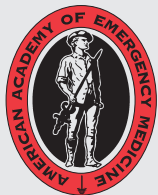


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VOLUME 16, ISSUE 6
NOVEMBER/DECEMBER 2009

THE NEWSLETTER OF THE AMERICAN ACADEMY OF EMERGENCY MEDICINE



PRESIDENT'S MESSAGE The Meaning of MEMC

Larry D. Weiss, MD JD FAAEM

As I write this article during a long Trans-Atlantic flight after the Mediterranean Emergency Medicine Congress (MEMC), I reflect on the centrality of this meeting for international emergency medicine. The approximately 1,500 delegates at MEMC make it the largest international meeting of emergency physicians. The coordinated efforts of AAEM with the European Society of Emergency Medicine (EuSEM) remain a model of cooperation. The meeting not only attracts emergency physicians from the U.S. and around Europe, but also the eastern and southern Mediterranean countries, as well as increasing numbers of physicians from Africa, Central and South America and throughout Asia.

We held another great meeting with fine speakers from around the world. Joe Lex and Gunnar Öhlén served as executive chairs, doing an outstanding job of organizing a complex meeting. Richard Shih organized the U.S. track chairs, Roberta Petrino and her team organized the European track chairs and speakers, and Antoine Kazzi and Peter Cameron organized track chairs and speakers from the rest of the world. The structure of the meeting blended speakers and delegates from around the world at almost every session. The Sociedad Española de Medicina de Urgencia y Emergencias (SEMES), served as gracious hosts. They have more than 5,000 members and have an active campaign to achieve primary board recognition from the Spanish Ministry of Health.

MEMC serves as an essential meeting for those interested in international emergency medicine. The Society for Academic Emergency Medicine (SAEM) sent a delegation of their international committee to forge links with emergency physician researchers around the world. The International Federation for Emergency Medicine (IFEM) staffed an exhibit booth promoting their International Conference in Emergency Medicine in Singapore (ICEM 2010). Delegations from South America, Mexico and Korea also met at MEMC to plan their upcoming meetings.

At MEMC, a number of representatives from national societies around the world requested AAEM presence at their upcoming meetings. Most of these requests did

not include material support, but only educational support because of the fine reputation of speakers at our CME conferences. I encourage any of our members with a strong interest in international emergency medicine to consider joining our international committee. Virtually unlimited opportunities for overseas involvement in emergency medicine education exist at this time.

Indeed, with great satisfaction, we now see the rapid proliferation of emergency medicine around the world. Many European countries now have multiple residency programs and organized boards. EuSEM recently issued a statement recognizing the primacy of residency training and developed a set of "core competencies" for European emergency physicians. We recognize EuSEM as an equal partner. I highly recommend not only our biennial MEMC conferences, but also EuSEM's conferences for cutting edge information of relevance to emergency physicians around the world. EuSEM holds its scientific assemblies in even years, with the next meeting set for Stockholm in October 2010. Our greater attendance at the EuSEM meeting will strengthen the relationship between our organizations and increase the involvement of AAEM in international emergency medicine.

Of course, I hope to see many of our members at the next MEMC on the Greek island of Kos in September 2011. We expect MEMC VI to be the most successful international meeting ever, in an incredibly beautiful beach setting. Come to the home of Hippocrates, renew your oath in the ancient amphitheatre of Odeum, cruise the Greek Isles or visit nearby Turkey whose beautiful shores can be seen from our conference center.

We owe a great deal of gratitude to the visionary founders of MEMC, Roberta Petrino and Francesco Della Corte of Italy, and our own Antoine Kazzi. They founded MEMC as a catalyst for all in the Mediterranean area and around the world with an interest in emergency medicine. What is the meaning of MEMC? MEMC serves as a shining example of emergency physicians from around the world interacting in a cooperative manner, learning from each other and building bridges in a manner not possible by politicians.

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Editor's Letter

David D. Vega, MD FAAEM

Legal Victory for Emergency Medicine Residency Training

In December of 2006, the American Association of Physician Specialists (AAPS) filed suit in the U.S. District Court, Southern District of New York, against various state officials in an attempt to force the New York State Department of Health (NYDOH) to recognize diplomates of the Board of Certification in Emergency Medicine (BCEM) as "board certified" in emergency medicine.¹ Unlike other boards such as the American Board of Emergency Medicine (ABEM) and the American Osteopathic Board of Emergency Medicine (AOBEM), BCEM certification does not require residency training in emergency medicine.²

On September 17, 2009, in a victory for emergency medicine residency training, a U.S. District Judge granted a motion for summary judgment in the case, finding in favor of the NYDOH. As expected, however, the saga continues, as the AAPS filed an appeal on October 19, 2009.

AAPS offers multiple pathways to becoming a diplomate of BCEM. It is not necessary to complete residency training in emergency medicine in order to be eligible for BCEM certification. According to the AAPS, an option equivalent to residency training in emergency medicine for eligibility includes a practice track with five years of experience practicing emergency medicine.² Applicants who would like a shorter route to BCEM certification may complete a 12 or 24 month graduate training program offered by family medicine programs through the University of Tennessee. According to one of these programs' websites, "A graduate of the fellowship program would be able to say that they are 'residency trained in family or internal medicine, board certified in family medicine and emergency medicine and that they completed a fellowship in emergency medicine.'"³

The New York Patient Health Information and Quality Improvement Act of 2000 requires the NYDOH to collect

continued on page 10



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AAEM Mission Statement

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

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

Membership Information

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

*Associate Member: \$250

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

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

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

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

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

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

Send check or money order to : AAEM, 555 East Wells Street,
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Research Abstracts at the Fifth Mediterranean Emergency Medicine Congress

Gary M. Gaddis, MD FAAEM
MEMC V Research Forum Chair, AAEM

The presentation of research abstracts at the Fifth Mediterranean Emergency Medicine Congress (MEMC V), held 14-17 September in Valencia, Spain, represented a sizable step forward for the research content of this international conference series. As has been mentioned elsewhere in this edition of *Common Sense*, MEMC has rapidly grown, such that by 2005 it had become the world's largest emergency medicine scientific meeting held outside the United States.

Under the leadership of Research Abstract Co-Chairs Eddy Lang (International/Canada), Marc Sabbe (European Society of Emergency Medicine/Belgium) and myself (AAEM/United States), over 1,000 English language written abstract submissions were received and judged by an international panel of abstract reviewers. In addition, another 84 Spanish language submissions were received and presented via poster at the Congress.

Drs. Lang, Sabbe and I thank all of those who reviewed the written abstracts submitted for consideration as possible oral abstract presentations by the 31 May 2009 deadline. The research abstract review process included reviews by one content expert from each of the three categories of attendees (European, International and United States).

From these reviews, three abstracts emerged with the highest scores, and these were presented at the Plenary Research Abstract Session just before the Opening Reception on 14 September. Presenters included:

- Chad Cannon, MD
- Jane Fansler, MD
- Jeffrey Cochran, MD

The winner, as judged by the three research abstract co-chairs, was Dr. Chad Cannon of the University of Kansas Medical Center, Kansas City, Kansas. The winner and the finalists were awarded plaques, along with a significant financial prize, by Stephen R. Hayden, MD, Editor-in-Chief of the *Journal of Emergency Medicine*, AAEM's official journal. On behalf of myself and the other co-chairs,

we thank Dr. Hayden for his foresight in suggesting that such awards be given for the first time, and then for following through and arranging for awards to be presented.

Over 270 other English language abstracts were selected for oral presentation based upon the scoring of the written abstracts. Attendance at the research abstract sessions was much improved over the 2007 meeting in Sorrento, with some rooms being filled to the point of leaving standing room only. The sessions were kept on time by 94 session moderators. Richelle Cooper, MD, of the University of California at Los Angeles, again provided a supremely valuable service by screening each of the international abstracts for proper use of English.

On behalf of the chairs, I also thank everyone who asked questions of the presenters at the meeting. Such questions help the abstract authors to prepare better drafts of papers for submission. One can think of a meeting abstract presentation as an opportunity for a free "peer review."

The Sixth Mediterranean Emergency Medicine Congress (MEMC VI) will be held on the island of Kos, Greece, just off the shore of Turkey. Please consider serving as an abstract reviewer for this meeting in September 2011. You may nominate yourself for one of these positions by forwarding your name, e-mail address and four areas of greatest expertise to Gary Gaddis at ggaddis@saint-lukes.org. Please send an abbreviated one-page curriculum vitae excerpt listing your publications and presentations over the past three or four years with your self-nomination.

Finally, it would be remiss of me not to mention the invaluable role of Amy Genc Moritz toward the planning and logistics of the Congress. As I have said publicly a number of times, Amy performed so well that there were occasions in which she asked me questions about the various processes and tasks performed by our committee before I realized that I would need to ask that question. Amy is the best meeting planner with whom I have ever had the pleasure to work!

Abstract Reviewers

Abdel Bellou	Marc Afilalo
Antonia Quinn	Marc Sabbe
Anwar Hasan	Mark Langdorf
Bruce Lobitz	Michael Bullard
Carlo Locatelli	Michel Baer
Chris Lee	Peter Pang
Colin Graham	Raemma Luck
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Tudor Codreanu
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Young Mi Choi
Ziad Kazzi

The Fifth Mediterranean Emergency Medicine Congress (MEMC V) was held 14-17 September 2009 in Valencia, Spain



Congress attendees enjoyed lunch outside the Congress Centre.



Dr. Larry D. Weiss, AAEM President, presents Prof. Gunnar Öhlén, EuSEM President and avid spoon collector, with a tasting spoon from Le Bec-Fin, a Philadelphia, PA, restaurant.



Attendees at the SEMES dinner included Prof. Gunnar Öhlén, EuSEM President; Dr. Tomas Toranzo, SEMES President; Dr. Abdel Bellou, EuSEM President-Elect; Dr. David Williams, EuSEM Past President; Dr. Howard Blumstein, AAEM Vice President; and Dr. Larry D. Weiss, AAEM President.



The MEMC V banner welcomed delegates to the Congress Centre.



There was standing room only at many of the didactic sessions throughout the Congress.



The MEMC V gala dinner was held at L'Hemisferic, part of the City of Arts and Sciences, in Valencia, Spain.

Did you go to MEMC V?

If so, go to <http://www.emcongress.org/2009/> to view the abstracts presented in Valencia!



Attendees at the gala dinner included Prof. Gunnar Öhlén, EuSEM President, and Dr. Tomas Toranzo, SEMES President.



Gala dinner attendees watched the firework display at L'Hemisferic in Valencia.



Dr. Stephen R. Hayden and Dr. Gary Gaddis presented awards to the top three oral abstract winners. The best oral abstract went to Dr. Chad M. Cannon; Dr. Jane Lee Fansler and Dr. Jeffrey Cochran rounded out the top three winners.



A tunos band provided entertainment for the opening reception attendees on 14 September.



Dr. Hezi Waisman presents an oral abstract on Paediatrics to a standing room only crowd.



More than 800 English and Spanish language posters were presented at MEMC V.

Go International

Scott G. Weiner, MD MPH FAAEM
Chair, AAEM International Committee

I'm writing this on the plane home from a wonderful conference in Valencia, Spain. It was a conference for reflection, particularly about the role of AAEM and other organizations internationally (spurred by a fantastic meeting discussing collaboration between SAEM and EuSEM, with leadership from AAEM and ACEP also present). It also occurred to me that many of the members of AAEM might wonder why AAEM should even be involved in the international arena. After all, one of the founding tenants of the organization is the protection of the individual practicing emergency physician in the U.S. (it is the "American" Academy). So why should our organization care how EM progresses around the globe?

The answer is compelling and complicated. Imagine that EM is a child, developing from birth to adulthood. Thanks to the founding members of the specialty, it was raised from birth to baby steps. The next generation brought about specialty recognition and establishment of residency training programs. All the while, its research activities progressed, giving it more academic respect. And now, EM finds itself in college. It knows a lot and is gaining a lot of experience, but it is still struggling with its identity (evident through ongoing turf battles with specialties like anesthesiology and critical care, and particularly through the lack of primary specialty recognition in multiple countries). EM is doing well but is not yet ready to graduate.

Has anybody you've known ever done a year abroad in college? In most cases, at this key stage of development of one's identity, removing the individual from a comfortable environment and forcing him or her to adapt to a new culture is perhaps the strongest builder of character and identity possible. That is what happened to me when I went abroad as a naive 20-year-old, and I still maintain that it is the year that helped most solidify my identity. Others have had similar growing experiences in the military, Peace Corps or other such activities.

Sending EM abroad is similar. Outside of its environment in the U.S., all of the rules of politics, reimbursement issues, issues of physician exploitation and quests for ideals, such as due process, change. And when the rules change, new enlightenments and developments can be kindled. We can examine how EM functions in a single-payer system without the need for speculation. We can see how EM would be different in a different malpractice environment. We can see how EM changes with pandemic infections (such as observing the behaviors of H1N1 influenza in the southern hemisphere before it comes to the U.S.) or learning from those who experienced disasters that did not occur in the U.S., but could. There is also room for innovation that may not be possible initially in our system but could happen when EM is allowed to develop outside of our home environment.

AAEM would like to introduce the new members only area of the website.

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

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

Visit www.aaem.org to learn more and watch for new features coming soon!

Please contact info@aaem.org or 800-884-2236 with any questions.

On yet another level, just as AAEM has championed protection of the individual practicing EP in the U.S., and arguably forced other EM organizations to change their ways as well, it can also effect change internationally, thereby increasing the scope and strength of the organization. We can use our experience to help develop EM in other countries, creating allies and promoting global standardization and improvement of care for patients with emergencies worldwide.

And finally, development of the specialty internationally is important to us domestically. With more emergency physicians, more research will occur internationally. Our journals will expand, the quality of our specialty's research will grow, and we'll learn more about how to better care for our patients in the U.S. by evaluating quality studies from abroad. It is truly a win-win situation.

It was mentioned several times at the Valencia meeting that Americans are fond of referring to "emergency medicine" as different than "international emergency medicine." However, this does not exist in other established specialties. We do not differentiate "cardiology" from "international cardiology," for example. Once we get past that hurdle and EM becomes truly global, our specialty can graduate, and we will all benefit.

If you have never been to an international conference, I hope you'll consider it in the future. It is always surprising to see how many great ideas come up that make one say, "Now why didn't I think of that?" They are the ideas that are allowed to grow outside the restraints of our environment, yet we can make them fit in our system as well. The next Mediterranean Emergency Medicine Congress will be in Kos, Greece, in 2011. It will be an incredible opportunity to see how EM is practiced and innovated elsewhere, and I hope you'll join us, especially if you've never been to an EM conference abroad before.

ICEM 2010
9-12 JUNE
The World Moves Forward
SINGAPORE
www.icem2010.org

Please visit our website for details on registration
& abstract submission

Final Announcement

Registration Opens	: 1 June 2009
Abstract Submission Deadline	: 31 January 2010
Early Bird Deadline	: 28 February 2010

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**EMERGENCY MEDICINE:
THE WORLD MOVES FORWARD**

The International Federation for Emergency Medicine

Scott G. Weiner, MD MPH FAAEM
Chair, AAEM International Committee

On October 7th, 2009, a board meeting of the International Federation for Emergency Medicine (IFEM) was held in Boston. IFEM was founded in 1989 with the goal of promoting emergency medicine internationally. IFEM is an "organization of organizations," in which countries with developed EM specialty groups can apply and become members. Currently, there are about 30 countries represented by the organization with more countries applying regularly.

IFEM allows one "full member" organization per country. The requirements are that the organization be the predominant specialty organization in the country, that the country has officially recognized EM as a medical specialty, and that it has at least one recognized EM training program. Additionally, there is a category for "affiliate members," which are national organizations for practicing emergency physicians in countries where EM is not yet formally recognized or in which there may be additional national EM organizations for countries already represented by another organization. Affiliate organizations appoint one non-voting member to the board. In the U.S., ACEP is the full member, and AAEM is an affiliate member.

Every two years IFEM sponsors the International Conference on Emergency Medicine (ICEM). This is a large, multi-national conference with participants from around the globe. Until recently, ICEM was limited to English-speaking countries: U.S., Canada, Australia and England. But the 13th ICEM will take place in Singapore from June 9-12, 2010, and represents the first time it will be in Asia. This is a reflection of the expansion of emergency medicine globally. Future conferences will be in Ireland in 2012 and Hong Kong in 2014. If you are interested in attending a truly global conference in an exciting location, visit www.icem2010.org for more information.

There are several committees in IFEM to manage specific issues. There are committees on finance and governance to manage the organization. There is a specialty implementation committee to help develop the specialty of EM internationally, a guidelines working party to develop guidelines that can be used throughout the world. There is also an organizing committee for ICEM. Joe Lex, MD FAAEM, sits on the curriculum committee, which has already established guidelines for suggested curriculum of medical students interested in pursuing a career in emergency medicine. Guidelines for post-graduate/residency training are in the final stages of development. The next step will be the creation of continuing professional development guidelines.

At the meeting, several topics were discussed, including the organization's relationship with the World Health Organization (WHO), new ideas to help create certifying exams for countries that do not currently have a national board of EM and a presentation of a new, updated website of the organization. Furthermore, Dr. Jim Holliman was awarded IFEM's Humanitarian Award in recognition of his work related to international emergency medicine which has led to major humanitarian benefits. We congratulate him on this well-deserved honor.

It is not possible to become an individual member of IFEM, but IFEM represents the entirety of our specialty on an international level on behalf of our national organizations. This is important for every AAEM member to know about. When the World Health Organization needs to involve emergency medicine or a country needs resources to help them develop EM as a specialty, it is important to have an organization that transcends national borders. Furthermore, the organization serves as a clearinghouse for information such as guidelines, curricula, and also hosts a website in which conferences and classes held around the world (including AAEM's) are listed. For more information about IFEM, visit their website at www.ifem.cc.

AAEM would like to thank the following 100% ED Groups for their membership in 2009!



Bay Care Clinic, LLP
Drexel University
Edward Hospital
Fredericksburg Emergency Medical Alliance, Inc.
Front Line Emergency Care Specialists
Northwest Tucson Emergency Physicians
OSF Saint Anthony
Physician Now, LLC
Providence-Newberg (ESO)
Santa Cruz Emergency Physicians (SCEP)
Southern Colorado Emergency Medical Assoc (SCEMA)
University of Louisville
West Jefferson Emergency Physician Group

The AAEM Foundation thanks

Larry D. Weiss, MD JD FAAEM

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

Member Feedback

Have an opinion about something you've read in Common Sense? Want to share your views on EM issues with thousands of other AAEM members? Send your thoughts to CSeditor@aaem.org and your comments may be published in a future issue of Common Sense!



AAEM member George Hossfeld, MD FAAEM, from the University of Illinois Department of Emergency Medicine sent the following:

"Dr Vega- In your column re Tort Reform, Sept/Oct 2009, you quote the AMA's estimate of \$99 to \$179 billion spent each year on defensive medicine. ... I feel strongly, that the cost of defensive medicine is actually much higher. I suggest keeping a list for a week of what tests, admissions, treatments, and procedures are done to "CYA". That includes all the patients that could have been triaged to clinics or PMD's in a few days time except for EMTALA causing us paranoia that one in a million of these patients will have a bad outcome and litigate. I think you will find that it is actually much, much higher, approaching 30% of all costs. With my [percentage] of head CT's that actually impacted patient care in the single digits, I am as guilty as any. That's why it is so disappointing that no organized medicine association has stepped forward to insist that meaningful tort reform must precede any other changes to our health care system."

We thank Dr. Hossfeld for his thought-provoking comments about tort reform. Rest assured that AAEM stands firmly in support of meaningful medical liability reform. In fact, unlike other emergency medicine organizations, AAEM came out clearly in opposition to the House of Representatives health care reform bill (HR 3962) primarily because of its failure to include tort reform, as noted in this press release:

American Academy of Emergency Medicine Opposes House Health Care Reform Bill

The American Academy of Emergency Medicine (AAEM) opposes the health care reform bill recently passed by the United States House of Representatives (HR 3962). AAEM opposes this bill because of the failure of Congress to include any tort reforms. Our tort system functions in such an aberrant and predatory manner that a large majority of lawsuits against physicians have no basis in fact. Recent figures released from the Congressional Budget Office estimate a savings of at least \$41 billion to government health programs through meaningful tort reforms. However, when including the costly effects of defensive medical practices, other estimates project a savings of more than \$200 billion per year through significant tort reforms.

Furthermore, the House version of the bill offers rewards to states that eliminate existing tort reforms. Eliminating caps on non-economic damages and caps on attorney fees will exacerbate the liability crisis. The United States has the world's only liability crisis because of the unique and highly atypical manner in which our tort system functions. HR 3962 will worsen our liability crisis and the stresses it places on our society. Therefore, AAEM urges the United States Senate to include significant tort reforms when it deliberates on the pending version of its health care reform bill.

Released November 19, 2009

Report Examines Recession's Impact on Emergency Departments

Kathleen Ream, Director of Government Affairs

To determine what impact the recession is having on hospital EDs, the Kaiser Family Foundation's Commission on Medicaid and the Uninsured conducted a set of interviews in July 2009 with ED heads and officials of groups representing emergency physicians and nurses. The EDs in which they practiced reflected a broad spectrum of settings across the country. The product of those interviews, a policy brief entitled *Emergency Departments under Growing Pressures*, indicates that the recession may be pushing EDs to their breaking point.

Key Findings

Strained ED Capacity and Rising Volume

While ED capacity has been strained for some time, nearly all the EDs surveyed reported rising volume. The recession, with its negative impact on health coverage and patients' ability to afford needed care, was widely viewed as the cause of the volume increases. To deal with such increases, EDs are raising the number of patients that doctors see per hour and adding to work shifts and staff. The situation is worrisome, as the pressure on staff to do more in less time increases the risk of errors.

Economic Pressures Produce New "Recession" Population

ED doctors and nurses report seeing more people who lost their jobs and became uninsured. They also report higher numbers of insured patients seeking primary care in the ED because they can no longer afford to pay deductibles and out-of-pocket costs at their doctor's office.

No Other Options for Uninsured Patients

Except for one ED, which was part of a large area health care system that included clinics for poor and uninsured people, all others surveyed cited sharp inadequacies in access to primary care in their communities, giving uninsured patients no other options. They reported that few private practices accept uninsured patients and waits for new-patient appointments at community health centers and clinics range from four to six weeks to four to six months. Also, when they have no other access to physician care and have run out of their medicines, uninsured adults come to the ED to get a refill, often having gone without the medications for weeks. The visit is likely to be repeated a month later, as few ED doctors will prescribe for more than a month. Several interviewees said that doctors' offices in their communities had directed uninsured clients, clients with Medicaid and insured clients whose benefits had run out to the ED for care.

No Access to Timely or Affordable Care

Faced with full primary care practices or unacceptably long waits for appointments with private physicians, insured patients turn to the ED for primary care. For some, their deductible or the co-pay required up-front in doctors' offices is a deterrent. They come to the ED instead where they receive needed care, but do not have to pay right away.

Long Waits

Whether insured or uninsured, patients face long waits due to ED overcrowding. In one large, urban hospital, the wait was 18 to 24 hours. One ED physician said, "It is only a matter of time before people are dying in the waiting room." It is expected that patients who give up waiting and leave will come back in worse shape. No inpatient capacity for those who need admissions leads to boarding.

Repeated Visits and Sicker Patients

Patients not receiving primary care come to the ED repeatedly as problems flare or they get sicker. As a result, the ED is burdened, and the patient faces higher costs and possibly more difficult treatment.

Costs Lead Patients to Decline Recommended Care

The interviews elicited numerous accounts of both insured and uninsured patients choosing not to follow medical advice because of the cost, including the cost of missing work. Such decisions put patients' health in jeopardy, leading to repeated ED visits and even costlier treatment.

ED Visits Linked to Stress from Job Loss/Financial Worries

Interviewees reported increases in complaints of anxiety, depression and stress due to joblessness and financial worries. When no physical cause can be found for such somatic complaints as stomach or chest pains, the symptoms may be stress-related.

Follow-up Care Unlikely

Interviewees described follow-up care for uninsured patients as an enormous problem, with fees and long waits for referred appointments the impediments. When ED physicians realize their patients are unlikely to get follow-up care, they practice differently to ensure the patient's safety – doing more extensive and costly work-ups, or admitting them in some cases. The effects of no follow-up, including worsened conditions, are seen at intake.

Inadequate Resources to Meet Mounting Pressures

In order to handle the increasing volume, EDs need additional staff, ancillary services capacity and greater inpatient capacity. If the H1N1 pandemic hits, EDs will have even more pressure. That could be more than EDs can handle.

The complete policy brief (publication #7960) is available at <http://www.kff.org/uninsured/7960.cfm>.

WV Court Finds No Evidence Supporting EMTALA Screening and Stabilization Claims

On August 7, 2009, the U.S. District Court for the Northern District of West Virginia dismissed claims brought by a driver involved in a racetrack accident, alleging that a hospital violated EMTALA screening and stabilization requirements (*Ramonas v. West Virginia University Hospital-East*, N.D. W.Va., No. 3:08-cv-136, 8/7/09).

The Facts

George Ramonas crashed his car on September 19, 2005, into a wall at a racetrack in West Virginia. The force of the impact broke Ramonas' safety helmet, and both airbags deployed, yet he managed to remove himself from the wreck. Ramonas was transported by ambulance to the trauma center at Jefferson Memorial Hospital (JMH) where he was triaged as "urgent" by a nurse. The nurse noted his pain level at "5" on a scale of 1 to 10, but decided that it was unnecessary to give Ramonas a full chest, abdomen and neurological evaluation because his vitals were within normal limits. The nurse's assessment also found Ramonas to be "cooperative and calm; his facial features symmetrical; oriented motor response and speech; limited movement due to pain; and abnormal numbness in three toes on his left foot."

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After triage, Ramonas was examined by the on-duty physician in the ED. The physician, understanding that Ramonas had a history of lower back pain, gave Ramonas a physical exam upon belief that the car wreck had aggravated the existing back pain. The physician noted that Ramonas did have "spasms in the left buttock," so he ordered X-rays of Ramonas' lumbosacral spine and pelvic region, but did not perform straight-leg-raising tests, and "never, ever evaluated the patient's ability to ambulate." Ramonas reported "pain with deep breaths," but the ED physician did not order X-rays of the chest or palpate the chest wall.

Upon reviewing the X-rays, the ED physician "concluded that Ramonas was only suffering from 'muscle spasms,' and ordered that Ramonas be given an injection of Toradol for his pain as well as prescriptions for Percocet, Flexeril, and Motrin." Orders were left for Ramonas' discharge. Ramonas asked to be admitted to the hospital, but the ED physician refused.

Ramonas returned to his home, and on September 23, 2005, an ambulance was sent to Ramonas' home to take him to George Washington University Hospital (GWH). An examination at GWH discovered a fractured left seventh rib, a left transverse process fracture, a fracture of the body of S2 and bilateral fractures of the sacral ala. The GWH physicians "also noted that Ramonas had a kidney injury, vision floaters, hematuria, and abdominal pain." Ramonas was discharged from GWH on October 3, 2005.

Ramonas filed suit against JMH for the alleged negligence of its ED staff and for "violating EMTALA by failing to provide an appropriate screening examination, failing to stabilize an emergency medical condition, and for transferring Ramonas in an unstable condition." Defendant JWH filed a motion for summary judgment.

The Ruling

With respect to the negligence claims, this federal court determined that JMH may be held vicariously liable for alleged negligent acts of a non-hospital employee, such as an ED physician, because such physician was an "actual agent" of the hospital, where the only real difference between this ED physician "and the other staff physicians was the duration of their appointments." Stating that the "existence of an agency relationship is a question of fact to be determined by the jury – not on summary judgment," the court denied the defendant's motion for summary judgment to the extent that a triable issue of fact did exist as to whether [the ED physician] was an "actual agent" of JMH.

The court also denied JMH's motion for summary judgment on the defendant's contention that the plaintiff failed to provide admissible expert testimony that the ED nurses strayed from the applicable standard of care. Rather, the court determined that the plaintiff "presented a report and deposition testimony by a board certified emergency medicine physician who appears . . . qualified to testify as to the standard of care for emergency room nurses. It is well established that physicians can opine as to the standard of care applicable to nurses."

In regard to EMTALA claims, to survive the defendant's motion for summary judgment a plaintiff has the burden of "proffering sufficient evidence from which a reasonable jury could find, by a preponderance of the evidence, that '(the defendant) actually knew of that (emergency medical) condition . . .'" The federal court in this case determined that Ramonas' claim fell short, because the "[d]efendant and its agent failed to actually appreciate Ramonas's condition as an 'emergency medical condition'." "If the emergency nature of the condition is not detected," the court explained in its decision, "the hospital cannot be charged with failure to stabilize a known emergency condition."

The court found that the ED physician's diagnosis and treatment did not violate EMTALA. Owing to "an absence in the record of any evidence suggesting that the hospital had ever treated another patient with symptoms the same as or similar to the defendant more aggressively than it treated him," the court determined that Ramonas did not establish disparate treatment in his medical screening. Iterating that EMTALA "does not provide a cause of action for routine charges of misdiagnosis or malpractice," any shortcomings in the screening or diagnosis in this case were outside the scope of EMTALA, according to the court.

The court was not convinced that the treatment Ramonas received veered from the minimum required under EMTALA and, thus, the motion for summary judgment in this part of the claim was granted.

Patient "Dumping" Claim Not Supported under EMTALA

The U.S. District Court for the Eastern District of Kentucky decided on August 24, 2009, that a hospital did not violate EMTALA screening and stabilization requirements when ED physicians transferred a patient from a hospital ED, in compliance with a court order, to a facility for treatment of suspected mental illness (*Caristo v. Clark Regional Medical Center Inc.*, E.D. Ky., No. 08-343, 8/24/09).

The Facts

On July 25, 2007, James Caristo presented himself to the ED at the Clark Regional Medical Center (CRMC) reporting that he had injured his left leg in a motor vehicle accident. The medical records completed in the ED reflect that Caristo was taking Klonopine and Lortab. An ED physician performed a complete medical examination on Caristo and ordered an X-ray of Caristo's left leg. Finding that Caristo had a fracture in his lower left leg, the physician ordered that the leg be immobilized with a splint and that Caristo be discharged to home with instructions to follow-up with an orthopedist on the following day. Caristo was also to contact his primary care provider or return to the hospital if his problem worsened or if he experienced new symptoms. Caristo was also given a prescription for Lortab. In an effort to further assist him after he was discharged, an ambulance transported Caristo to his residence.

Caristo failed to see the orthopedist on the following day, nor did he fill the prescription. But five days later, on July 30, Caristo returned to the CRMC ED, delivered by police officers responding to Caristo's mother seeking assistance for his erratic behavior. Caristo was in the ED for more than 5½ hours. The medical records contained no reference to any complaints by Caristo with respect to the prior injury to his left leg. However, Caristo was examined and treated by two ED physicians who ordered various tests and diagnostic checks in an effort to ascertain the cause of his behavior. Among the tests, Caristo underwent a consult with a licensed clinical social worker, who documented that Caristo became "angry," began to remove his IV, "and started demanding to leave." One of the physician's diagnosis of Caristo included "psychosis," "hostility," and "substance abuse." Determining that Caristo would benefit from further evaluation and treatment at a behavioral health facility, an involuntary admission was filed.

The district court judge, finding probable cause to believe that Caristo presented a danger or threat of danger to himself and/or others, ordered Caristo be transferred to Comprehensive Care, a community mental health center, for examination by a qualified mental health professional. Caristo was delivered to Comprehensive

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Care, where a certified social worker filed a certification indicating that she did not regard Caristo to be mentally ill. Based on that certification, the district judge ordered Caristo to be released, and Caristo returned to his mother's home.

On the following day, Caristo presented himself to Saint Joseph East Hospital, where he was hospitalized for five days while being treated for the broken bone in his lower left leg and for alcohol withdrawal. Caristo sued CRMC alleging that when he presented himself to the ED for treatment on July 30, CRMC's employees and agents failed to "provide needed medical care and either refused to treat him or transferred him without providing sufficient emergency care to stabilize and/or treat his emergency medical conditions," all in violation of EMTALA. Defendant CRMC filed a motion seeking summary judgment.

The Ruling

The court found that defendant CRMC did not violate EMTALA when discharging plaintiff Caristo on July 30, because Caristo was released and transferred to Comprehensive Care in compliance with a court order, "after he had been screened at the Emergency Department at CRMC where the medical staff there thought that he was experiencing some form of mental illness and concluded that CRMC did not have the resources to adequately diagnose or treat his condition." The court concluded that plaintiff was not "dumped" by CRMC.

The court further stated that the "plaintiff's hospitalization at St. Joseph East and surgery on the fractured bone in his lower left

leg are of no consequence to plaintiff's EMTALA claim [based on Caristo's return to CRMC on July 30] because the subsequent care and treatment of the broken bone in plaintiff's lower left leg are related to plaintiff's visit to the emergency room at CRMC on July 25." Similarly, the court concluded that "such behavior that plaintiff exhibited on July 31 is of no consequence to his visit to the Emergency Department at CRMC on July 30, as it is unknown whether plaintiff had ingested any alcohol and/or prescription medication subsequent to his release from Comprehensive Care on July 30."

Additionally, the court stated that Caristo could not satisfy the evidentiary burden necessary to prove an EMTALA claim in the absence of expert testimony. The court defined expert medical testimony for this case as "from a trained, licensed physician and preferably from a physician who has knowledge acquired from having practiced in the emergency room setting."

The plaintiff also contended that defendant was not entitled to summary judgment because there was a genuine issue of material fact as to whether CRMC's physicians were ostensible agents of CRMC. "The record reflects," according to the court, "that when plaintiff visited CRMC's Emergency Department, he was presented with a consent form which advised him that the physicians at CRMC were not employees or agents of CRMC Consequently, the court [was not] persuaded by plaintiff's argument that there is a genuine issue of material fact concerning the status of the medical personnel at CRMC." The court granted defendant summary judgment on plaintiff's EMTALA claims.

Editor's Letter - continued from page 2

and make publicly available certain information about licensed physicians, including "specialty board certification." The stated goals of the act include improving the quality of health care and increasing public information about health care providers, practitioners and plans.⁴ NYDOH does not currently recognize BCEM diplomates as "board certified." According to the state of New York, "Board certification means a specialty or subspecialty in which a physician is certified by the American Board of Medical Specialties (ABMS), American Osteopathic Association (AOA) or Royal College of Physicians and Surgeons of Canada (RCPSC) [or The College of Family Physicians of Canada (CFPC)]."⁵

AAPS argued that NYDOH's non-recognition of BCEM diplomates as board certified violates the equal protection rights of its diplomates under the fourteenth amendment and other federal law. It presented several examples of physicians certified through their pathway who "are equally qualified to practice emergency medicine and yet have encountered various professional handicaps due to the fact that they only have specialty board certification from [AAPS]."¹ AAPS also claimed that "anti-competitive lobbying groups have misled the Department [of Health] about the importance of emergency medicine residency in specialty board certifications."¹ The defense presented documents and testimony from representatives of emergency medicine organizations, including AAEM Immediate Past President Tom Scaletta, supporting the importance of residency training in emergency medicine to board certification.

In making its decision, the court noted that "It is fair for the Department to conclude . . . that physicians with residency training in emergency medicine are more qualified than those who took a practice-track to specialization."¹

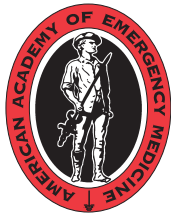
AAEM's official news release on this issue adds:

"AAEM monitors the activities of AAPS, and we attempt to be present at any hearing in any state where AAPS argues that residency training in EM is unnecessary. It's embarrassing that we must still argue that EM is a legitimate specialty requiring residency training before one may call oneself 'board certified.' We expect a similar result in every state where AAPS makes a similar argument, and we will always be there to advocate for the academic integrity of EM."

Over the balance of your career, you can rely on your Academy to always stand up for your practice rights and to always stand up for the academic integrity of emergency medicine."⁶

References

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October 21, 2009

American Board of Emergency Medicine
3000 Coolidge Road
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Dear ABEM Board of Directors:

On behalf of the board of directors of the American Academy of Emergency Medicine (AAEM), I congratulate you on your collaborative efforts with the American Board of Internal Medicine in reaching the agreement to co-sponsor critical care medicine certification. Collaborative efforts such as this help board certified emergency physicians meet the diverse needs of our patients.

In addition, these efforts help meet the needs and interests of emergency medicine residents. AAEM believes in the goal of providing every emergency department patient access to a physician board certified in emergency medicine. AAEM also supports the candidacy of emergency physicians for fellowship positions in critical care medicine.

Thanks again for your work in making certification in critical care medicine possible for emergency physicians.

With warm regards,

Larry D. Weiss, MD JD FAAEM
President

American Academy of Emergency Medicine

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WMIG Update

Jasmine B. Bookert, MD
with Lisa D. Mills, MD FAAEM

"Nurse, nurse, when am I going to see my Doctor?!" How many times have I heard this question after introducing myself as the physician, treating the patient and discussing the treatment plan. While we ponder the glass ceiling in the boardroom, female physicians face gender stereotypes everyday, with the preconception that women in the ED are "the help" and men are the physicians.

The reality is women are expected to play an expanded role in the ED that includes the duties of both doctor and nurse. The resulting discrimination was identified early on by one of the pioneers of emergency medicine: "Women physicians experience greater demands from patients and nursing staff for gender-related tasks that are not expected of their male colleagues. For example, male physicians are not expected to help the nurse with bladder catheterization or to get a box of tissues for the patient." (McNamara, RM *Physician Wellness*. eMedicine. February 2005

<http://www.emedicine.com/emerg/topic678.htm>).

Solutions to the "loss" of identity and over-expectations for women emergency physicians are challenging. However, there is a flip side to the coin. This was brought to my attention by a patient who told me that she assumed I was the nurse because my bedside manner was more caring and invested than that of the typical male doctor. Frequently, female physicians are identified as being more caring, compassionate and involved in their patients' care.

Women in emergency medicine demonstrate that physicians can be efficient and compassionate at the same time. Giving undivided attention during those infrequent interactions builds patient trust and confidence. Now, when a patient refers to me as a nurse I smile, correct them, and realize that it may be my responsiveness that earns me that title.

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AAEM Young Physicians Section

Electronic Patient Tracking Systems: A Healthy IT Investment for Emergency Departments

Damon Dietrich, MD MHCM FAAEM
AAEM Young Physicians Section Treasurer
AAEM Louisiana State Chapter President

Emergency department visits are on the rise while EDs continue to close at an alarming rate. Effective internal strategies for any hospital must encompass measures to improve operational flow and throughput to meet the demands of increasing volume. In the evolving environment of customer-centric health care, hospitals must implement information technology (IT) products and solutions to improve patient safety, to remain competitive and to survive financially. Dr. David J. Brailer, who was the National Coordinator for Health Information Technology from 2004 to 2006, was responsible for coordinating the development, maintenance and oversight of a national strategic plan to promote adoption of health IT in the public and private sectors.¹ This national urgency for implementation of IT products still exists in a health care sector that faces awesome challenges. Health care spending and health insurance premiums continue to escalate at rates that outpace the Consumer Price Index (CPI) or general inflation. It is estimated that the Medicare trust fund will go bankrupt by 2012. Although U.S. health care spending totals over \$2.2 trillion annually, or 16.2% of the Gross Domestic Product (GDP),² challenges continue, including preventable errors, uneven health care quality, and poor communication among physicians and hospitals. Administrative inefficiencies, high costs, medical errors, variable quality and lack of coordination are directly linked to the inadequate use of IT as a vital part of the health care delivery system.¹

In 2006, the Institute of Medicine (IOM) released a report titled "Hospital-Based Emergency Care: At the Breaking Point," which identified weaknesses in the nation's ability to respond to large-scale emergency situations, whether disease outbreaks such as pandemic influenza, naturally occurring disasters or acts of terrorism.³ Partly underlying these weaknesses is the fact that over the last several decades, the role of EDs has expanded from treating seriously ill and injured patients to also providing urgent unscheduled care to patients unable to gain access to their providers in a timely fashion and to providing primary care to Medicaid beneficiaries and persons without insurance. At least 15% of the population is completely uninsured, and a substantial additional portion of the population is "underinsured," or less than fully insured for medical costs they might incur. Additionally, more money per person is spent on health care in the United States (\$7,026 per person annually in 2006) than in any other nation in the world, and a greater percentage of total national income is spent on health care in the U.S. than in any United Nations member state except for Tuvalu.⁴ Medical debt is the principal cause of personal bankruptcy in the United States.

EDs are now also frequently overloaded. ED visits in 2006 rose to 119.2 million, up from 90.3 million in 1996. As ED visits have increased, the number of hospital-based EDs has decreased by almost five percent between 1996 and 2006, resulting in dramatic increases in patient volumes and waiting times.⁵ One of the most common factors related to ED crowding is the inability to transfer

ED patients to inpatient beds once a decision has been made to admit them.¹ As the ED begins to "board" patients, the space, staff and resources available to treat new patients are further reduced. Another consequence of overcrowded EDs is ambulance diversion, in which EDs close their doors to incoming ambulances. The resulting treatment delay can be catastrophic for the patient. Approximately 500,000 ambulances are diverted annually in the United States (about one ambulance diversion per minute).⁶

Over the last 10 years, U.S. emergency departments have experienced a transition from a patient focus to a customer or consumer focus. This customer-centric atmosphere marks a renaissance in the design and function of U.S. emergency departments. Disaster incident preparedness, ED closures, higher acuity patients, rapidly increasing volume, regulatory pressures and a change in the functional mission of hospitals have all contributed to this transformation.⁷ Hospitals must focus on high quality, cost-effective care to drive their missions in an environment of narrower operating margins. This current challenging and competitive environment dictates that EDs incorporate measures such as electronic patient tracking systems into facility design and process to reduce the operating expenses of a continuously running ED.⁷

To surmount these new challenges, competitive hospitals have incorporated new concepts borrowed from other industries to facilitate superior customer service. Electronic patient tracking systems (EPTS) have been shown to improve operational flow and throughput with multiple benefits. The application of IT support systems, such as an EPTS, is of paramount importance to meeting the needs of patient consumers in the ED. With the ED and labor and delivery unit providing the majority of first impressions about overall hospital operations and service delivery, IT solutions should be designed and implemented in these arenas. The ED is the "front door" or "front line" for over 50% of all patients admitted to most U.S. hospitals, while serving as a central community outreach center, most notably for the indigent and uninsured population. As we all know, EMTALA is not going away. ED encounters average 405 visits per 1,000 population each year in the U.S.⁵ Therefore, for many patients, the ED drives the perception of overall hospital service.⁷

Because the ED drives the majority of overall hospital service perception, ED systems and processes must maintain adequate surge capacity. The hospital must recognize and address the highest community expectations and perceptions of treatment for an emergent condition. In times of increasing volume, the ED is under intense pressure to remain open to avoid triggering a cascade of events that lead to ED diversion. Diversion leads to increased customer dissatisfaction and declining operating margins due to falling revenue generation.⁷ Dissatisfaction can evolve into decreasing market share in a competitive environment where

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consumers choose other EDs for treatment. In addition, if patients prefer to use other EDs, then they may also choose a different hospital for other non-emergent health care needs which contributes to declining market share and revenues in other hospital service lines.

EPTS's have been shown to increase throughput and revenues through improved operational efficiencies and work flow processes. Both of these enhancements lead to decreasing diversion times. With EDs having wide variations in capacity requirements, EPTS increase the bandwidth of an ED. Bandwidth refers to the ability of an operating unit such as an ED to tolerate wide variances in work requirements. Essentially, an EPTS increases ED tolerance and efficiency during volume surges. With length of stay (LOS) increasing in emergency rooms, particularly for admitted patients waiting for inpatient beds, EPTS's serve to decrease LOS thereby increasing volume and throughput.

Due to the potential capacity constraints for most EDs, it is imperative for ED leadership to invest considerable energy in managing spatial and functional relationships. For instance, the timely management of ED patients is critically connected to inpatient bed management, radiology and laboratory services. An EPTS allows for effective operational oversight of the efficiencies or inefficiencies of all respective departments. All services can be held accountable, as the system tracks workflow processes in all departments allowing for identification, correction and process improvement of workflow inefficiencies and bottlenecks. The EPTS serves as a highly functional status board to improve inter-connectivity and operational flow.⁷

Goals and Benefits of Electronic Patient Tracking Systems

- Tracking of the physical location of patients after triage
- Identification of patients' current status and visit progression
- Tracking of ED utilization and specific room status
- Indication of specific providers involved with each patient's care
- Identification of bottlenecks contributing to decreased operational flow
- Maintenance of patient privacy, including HIPAA standards
- Ability to interface with existing hospital IT products (interoperability)
- Improvement of process flow and throughput
- Increased accountability of all interactive departments
- Improved patient safety
- Streamlining of coding and billing for faster revenue generation

EPTS's can also incorporate evidence-based decision support systems. Doctors are then able to have the most current information about treatment options and new drugs, as well as immediate access to relevant patient information. With an Electronic Health Record connected to an EPTS that stores demographics and billing information, hospital and physician reimbursement increases. The link provides accurate, detailed documentation of care. This helps

to avoid denial of payment from managed care companies and to avoid allegations of fraud from Medicare.⁸ A bill can be generated in a more efficient system through linking documentation with billing information. Physician documentation can be linked through the system to CMS documentation audit criterion, which ensures adequate documentation for the nature and severity of each patient encounter. This ensures appropriate reimbursement by eliminating mandatory down coding secondary to insufficient documentation.⁷

Emergency departments must undergo transformation to meet the needs of consumers. As the U.S. hospitality industry is committed to setting progressively higher standards for customer service, the health care industry is addressing increasing patient volumes and acuity with a reduction in the total number of EDs, worsening cost pressures, and increasing regulation.⁷ In addition, ED providers need to avoid adverse outcomes and medical errors, while implementing strategies for disaster preparedness and bioterrorism surveillance and detection. IT advances such as an EPTS provide countless benefits through improved patient safety, increased operating margins, increased revenue and throughput, decreased LOS and improved patient satisfaction. The EPTS also serves to enhance operational process flow through accountability and oversight leading to bottleneck identification and elimination. For U.S. health care to improve, a committed and determined focus on IT solutions such as EPTS for EDs must be recognized as vital to the financial solvency and future of any health care organization.

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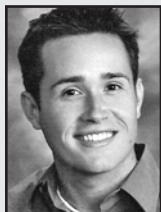
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Resident & Student Association



RESIDENT PRESIDENT'S MESSAGE

Health Care Around the World

Michael Ybarra, MD
AAEM/RSA President

The success of the Fifth Annual Mediterranean Emergency Medicine Congress was inspiration to investigate how other countries provide health care. Meeting physicians from around the world, a frequent point of discussion was about the future of health care in America. All were eager to share the way that their country provides health care for its citizens.

AAEM and the Resident & Student Association continue to be involved in advocating for physicians' practice rights, emergency medicine's place in the "house of medicine," and national tort and reimbursement issues, as well as broader health care reform. As the national debate on the future of health care smolders on, here is a glimpse of health care around the world.

England

In the wake of World War II, The United Kingdom faced the challenge of rebuilding their country. It was in this tumultuous decade that Winston Churchill, a conservative icon, spoke to the Royal College of Physicians and Surgeons, stating:

"The discoveries of healing science must be in the inheritance of all... Our policy is to create a national health service in order to ensure that everybody in the country, irrespective of means, age, sex, or occupation, shall have equal opportunities to benefit from the best and most up-to-date medical and allied services available."¹

The official bill authorizing the National Health Service (NHS) in England and Wales was signed in to law in 1946. It provides free point of care health services to all citizens of England and is paid for by tax dollars. The budget was roughly \$200 billion in 2008-2009 and has seen an approximately 3% annual rise in costs since it's founding in the late 1940s.² For comparison, the 2007 budget of Medicare in the United States was over \$400 billion and rises annually anywhere from 5-15%.³ 60% of the NHS budget pays salaries for the staff, 20% for drugs and supplies and 20% for buildings and equipment.

The NHS is the world's largest provider of health care and is also the world's fourth largest employer. There is a small market for private health care, paid for out-of-pocket or by insurance policy. Life expectancy at birth in the United Kingdom is 79 years, higher than in the U.S. Though outcomes are generally exceptional, there is less access to some novel therapies, contributing to a lower survival rate for certain cancers.

China

China currently has a disorganized health system. In the late 1970s, the government privatized the health care system and took away a chunk of government subsidies. Now, the nearly 700 million rural Chinese citizens have little to no access to care, and most of the 1.3 billion citizens must pay for any care they receive almost entirely out of pocket. According to *The Lancet*, the average cost of hospitalization exceeds the average person's wage.⁴ The Chinese have one of the world's highest personal savings rates, and many believe this is because individuals shoulder the majority of the cost of illness.⁵

The government has introduced a plan called Healthy China 2020, which ambitiously intends to create universal health care for 1.3 billion people over the next ten years. The plan provides some form of health insurance and drug coverage to all citizens. China has invested \$120 billion on hospital infrastructure and set price controls on 300 of the most commonly used drugs.⁶

France

Health care in France, like in England, is provided to all citizens, financed through a national health insurance system, paid for by the government through tax revenue. France spends approximately 11% of their GDP on health care, which is the highest of any country in Europe but less than the 16% spent in the United States.⁷

Physicians are "self-employed" but receive reimbursement from a single-payer government insurance fund on a fee-for-service basis. The government sets the reimbursement schedule. Individuals have the option of purchasing private supplemental insurance. Many employers offer supplemental insurance as part of their benefits package. The government programs pay the vast majority of hospitals' (public institutions) and doctors' fees, and private insurance can be purchased to pay for drugs, prostheses, dental care and health care at private for-profit hospitals.

In general, taxes in France are higher than in the United States, but because of the complexity of both nations' tax codes, it is difficult to compare apples to apples. Individuals in France pay 5.25% of their income to the health care plan.⁸ The government then plays a role in managing the health insurance funds themselves and negotiates drug costs and physicians' reimbursements.

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Resident President's Message - continued from page 20

Japan

The Japanese have one of the longest life expectancies in the world. They have a two-pronged approach to health insurance: employer-based health premiums and taxes. Profits at health insurance companies are banned. The program costs 8% of the GDP.⁹

The Japanese see their physician on average 14 times per year (four times more frequently than U.S. citizens). Patients have access to preventive services and low cost prescription drugs, all leading to a lower prevalence of chronic diseases than in the United States, contributing to their longer lifespan.

Despite the inexpensive, easy access system, the limitations on doctors' fees and a number of novel therapies may be unacceptable to many well-insured Americans. And, while the Japanese have a much lower incidence of heart disease, the chances of surviving a heart attack are about two times higher in the U.S.

There are as many approaches to providing and funding health care as there are countries and localities in the world. The challenges we face in the United States today are not as unique as we may think. No one country has the perfect system, but there is always something to be learned by looking at others' successes and shortcomings along with our own.

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The Coming Wave

RESIDENT EDITOR'S LETTER

Ryan Shanahan, MD
AAEM/RSA Resident Editor



If health care reform in some form does not pass this year, it will certainly not be for lack of trying. What happens to millions of newly insured people who suddenly find themselves looking for primary care? Chances are they will find themselves waiting in our waiting rooms and urgent care clinics.

If Massachusetts, a state that recently went from an uninsured rate of 9.8% in 2005 to 2.6% in 2008, can serve as any guide, we are in for some busy times ahead. During this same time, ED visits have increased by 7% and costs for emergency department care have increased by 17%. At the same time, the number of low-income people (defined as three times the federal poverty level) who self-report going to the emergency room for "non-urgent" care remained steady at 23%. It seems obvious that having insurance does not equal access to primary care as many family practice and internists are not accepting new patients.

What should emergency physicians do with these patients who come to us for non-urgent complaints? The broader question is whether or not we should take small steps to formalize our role as an initial primary care physician for those that otherwise would have no access.

Much of our reluctance to deliver primary care services can be summed up in two words: "no follow-up." We try very hard to ensure

that patients are "done" when they leave our doors. About the only patients who we will consider taking back are those with lacerations that need suture or staple removal.

Imagine an emergency department, however, which prescribes HCTZ for all of the incidental untreated hypertension that exists in our communities. Imagine one that does pap smears for women that require a pelvic exam for some other reason, or one that does brief tobacco counseling routinely whenever discovered in a patient history.

These changes would entail some risk. What happens when the patient runs out of HCTZ? Surely someone should recheck their blood pressure and electrolytes before prescribing long term therapy. What happens if a pap smear is abnormal and no one is able to reach the patient? To take these risks as reasons to avoid providing basic primary care, however, ignores the fact that the risk is the same as that taken by a primary care provider who does the same testing and treatment in a new patient. Compare that risk to the risk of doing nothing and having essential hypertension turn into hemorrhagic stroke and low-grade carcinoma in situ into a stage IV cervical cancer.

Emergency physicians tend to focus on the life threatening aspects of medicine. Coming changes to health care, however, may push us increasingly into primary care concerns. Rather than defer treatment of chronic conditions to other physicians, we may find ourselves using every health care encounter as a chance to make people healthier.

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Resident Journal Review: November-December 2009

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

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

Seamon MJ, Smoger D, Torres DM, et al. A prospective validation of a current practice: the detection of extremity vascular injury with CT angiography. *J Trauma*. 2009 Aug;67(2): 238-243

For the evaluation of suspected vascular injuries from blunt and penetrating traumas, conventional arteriography (CA) has been the gold standard. Although less invasive than surgical exploration, there is still morbidity and mortality (1-3%) with the procedure as well as the potential for delays to definitive care. With advances in CT technology, the authors hypothesize that CT angiography (CTA) with timed contrast injection can provide the same injury detection ability as CA.

In this prospective cohort study, 21 patients with 22 injured extremities were enrolled in a single urban hospital. These patients exhibited no "hard sign" of vascular injury (arterial bleeding, absent distal pulses, limb ischemia, expanding or pulsatile hematoma, bruit or thrill over injured area, or hemorrhagic shock without other cause) and had ankle-brachial index (ABI) less than 0.9. Exclusion criteria included IV contrast dye allergy, renal insufficiency, diabetes, hypertension, multiple myeloma and hyperuricemia. All injuries underwent CTA with either 16- or 64-slice CT scanner, depending on availability during the time of the day. If limb-threatening injuries were found on CTA, these patients underwent surgery for evaluation and repair; otherwise, the patients underwent CA.

The patients in this study suffered from a variety of mechanisms including gunshot wounds, stab wounds and blunt MVAs. 21 of the 22 CTAs were diagnostic, and all were confirmed by surgical exploration or CA. A total of nine vascular injuries were found on CTA. Two were limb-threatening injuries and were confirmed in surgery. The other seven injuries were all found on CA. No new injuries were found on CA that were not seen on CTA. The authors propose a 100% sensitivity and specificity for CTA compared to CA.

This study suggests that CTA can be used reliably to detect clinically relevant vascular injuries in patients with abnormal ABIs. Limitations to this study include its small sample size, as well as its small number of patients with blunt injuries (n=2), which reduces applicability to blunt trauma victims. In addition, this study does not address sensitivity of finding false aneurysms or intimal tears that can present with normal ABIs. Of note, CTA sensitivity may also be affected by streak artifacts due to shrapnel. Overall, the use of CT may confer advantages of cost, availability and speed without missing significant injuries. This supports results from previous studies and makes a good case that CTA may supplant CA as the standard in evaluation of extremity vascular injuries along with ABIs and APIs (arterial pressure indices).

Jabre P, Combes X, Lapostolle F, et al. Etomidate versus ketamine for rapid sequence intubation in acutely ill patients: a multicentre randomised controlled trial. *Lancet*. 2009 Jul 25; 374(9686): 293-300

Etomidate has been a first-line agent for ED rapid sequence intubation (RSI) due to its sedative-hypnotic properties, ease of use and neutral hemodynamic properties. However, recent studies have questioned the use of etomidate due its potential for adrenal suppression and resultant effects. The authors of this study sought to compare the use of etomidate and ketamine, another popular sedative-hypnotic induction agent, in RSI.

In this prospective, randomized, controlled, single-blinded study, 655 consecutive patients who needed endotracheal intubation were enrolled from a large group of EDs and ICUs in France. Patients with pregnancy, cardiac arrest or contraindications to etomidate, ketamine or succinylcholine were excluded. Patients who were discharged alive less than three days after admission were also excluded to select for the most severely ill patients. All patients received either etomidate 0.3mg/kg or ketamine 2mg/kg as an IV bolus, followed by succinylcholine 1mg/kg. The primary endpoint was the maximum sequential organ failure assessment (SOFA) scores during the first three days in the intensive care unit. Secondary outcomes included ICU length of stay and 28 day all-cause mortality.

Results show that there were no statistically significant differences in the maximum SOFA scores or secondary outcomes. There were also no significant differences in difficulty of intubation scores or other safety measures such as blood pressure and oxygen saturation changes. Among patients in whom adrenal axis function was assessed, patients receiving etomidate had a significant reduction in basal cortisol levels, an increased rate of adrenal insufficiency, and non-response to the adrenocorticotropin stimulation test. There was no mortality difference among non-responders. There were also no significant differences in the trauma or sepsis subgroups with respect to SOFA scores or mortality.

The study supports the use of ketamine as a viable first-line alternative to etomidate for RSI. Patients who received etomidate had evidence of adrenal axis suppression; however, this did not appear to be clinically significant as evaluated by the outcome measures. Conclusions were limited in that criteria for adrenal axis evaluation were not clearly delineated. Nevertheless, ketamine and etomidate had similar safety profiles and intubation difficulty scores. While the debate over the role of etomidate for RSI continues, this study supports ketamine as a comparable alternative in the emergency physician's bag for RSI induction.

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Bhatt M, Joseph L, Ducharme FM, et al. Prospective validation of the pediatric appendicitis score in a Canadian pediatric emergency department. Acad Emerg Med. 2009 Jul; 16(7): 591-596

Appendicitis is a challenging diagnosis in the pediatric population, with misdiagnosis rates reportedly greater than 1 in 3. In order to provide the most appropriate treatment for this surgical emergency, EM providers must balance risks associated with diagnostic imaging (namely, radiation exposure) with the risk of misdiagnosis and/or negative laparotomy. Recently, the Pediatric Appendicitis Score (PAS) was developed to aid in the diagnosis and management of appendicitis. However, two subsequent validation studies had variable results. The authors of this study attempted to validate the use of the PAS.

This study was a prospective, observational study, which included 246 children age 4 to 18, presenting with abdominal pain of <3 days duration and in whom the treating ED physician considered the diagnosis of appendicitis based on their clinical judgment and results of testing. Children were excluded if they were nonverbal, had a prior appendectomy or had chronic abdominal pathology. The PAS incorporates the presence of cough/percussion/hop tenderness (2 points), RLQ tenderness (2 points), anorexia, pyrexia, nausea/vomiting, leukocytosis, neutrophilia and migration of pain (1 point each).

At the best cut-off point (score 6), sensitivity and specificity were 92.8% and 69.3%. This translates into a 37.6% negative appendectomy rate and 7.2% missed appendicitis rate. Results were improved when two thresholds were used; a score of ≤ 4 used to discharge to home, ≥ 8 for appendectomy, and further imaging studies for scores in between. With this scoring system, a score of 4 would result in sensitivity of 97.6% and at a score of 8, a specificity of 95.1%. Of the studied patients, 2.4% would have been erroneously sent home and 8.8% would have had appendectomies unnecessarily. 41% of imaging investigations would have been avoided.

This study has several important limitations to consider. First, patients were enrolled on a convenience basis and at the discretion of the treating physician if he/she "considered" a diagnosis of appendicitis. Furthermore, enrolled patients had a high rate of appendicitis (34%), possibly related to the noted pre-screening considerations. Eligible patients who were not enrolled may include a larger percentage of "missed" cases. Despite the significant limitations, the study lends credence to the use of a scoring system for pediatric appendicitis. Further prospective, standardized investigations may provide stronger support for such a tiered scoring system and improve diagnostic accuracy while limiting unnecessary radiologic studies.

Lucas R, Farley H, Twanmoh J, et al. Emergency department patient flow: the influence of hospital census variables on emergency department length of stay. Acad Emerg Med. 2009 Jul;16(7): 597-602

Overcrowding is a ubiquitous problem affecting many aspects of the care provided in our nation's EDs. It is associated with worsened

clinical outcomes, decreased patient/provider satisfaction, litigation and potential financial losses. This phenomenon has come under increased scrutiny and evaluation after the Institute of Medicine highlighted the critical importance of crowding in its 2006 report on the state of emergency care. The authors of this study sought to further explore hospital based factors associated with ED length of stay (LOS) in order to shed light on strategies to relieve ED crowding.

This was a multicenter cohort study which included data from five diverse hospitals, located in different states, encompassing a range of patient volumes, trauma acuity and academic versus community affiliations. Data from 27,325 consecutive ED patients presenting to the hospitals during the second week of the month for a five month period was compiled. All hospitals had electronic medical record systems that recorded time of patient arrival, time of admission request and time of physical patient departure from the ED. Daily median LOS over a 24-hour period was calculated as were other ED and hospital-wide variables, including ED daily admissions, total hospital census, hospital capacity, ICU census, cardiac telemetry unit census, cardiac procedures and surgical procedures.

Median ED LOS was 247 minutes. The hospitals, on average, operated at 86% of total capacity. For the pooled cohort, median ED length of stay demonstrated a significant relationship with ICU census (Pearson correlation coefficient 0.46, $p < 0.001$), telemetry census (0.62, $p < 0.001$), and the percentage of ED patients admitted each day (0.40, $p < 0.001$). Median ED LOS did not have a significant relationship to total hospital census, cardiac procedures or surgical procedures. When each hospital's data was analyzed individually, median LOS correlation to other examined factors was variable and did not always reach significance.

In this study, ED overcrowding correlated not only with intrinsic ED factors (percentage of ED patients admitted), but also with hospital-wide variables including telemetry unit census and intensive care unit census. While hospitals undoubtedly have unique practices, operations and process flow relationships, this study points to several hospital census variables that may play a critical role in contributing to ED overcrowding. Indeed, the challenge of solving the nation's overcrowding crisis requires that emergency department physicians and administrators look not only at the operations of the emergency department itself, but also to hospital wide factors that play a significant role.

Hayward G, Thompson M, Heneghan C, et al. Corticosteroids for pain relief in sore throat: systematic review and meta-analysis. BMJ. 2009 Aug;339:b2976

Sore throat is a common ED complaint stated to be associated with almost 2% of all ambulatory care visits. Antibiotics have only shown modest benefits in regards to reducing symptoms and fever. Corticosteroids inhibit pro-inflammatory mediators to reduce pharyngeal inflammation and pain. They have been beneficial in other upper respiratory tract diseases and are hypothesized by the authors to offer symptomatic relief in patients with sore throat.



Resident Journal Review - continued from page 24

This review included only RCTs comparing systemic corticosteroids with placebo in children and adults in the outpatient setting. Studies involving infectious mononucleosis, recent tonsillectomy or intubation or peritonsillar abscess were excluded. Primary outcomes were improvement or resolution of symptoms, mean time to pain relief and mean time to complete resolution of symptoms.

The eight studies from four countries included 743 patients (369 children and 374 adults); 47% had exudative pharyngitis and 44% were positive for group A beta-hemolytic streptococcus. Patients received comparable dosages of beclomethasone, dexamethasone or prednisone. In the pooled analysis, patients treated with corticosteroids were three times more likely to have complete resolution of pain at 24 hours and 48 hours, with a number needed to treat (NNT) of 3.7 and 3.3, respectively. Mean onset of pain relief was also an average of 6.3 hours faster in the treatment group (95% CI 3.4 to 9.3). There was no significant change in time to onset of pain relief in children. Time to complete resolution of symptoms was 15-45 hours in the corticosteroid group vs. 35-54 hours in the placebo group.

This study compiles good evidence that corticosteroids can be beneficial in the treatment of sore throat, with a reasonable NNT to reduce pain at 24 and 48 hours and possibly reduce time to complete resolution of symptoms. Limitations to this study include variation in the use of antibiotics, heterogeneous outcome measures of clinical improvement, and patient recall bias. Further, studies are needed to review corticosteroid use with and without antibiotics and for comparison of single dose corticosteroid versus multiple-day regimens, since most of the improvements are within the first 24-48 hours. Although the 6.3 hour difference in time of onset to pain relief may not be large, reduction in pain at 24-48 hours for the symptomatic patient may warrant corticosteroids.

Arnold RC, Shapiro NI, Jones AE, et al. Multicenter study of early lactate clearance as a determinant of survival in patients with presumed sepsis. Shock. 2009 Jul;32(1):35-39

Severe sepsis has high morbidity in critically ill patients. With early-goal directed therapy (EGDT), much focus has been placed on early resuscitation to improve patient outcomes. An elevated serum lactate level has been used as an indicator of tissue under-perfusion even in patients without significant arterial hypotension. The authors of this study look to see if early lactate clearance is associated with improved survival in the ED patient and if there is a correlation between lactate clearance and central venous oxygen (SVO₂) improvement.

This prospective cohort study enrolled 166 consecutive patients from three urban emergency departments. Inclusion criteria included age >17, suspected infection, two or more systemic inflammatory response syndrome criteria, SBP <90mmHg after 20ml/kg fluid bolus or initial lactate >4mmol/L, initial and repeat lactate levels within six hours of resuscitation initiation and ICU admission. Patients enrolled underwent resuscitative efforts following EGDT guidelines including the use of a central line catheter with continuous ScvO₂ monitoring ability. The primary outcome was in-hospital mortality. Lactate clearance was an *a priori* value defined as ≥10% decrease in initial level.

Of the 166 patients, 9% (n=14) failed to clear lactate. In these patients in-house mortality was 60% compared to 19% in the lactate clearance group. There was no significant difference in initial lactate level, incidence of vasopressor use, total SOFA scores or optimization of ScvO₂ to >70%. However, those in the non-clearance group did have a higher percentage of patients whose blood pressure was non-responsive to IV fluid boluses.

This study shows that lactate non-clearance (<10% decrease) in patients with severe sepsis undergoing aggressive resuscitation correlate with a higher in-house mortality. Optimization of ScvO₂ was not associated with improved mortality. Since this was an observational study, one can not state that this is a cause and effect relationship. Another limitation is the non-standardization of serial lactate levels between patients - the authors did not clarify the timing of the repeat values; something very important if evaluating its impact on mortality. Thirdly, the low incidence of the lactate non-clearance group does not provide significant power. Overall, this study is not definitive but does add to the literature that shows a persistently elevated lactate level can be prognostic in critically ill patients.

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residency programs listed below on their recent accreditation by the Accreditation Council for Graduate Medical Education. Residency training in emergency medicine is an essential step towards recognition as a specialist in emergency medicine. Faculty and staff at these programs are to be commended for their work in establishing these programs and contributing to the continued growth of our specialty.

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STUDENT PRESIDENT'S MESSAGE

Jamie "Akiva" Kahn

President, AAEM/RSA Medical Student Council



On September 12th the Western Regional Symposium was hosted by the University of Southern California in collaboration with University of California, Irvine. This event was a resounding success with over 200 participants and a residency fair representing ten California programs.

During this event, Dr. Shahram Lotfipour spoke about the importance of membership to national organizations, including AAEM and AAEM/RSA. I was honored to represent our organization by talking with students about the benefits of involvement, signing many of them up for the free student membership. Afterwards, I realized that although publications such as *Common Sense* and *Rules of the Road for Medical Students* are important for educating students on current issues in emergency medicine, I hoped that students would use the information to advocate not just for their patients, but also for their specialty.

Advocacy takes all forms, from discussion among peers to meeting with policy makers on a state level to writing letters to national representatives. Local and national organizations are not only important for learning about current issues, but also for finding a

group of like-minded people interested in advocacy. In addition to joining organizations at your school, consider attending a local chapter meeting of a national organization to advocate on a larger scale.

Personal email, letters, newspaper editorials and telephone call campaigns are all useful, inexpensive tools in political activism. Writing and calling policymakers is extremely effective as legislators are influenced by their constituents. For best effect when lobbying, address only one issue at a time, be considerate of your audience's time, make sure that you have thoroughly researched the topic, and know the background of the legislator you are addressing. You may not always have a meeting with the elected officials themselves, but their staff members are also important as they often advise the policymakers and assist in drafting legislation.

Whether you are just starting out by sharing what you have learned with your classmates or if you are ready to lobby your policy makers, I hope you find all the information that organizations such as AAEM/RSA have to offer useful! We are fortunate to be entering a specialty that sees first-hand how health care policy affects our patients and our practice. With game-changing policy issues being considered today, now is the time to get out and start advocating!



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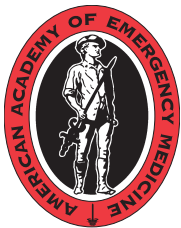
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