role of the federal government in healthcare and also the potential increase in the unfunded liabilities of Medicare. There is significant concern that employers will choose to drop their healthcare coverage and dump their employees into this new plan – the crowd out effect. The same Lewin group study predicted that 131 million Americans would be covered by this new plan, 119 million of them currently covered by private insurance.

Physicians have been wary of this public plan option. This wariness mainly stems from Medicare's 20-30% lower payments to physicians and hospitals. In Senate testimony, the AMA stated they do "not believe that creating a public health insurance option for non-disabled individuals under age 65 is the best way to expand health insurance coverage and lower costs. The introduction of a new public plan threatens to restrict patient choice by driving out private insurers, which currently provide coverage for nearly 70 percent of Americans."² After President Obama's speech to the AMA in June, they modified their position, stating that they "support health system reform alternatives that are consistent with AMA principles of pluralism, freedom of choice, freedom of practice, and universal access for patients." They specifically declined to endorse a public plan option.³

Emergency medicine differs from other specialties; we do not choose our patients, and we are obligated to treat all patients regardless of insurance status. Any increase in the percentage of insured in the population has the potential to increase revenue. More patients with insurance might also reduce the tendency of emergency departments to be used as primary care clinics, thus reducing overcrowding.

The Institute of Medicine estimates that 18,000 people die yearly⁴ due to lack of health insurance. Something certainly needs to be done to redress this fact. The public plan option is one potential fix. Whether it will, or should, become reality will depend on all the players at the table – businesses, patients and physicians – including you.

1. John Sheils Randy Haught The Cost and Coverage Impacts of a Public Plan: Alternative Design Options Lewin Group April 2009.
2. <<http://www.nytimes.com/2009/06/11/us/politics/11health.html>>.
3. <<http://www.ama-assn.org/ama/pub/news-events/news-events/policy-hsr-alternatives.shtml>>.
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Resident Journal Review: July-August 2009

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

This is a continuing column providing journal articles pertinent to EM residents. It is not meant to be an extensive review of the articles, nor is it wholly comprehensive of all the literature published. Rather, it is a short list of potentially useful literature that the busy EM resident may have missed. Residents should read the articles themselves to draw their own conclusions. This edition will include articles published over a two month period. These selections are from papers published in March and April 2009.

Rizkallah, J, S. F. Man, et al. (2009). "Prevalence of pulmonary embolism in acute exacerbations of COPD: a systematic review and meta-analysis." *Chest* 135(3):786-93.

The purpose of this review was to determine the reported prevalence of pulmonary embolism in patients experiencing a COPD exacerbation. The authors conducted a structured search of the literature, along with a hand search of bibliographies to identify additional titles. The authors' selection criteria excluded studies containing another obvious cause of respiratory deterioration (e.g., sepsis, bacteremia, malignancy, pneumothorax, myocardial infarction). From the 2,407 articles identified, five articles (comprised of 550 total patients) were included in their final analysis.

Overall, the prevalence of PE was 19.9%; in studies limited to patients hospitalized for COPD exacerbations, the prevalence was 25.5%. In one study that evaluated emergency department patients who were not admitted to the hospital, the prevalence of PE was 3.3%. Overall, the prevalence of deep venous thrombosis was lower than PE. For hospitalized patients, the prevalence of DVT was 16.6%. The physical exam, EKG and chest radiograph of patients with and without pulmonary embolism were similar. In two out of three identified studies, there was no difference in the occurrence of dyspnea, chest pain, cough, hemoptysis or palpitations between groups.

The authors identified a high prevalence of pulmonary embolism among patients with COPD exacerbations that were admitted to the hospital. With COPD patients having nearly double the mortality from PE, a careful consideration of this diagnosis should be entertained when there is not a clear cause for their exacerbation. Complicating matters further, no clinical decision rules for pulmonary embolism have been validated in this population. Further studies are needed to more clearly define the features of PE in the COPD population, as well as to help develop rational management strategies for this challenging disease. Until then, emergency department physicians should stay on the lookout for this common, deadly and protean condition.

Dowling S, Spooner CH, Liang Y, et al. Accuracy of Ottawa Ankle Rules to exclude fractures of the ankle and midfoot in children: a meta-analysis. *Acad Emerg Med.* Apr 2009;16(4):277-287.

Ankle and midfoot injuries are common presenting complaints to the emergency department. Radiographs are a mainstay of the emergency department evaluation to determine the presence of fracture. The Ottawa Ankle Rules (OAR) are a set of clinical decision rules developed and validated in adults to guide the use of x-rays in this evaluation. Subsequently, several studies have applied these rules to children with similar injuries. The authors in this study reviewed the literature and data for the use of the Ottawa Ankle Rules in children.

The authors conducted a structured search of the literature, along with a hand search of bibliographies to identify additional titles. Standard inclusion and exclusion criteria were applied. Among other criteria, studies with patients <18 years old, in which the criterion standard diagnostic test was ankle and/or foot x-ray were included. From the 451 articles identified, 12 articles (comprised of 3,130 total patients) were included in their final analysis.

Study quality was assessed via QUADAS. The pooled sensitivity for identifying fracture was 98.5%. Specificities ranged from 7.9-50%. The pooled negative likelihood ratio was 0.11 (0.05-0.26 95%CI). There were ten missed fractures – one Salter Harris-I, one SH-IV, two "insignificant" (SH-I or <3mm avulsion), six unreported. Based on the 21.4% prevalence of fractures and the pooled negative LR, the posterior probability of fracture after a negative OAR assessment was 2.9%. Applying the OAR to the included population would result in a missed fracture rate of 1.2%. The pooled estimate of x-ray reduction after applying the decision rules was 24.8%.

Based on this review, the OAR appears to be a valuable clinical decision rule to help reduce unnecessary x-rays while maintaining a high sensitivity for identifying fracture. However, there were several important limitations to the analysis. In eight included studies, the OAR were applied retrospectively to data collected at time of assessment. Furthermore, of the ten missed fractures, six were not completely described (five from one single study). Also, most included patients were over the age of five. Despite these limitations, the review provides compelling evidence for the use of Ottawa Ankle Rules in children over five.

Liteplo AS, Marill KA, Villen T, et al. Emergency thoracic ultrasound in the differentiation of the etiology of shortness of breath (ETUDES): sonographic B-lines and N-terminal pro-brain-type natriuretic peptide in diagnosing congestive heart failure. *Acad Emerg Med.* Mar 2009;16(3):201-210.

Thoracic sonography has been increasingly used in the diagnosis of undifferentiated cardiorespiratory complaints. B-Lines (vertical "comet tail" artifacts) are sonographic signs of lung edema (interstitial/alveolar) and/or fluid-filled lung – findings commonly found in CHF. The authors in this study examined the diagnostic value of two- and eight-zone lung sonography as compared to and combined with NT-ProBNP, for predicting CHF.

This prospective, observational study enrolled a convenience sample of 100 adult patients who presented to the emergency department with shortness of breath. Patients who had NT-ProBNP levels sent as part of the diagnostic work-up were selected for thoracic lung zone ultrasound. Comprehensive medical charts were independently reviewed after hospital courses were completed to

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determine final diagnoses. This was used as the criterion standard. Technicians/RDMS ultrasound reviewers and physician chart reviewers were blinded to NT-ProBNP levels and ultrasound results, respectively.

A positive eight zone ultrasound, defined as at least two positive zones (presence of three B-lines per zone) on each side, had a positive likelihood ratio of 3.88 (1.55-9.73 99% CI) and negative likelihood ratio of 0.5 (0.3-0.82 95% CI) for the diagnosis of CHF. NT-ProBNP had a LR+ of 2.3 (1.41-3.76 95% CI) and LR- of 0.24 (0.09-0.66 95% CI). For two-zone US, interval LRs were 4.73 (95% CI = 2.10 to 10.63) when inferior lateral zones were positive bilaterally and 0.3 (95% CI = 0.13 to 0.71) when these were negative. These changed to 8.04 (95% CI = 1.76 to 37.33) and 0.11 (95% CI = 0.02 to 0.69), respectively, when congruent with NT-ProBNP.

This study provided support for the value of thoracic sonography in the diagnosis of CHF. The results show lung sonography to be comparable to NT-ProBNP for the diagnosis of CHF. Combined, the two represent a powerful diagnostic tool. Despite a relatively small convenience sample size and observational nature, the study suggests a promising role for lung sonography and demonstrates the need for a larger, randomized evaluation.

Hollander JE, Chang AM, Shofer FS, McCusker CM, Baxt WG, Litt HI. Coronary computed tomographic angiography for rapid discharge of low-risk patients with potential acute coronary syndromes. Ann Emerg Med. Mar 2009;53(3):295-304.

Evaluating low-risk patients who present to the emergency department with chest pain has been the subject of much discussion in recent years, as the tools available to clinicians in the ED have expanded. Coronary computed tomographic angiography (CTA) is a diagnostic technique examined by a number of authors for the evaluation of this group.

In their prospective, observational study, Hollander et al. looked at 568 adult patients who presented to their emergency department and who were determined to be low-risk patients. Low-risk patients were defined as patients with a TIMI risk score of 0-2. In these low-risk patients, 285 underwent coronary CTA during hours when it was immediately available; the remaining 283 who presented at other times of the day had serial cardiac enzymes measured followed by coronary CTA. Patients who had findings of <50% maximal stenosis and calcium scores of less than 100 on CTA were considered to have negative results and were discharged home. Cardiac stress testing and coronary catheterization were considered the criterion standard in patients who had such testing.

Overall, 214 patients in the immediate CTA group (75%) and 262 patients in the delayed CTA group (93%) had negative results and were discharged without further evaluation. At 30-day follow-up, none of these patients suffered cardiovascular death or non-fatal myocardial infarction. Using a cutoff of a 50% coronary lesion, the diagnostic accuracy of coronary CTA had a sensitivity of 100% and specificity of 91.5%.

The results of this paper seem to indicate that low-risk patients presenting with chest pain, who have a negative coronary CTA, are

safe for discharge to home without the need for further diagnostic testing. However, there are a few caveats to bear in mind with this study. First, these results were from a subset of patients who were already at very low risk for adverse events at 30 days. Additionally, this study was observational and offered no comparison group as a diagnostic control. As such, it is difficult to make practice-changing conclusions from this single paper. Nevertheless, coronary CTA appears to be a highly sensitive diagnostic study that is available in the ED and may allow for further risk stratification with reduced admissions for patients with low cardiac risk chest pain. Larger, prospective, controlled, trials are still needed to work out the role of coronary CTA in the evaluation of low-risk patients in the emergency department.

Friedman BW, Bender B, Davitt M, et al. A randomized trial of diphenhydramine as prophylaxis against metoclopramide-induced akathisia in nauseated emergency department patients. Ann Emerg Med. Mar 2009;53(3):379-385.

Metoclopramide is a commonly used medication in the emergency department for the treatment of nausea, acute migraine and gastroparesis. An adverse side effect of this medication is akathisia – a complex of signs of symptoms characterized by restlessness and agitation. Various methods have been used to prevent or treat akathisia including anticholinergics, benzodiazepines and slower delivery of medication. To date, no clear consensus on which agent should be used as prophylaxis has been reached.

This randomized, double-blinded study investigated whether co-administration of diphenhydramine along with metoclopramide would decrease the incidence of akathisia. 289 patients were enrolled from a single emergency department. Exclusion criteria included patients with extrapyramidal illnesses or movement disorders, pregnancy, and use of antiemetics, antihistamines or antipsychotics within three days of presentation. Patients were randomized to receive either 10mg or 20mg of metoclopramide IV along with 25mg of diphenhydramine IV or placebo. Development of akathisia was evaluated by a Short Akathisia Instrument (SAI), a version of the Prince Henry Hospital Rating Scale of Akathisia modified for use in the ED setting. Akathisia was present if SAI scores were increased at either assessment at 30 minutes or 60 minutes or if rescue medications such as benzodiazepine were given by the primary physician.

34 patients developed akathisia and the incidence did not vary significantly among the different arms of the study. There was a trend towards akathisia in those patients who received 20mg vs. 10 mg of metoclopramide (OR 1.7) but this was not statistically significant (CI 0.8 -3.6). Only 3 of the 14 patients who developed akathisia and were not treated with rescue medications still had symptoms at 60 minutes.

Akathisia can be an adverse effect of metoclopramide administration and is often not evaluated for in the emergency department. This study showed that administration of diphenhydramine did not decrease the rate of akathisia and is not recommended for prophylactic use in this setting.



Pedrosa I, Lafornera M, Pandharipande PV, Goldsmith JD, Rofsky NM. Pregnant patients suspected of having acute appendicitis: effect of MR imaging on negative laparotomy rate and appendiceal perforation rate. Radiology. Mar 2009;250(3):749-757.

Acute appendicitis (AA) is the most common cause of abdominal pain requiring surgical treatment in the pregnant patient. Timely and accurate diagnosis is very important as delayed treatment can lead to significant morbidity to the mother and fetus. Negative laparotomy rate (NLR) and perforation rate (PR) are important clinical outcomes in patients with suspected AA. In pregnant patients, a higher NLR (20%) is generally accepted in order to avoid a high PR. At the same time, high NLR is concerning due to the increased risks associated surgery in the pregnant patient. Computed tomography (CT) has become the standard in assessing AA in non-pregnant patients. However, due to the radiation exposure involved with CT, other diagnostic tests such as ultrasonography (US) and magnetic resonance (MR) imaging have been considered.

This retrospective cohort study assessed the effects of MR imaging in the examination of AA using NLR and PR as objective measures of outcome. 148 patients from a single hospital were found to have MR imaging in their evaluation for suspected AA. Reference standards for the final diagnosis were surgical pathology after laparotomy or laparoscopy, confirmatory CT (for one of the patients) or clinical follow-up (median follow-up time of seven days).

Of the 148 patients, 14 were found to have AA confirmed by either pathology or CT and all were identified by MR imaging (fluid filled appendix >7mm diameter or non-visualized appendix with peri-appendiceal fat stranding or abscess). Of the 134 patients who were negative for AA by criterion standard, 2 had false-positive findings with MRI. The authors contend that if the decision for laparotomy or laparoscopy was based on these MR findings, only 2 of the 27 total patients who underwent surgery would have negative findings, for a NLR of 7% while the PR in this study would remain at 21%.

Limitations to this study include the low prevalence of AA, the 24 hour availability of MRI in this facility and the potential bias inherent to any retrospective study. Despite this, the findings suggest that the use of MRI in the evaluation of AA in pregnant patients results in clinically favorable negative laparotomy and perforation rates while avoiding the radiation exposure related with CT examinations.

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STUDENT PRESIDENT'S MESSAGE

J. Akiva Kahn

AAEM/RSA Medical Student Council President



Congratulations on completing another challenging year of medical school. For the first-year students reading, welcome to an exciting educational journey! Throughout our time in medical school, we are expected to learn and retain an immense amount of information, from antimicrobials to arrhythmias, poisoning symptoms to personality disorders, and vitamin deficiencies to Virchow's triad. In addition to the required exam material, we are also encouraged and expected to keep up with current journal articles and newsworthy events while researching residency programs and juggling interviews. This may be more challenging in the first few years when the light at the end of the tunnel is dim, but it's never too soon to start immersing yourself in relevant knowledge about your future specialty of emergency medicine.

AAEM/RSA provides practical resources for medical students interested in emergency medicine which will help you to stay organized. We do the legwork of sifting through relevant journals and news sources, highlighting the crucial facts and summarizing the important issues in emergency medicine. Check your email regularly for our monthly updates featuring journal articles, current controversies in emergency medicine, and practical advice from *Rules of the Road for Medical Students*.

As a student member of AAEM/RSA, a myriad of resources is available to supplement your education on our website, www.aaemrsa.org. The information it encompasses will help you succeed not only as a medical student, but also in the future as a resident and attending physician. If you have not done so already, I strongly recommend reading *Rules of the Road for Medical Students*, by Dr. A. Antoine Kazzi and Dr. Joel Schofer. Articles in *The Journal of Emergency Medicine* and *Common Sense* are other helpful ways to keep abreast of the latest developments in emergency medicine. These publications are mailed to paid student members and are also available online. We hope that you will take advantage of all of these resources and also spread the word about AAEM/RSA to your colleagues.

Another way to stay updated and get involved is through your medical school's Emergency Medicine Interest Group (EMIG). If your school does not already have an EMIG, contact us or check out our EMIG Starter Kits at <http://www.aaemrsa.org/resources/emig-starter-kits.php>. This year, the AAEM/RSA Medical Student Council is making an effort to improve communication between AAEM/RSA and the EMIGs. Another one of our goals is to increase the number of EMIG Workshop Starter Kits. Ideas for new PowerPoint presentations may be emailed to info@aaemrsa.org.

For students starting the residency application process, we recommend logging on to EM Select (www.emselect.org). Here, one can search through a residency database, save a list of programs along with personal notes, compare programs side-by-side in preparation for creating a rank order list and much more.

Save the dates! We have some exciting events this year including the 3rd Annual Midwest Medical Student Symposium to be held at Loyola University Chicago Stritch School of Medicine on August 22, 2009, and the 16th Annual Scientific Assembly to be held at Caesars Palace in Las Vegas, NV, on February 15-17, 2010.

Finally, I would like to congratulate the new Medical Student Council: Vice President Deena Ibrahim (University of California, Irvine); West Regional Representatives Meaghan Mercer (Western University) and Mike Mitchell (University of Washington School of Medicine); South Regional Representatives Cassandra Bradby (Meharry Medical College) and Michael Buscher (Virginia College of Osteopathic Medicine); Midwest Regional Representatives Lauren Pandolfe (Loyola University Stritch School of Medicine) and Lisa Weber (Michigan State University College of Human Medicine); Northeast Regional Representatives Erica Adams (Georgetown University School of Medicine) and Brett Rosen (Drexel University College of Medicine); and the Ex-Officio Representative Ali Farzad (St. George's University).

The 2009-2010 AAEM/RSA Medical Student Council is dedicated to continuing the tradition of excellence set forth by previous councils. We look forward to working hard to improve the services and outreach of the council, and we invite you to become more involved with AAEM/RSA.

Good luck with all of your endeavors and especially your journey into emergency medicine!

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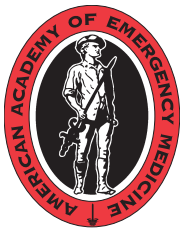
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