

# COMMON**SENSE**

VOLUME 19, ISSUE 6  
NOVEMBER/DECEMBER 2012



[www.AAEM.org](http://www.AAEM.org)

19<sup>th</sup> Annual  
Scientific Assembly  
Las Vegas, Nevada  
February 9-13, 2013

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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: \$425 (Must be ABEM or AOBEM certified, or have recertified for 25 years or more in EM or Pediatric EM)

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

Associate Member: \$250 (Limited to graduates of an ACGME or AOA approved Emergency Medicine Program)

\*Fellows-in-Training Member: \$75 (Must be graduates of an ACGME or AOA approved EM Program and be enrolled in a fellowship)

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

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

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

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

International Resident Member: \$20 (voting in AAEM/RSA elections only)

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\*Fellows-in-Training membership includes Young Physicians Section (YPS) membership.

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## President's Message

# Unintended Consequences and Mr. Scrooge Overseeing Payments

William T. Durkin, Jr., MD MBA FAAEM

As most ED's have now converted to an electronic medical record (EMR), we find ourselves on the OIG's list as one of the specialties with the top increases in billings and, therefore, one of those being investigated for Medicare fraud. I find this rather odd, and had they thought it through when the edict for the EMR came down, very predictable. Most EMR's are designed so that they capture all of the necessary data to maximize billings. In fact, most mention that as one of their selling points. Many records done by hand, or even those dictated, leave out a piece of information that results in the record being down coded by the billing department. Hence, what may have been a level four is now billed as a level three. An EMR that is set up to adequately document a level of care will generate a higher bill. They also specifically ask for other points, such as pulse ox reads, that some of us would skip over as we are busy finishing a chart so we can keep up. No fraud on the part of the physician, they just documented in each little box as it came up. Nothing was left out so it qualified for the higher level. As we have become more efficient in preparing a record that can be correctly coded, our charges increase. Increases in billings and charges may represent fraud to a bureaucrat, not better documentation. An unintended consequence, perhaps, of the specialty using an EMR. So the investigation begins. Our members should all be aware of this. According to the feds, we are all liable for what is billed in our names. If they feel the charges are in excess, they will approach both you and the billing company. This shows why it is so important to be able to see what is being billed in your name. Not being able to do so may place you at an increased risk of being audited.

In December, we are scheduled to attend a hearing at the IRS/Treasury regarding being able to submit a bill for services in a timely fashion. The original proposal was to wait 240 days until one could submit a bill to a "cash paying" patient that was seen at a non-profit institution. The media jumped on this and began showing an outlier that was approaching families of patients on life support about paying their bills. We would all agree that that practice is extreme. I think we would also agree that having to wait eight months to ask for payment is also a bit extreme. I know of no business that could do that and survive. Thirty days is the practice of most businesses and is the time limit for which we have advocated. There are many groups who would suffer financial hardship if they could not even bill such a patient for eight months. No telling when/if the actual payment would occur.

Another issue coming to the forefront is that of state Medicaid insurers not paying for services rendered by the emergency physician since the condition, per discharge diagnosis, was not a true medical emergency. Thus, a middle-aged patient with a chief complaint of "chest pain" and a discharge diagnosis of chest wall pain would be denied payment. This goes on despite the prudent layperson law. Washington state fought this at the start of the year, as did TN, now VA and LA Medicaid payers have initiated the practice. I have taken this issue to the Emergency Medicine Action Fund. They suggested that it was more of a state issue, despite state Medicaid being regulated by CMS. They are writing a letter to the regulators, as is the Academy. We will also work with the affected state chapters to assist them in stopping this practice. As state treasuries become depleted and they look for ways to decrease expenditures, this looks to them to be one way to do so. They continue to provide the benefit to the constituents yet do not pay the providers. Not exactly a prudent practice, Ebenezer!

In this issue you will find the candidate statements for the upcoming board of directors election this February. Each candidate has taken the time to write these statements and is volunteering to serve you for the next two years. I would ask that you take the time to read each one and determine those that would best represent you and your concerns. Ideally, you will all come to the Scientific Assembly, listen to each candidate at the Candidates' Forum, perhaps ask a question or two of them, and then vote. Knowing that that isn't possible for the entire membership, I do ask that you fill out the ballot sent to you and return it to us. Having a representative board is very important to the success of the Academy. Your vote counts; there have been elections decided by one or two votes in the past!

On behalf of the executive committee and the board of directors, I would like to wish each and every one of you a joyous holiday season as well as a prosperous new year. ■

Contact the President: [president@aaem.org](mailto:president@aaem.org)



# Hope and Change

Andy Walker, MD FAAEM  
Editor, *Common Sense*  
AAEM Board of Directors



Our national elections are over, and whether you were left ecstatic, crushed, or just numb, we can all bid good riddance to another season of rudeness, deception, and manipulation. No matter which side wins or loses, I always seem to feel dirty by Election Day. In election years, November should be renamed "The Month of Compulsive Hand-Washing." I wonder what the

Founding Fathers would think of TV and how it has changed political campaigns.

Those of us in AAEM, however, can now look forward to elections of a completely different sort. Elections in which there is almost never a bad choice. Elections in which we aren't forced to choose between the lesser of two evils. Elections in which the candidates talk more about their own qualifications and their own plans than about how flawed their opponents are. Elections in which those candidates who were friends beforehand remain friends afterward. AAEM elections — for the board of directors and the directorship of the Young Physicians Section.

My third term on the board of directors will end after the election in February. In my time on the board, I have participated in many vigorous debates and made many hard decisions. Despite over six years on the board and being outvoted many times, in every case my opponents were smart, experienced, honest, fair, and motivated only by the best interests of individual emergency physicians and the Academy that fights for them. I may have disagreed with other board members or Academy officers at times, but I never doubted or disrespected them. I believe they feel the same way about me. Unlike national or state politics, my time on the board of directors has left me feeling not only clean, but proud. Proud of my service, proud of those I worked with, and even more proud of AAEM itself.

I have written before that the worst enemy physicians have is their own sense of hopelessness. This hopelessness keeps them from joining state medical societies and specialty organizations such as AAEM, from donating to political causes they believe in, from opposing outside interference in their medical practice — whether from government, insurance companies, other corporations, or tort lawyers — and sometimes even from being passionate advocates for their patients. We think, "Lawyers control every branch of government, we'll never get fair tort reform." Yet many states have achieved profound tort reform. Alaska has a "loser pays" rule. Other states have passed tort reform specific to emergency medicine, such as raising the burden of proof from "a preponderance of the evidence" to "clear and convincing evidence," changing the definition of malpractice from simple negligence to gross negligence, or both. Texas even amended its constitution to make tort reform possible. The reason we find it so hard to defeat tort lawyers is that they are politically active and generously support candidates who favor them, while physicians tend to be politically inactive and reluctant to donate to candidates who favor medicine. Our



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hopelessness is a self-fulfilling prophecy! The same goes for government policies that are unfair to us, insurance companies that try to avoid paying us for work already performed, corporations and others that seek to exploit us, and hospital administrators who haven't a clue about what we do but tell us how to do it anyway. And now, in addition, we have EMRs, CPOE, and ACOs to deal with. Organizing and fighting for ourselves and our patients is now more important than ever. The rational response to bad odds isn't to surrender; it is to fight harder and try new tactics. I certainly don't think we will win every battle we fight, but I guarantee you we will lose every battle we don't fight.

So get involved. Join your state medical society. Recruit new members for AAEM. Become a leader in AAEM or in your state chapter. Or, if you don't have a state chapter, form one. The Academy's staff can walk you through the process, which is easy. Get to know your state and national legislators. Write or call them often. If you like their positions on issues you care about, give them a little money. It doesn't take much to get you noticed, especially at the state level. Educate your hospital administrators a little bit at a time, starting now, on the realities of emergency medicine so that they are open to reason when a problem comes up. Keep fighting for tort reform, no matter how many times you are defeated.

Most of all, don't give up hope. AAEM remains an ethical, uncorrupted organization of and for board certified emergency physicians and should fill you with hope. In my opinion, the Academy has done more to protect emergency medicine and move it in the right direction than any other group. David slew Goliath, and the Academy continues to battle with giants — often successfully. With your help, we can and will change the toxic environment in which many emergency physicians practice.

And don't forget to vote, either in person at the Scientific Assembly or by mailed ballot. I hope to see you at the best emergency medicine meeting in the world, the AAEM Scientific Assembly in Las Vegas. ■

Contact the Editor online at [www.AAEM.org](http://www.AAEM.org)

*A "Letters to the Editor" feature is now available on the Common Sense section of the AAEM website. Members must log-in with their AAEM username and password to read or post letters, or to comment on letters. If necessary, you may request that we post your letter anonymously and such requests will be reviewed on a case-by-case basis. The letters that I think are interesting, entertaining, educational, provocative, or of general interest, will be printed in Common Sense. The first of these is below, along with my reply. I hope to hear from many of you, even if you are criticizing me. I need your feedback to make Common Sense an interesting read and a good use of your time. I also want it to attract new members to the Academy. If you like something you see, let me know. If I make you mad, let me know. Especially if I make you mad. I want the letters to the editor feature to become a forum for civilized but vigorous argument, and the more vigorous the better.*

# Letters to the Editor

Andy Walker, MD FAAEM  
Editor, *Common Sense*  
AAEM Board of Directors

## Letter in response to the July/August 2012 "From the Editor's Desk" article, titled "Law of the Land."

Dear Dr. Walker:

Reading your article in the latest edition of *Common Sense*, I beg to differ on your claim that entitlement spending consumes almost 60% of the federal budget figures.

I think that dubious honor goes to military expenditures. If you meant discretionary spending perhaps the 60% figure is correct, but do you not think it only honest and fair to so state this?

You sound like our presidential candidates who bandy numbers and figures around without regard to what is truthful and what is misleading.

James Koss, MD FAAEM

Dr. Koss:

Thank you for responding to my column, "Law of the Land." Even though you disagree with me, I appreciate it very much. I hope the web-based "Letters to the Editor" section of *Common Sense* will become a popular forum for spirited, cordial debate among Academy members, and we can't have a good argument unless people argue!

The United States spends more money on defense than I can comprehend. We spend more than the rest of NATO, China, Russia, North Korea, South Korea, Iran, and Israel — combined. In fact, we spend roughly as much on defense as every other nation in the world — combined. Does that mean military spending is the largest category in the federal budget? Not at all. We spend so much on entitlements (mainly Medicare, Medicaid, and Social Security) that military spending isn't even close. As you can see from this chart from The Washington

Post, which is hardly known for conservative bias, in 2010 entitlements consumed 57% of the federal budget (<http://www.washingtonpost.com/wp-srv/special/politics/budget-2010/>).

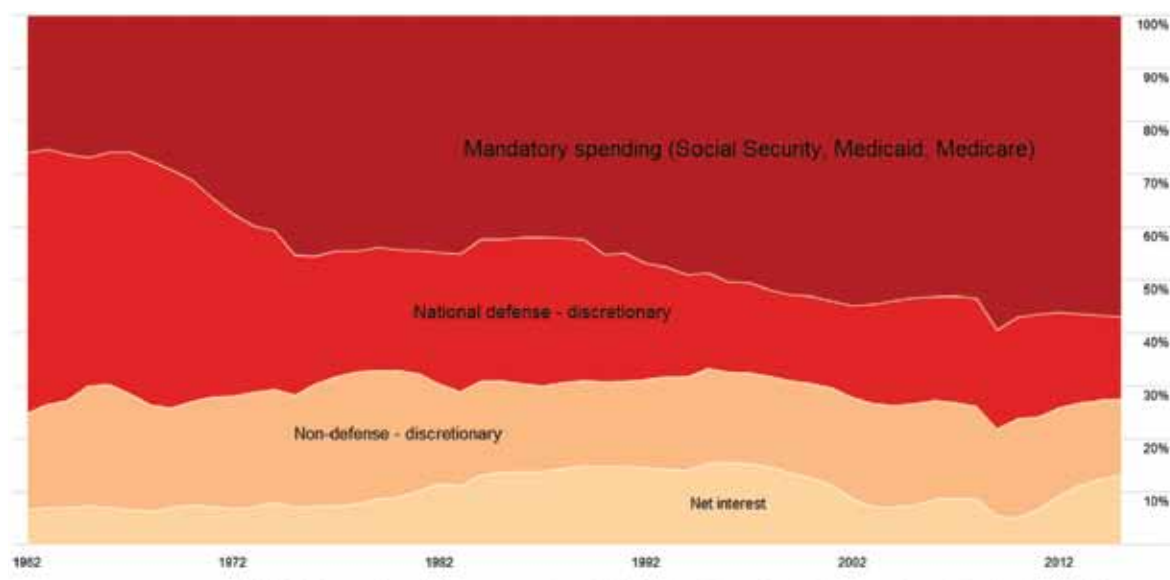
Defense spending accounted for 19%, interest on the federal debt accounted for 5%, and discretionary spending took the remaining 19%.

I have found that most budget analysts don't include veterans' benefits in defense spending, which I regard as a mistake. If that is included in defense spending, the percentage of the budget going to defense goes up by about 3%. That still pales in comparison to entitlement spending, and entitlements will explode over the next few years as the population ages — and as Medicaid expands under Obamacare. Interest on the debt has already started rising, and like entitlement spending, will explode in the near future.

Since the federal government currently borrows about 40% of every dollar it spends, both military and discretionary spending (everything else the government does — such as environmental protection, law enforcement, interstate highways, national parks and forests, food and drug regulation — everything) could be totally eliminated without balancing the budget. Although other analysts come up with slightly different figures, the numbers are close no matter who you trust to accurately analyze the federal budget. Here are other websites you can check for verification: <http://www.factcheck.org/2011/07/fiscal-factcheck/>, <http://www.cbpp.org/cms/index.cfm?fa=view&id=1258>, <http://www.fas.org/sgp/crs/misc/RL33074.pdf>, and <http://www.cato.org/pubs/handbook/hb111/hb111-4.pdf> (see figure 4.1).

While politicians frequently "bandy numbers and figures around without regard to what is truthful and what is misleading," I do not. Any American who loves his country should be frightened by these facts — especially any American who pays income taxes. ■

— The Editor



SOURCE: White House Office of Management and Budget; GRAPHIC: Wilson Andrews, Jacqueline Kazil, Laura Stanton, Karen Yourish - The Washington Post

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# NIH Office Established to Improve Emergency Care

Kathleen Ream, Director of Government Affairs

*The third and final item below should be a warning to all emergency physicians evaluating job offers. Be alert for any clause that includes the words “hold harmless” or that waives your right to due process. Read contracts carefully and have them reviewed by an attorney with experience in medical employment, and always ask about the process for dismissal. Can you be fired on the whim of one person, or does it take the agreement of a majority or supermajority of your colleagues?*

— The Editor

To help improve the health outcomes of patients who require emergency care, the National Institutes of Health (NIH) has created the new Office of Emergency Care Research (OECR). The formation of OECR is a result of more than five years of discussions between NIH and the emergency medical community, as well as a response to reports about the nation's emergency medical system issued in 2006 by the Institute of Medicine. Serving as the focal point across NIH for basic, clinical, and translational emergency care research and training, OECR will foster and coordinate all such research and training in the emergency setting.

In announcing the new office, NIH Director Francis Collins said, “NIH has supported research to advance emergency care for years; however, now we have a single office to coordinate and foster our activities in this arena. The NIH Office of Emergency Care Research will focus on speeding diagnosis and improving care for the full spectrum of conditions that require emergency treatment.”

Although OECR will not provide funding for grants, it will encourage innovation and improvement in emergency care and in the training of future researchers in the field by:

- Coordinating funding opportunities that involve multiple NIH institutes and centers
- Working closely with the NIH Emergency Care Research Working Group, which includes representatives from NIH institutes and centers
- Organizing scientific meetings to identify new research and training opportunities in the emergency setting
- Catalyzing the development of new funding opportunities
- Informing investigators about funding opportunities in their areas of interest
- Fostering career development for trainees in emergency care research
- Representing NIH in government-wide efforts to improve the nation's emergency care system

While a search is being conducted for a permanent director of OECR, Walter Koroshetz, deputy director of the National Institute of Neurological Disorders and Stroke, is serving as acting director. A steering committee chaired by the director of the National Institute of General Medical Sciences, where OECR is housed, is overseeing the office.

For more information about this new NIH Office, visit: <http://www.nigms.nih.gov/About/Overview/OECR>.

## From the States

### Oregon Workgroup Drafting Tort Reform Legislation Considers Disclosure

When the Oregon Legislature convenes next February, lawmakers are expected to take up tort reform. To get those discussions moving, a Patient Safety and Defensive Medicine Workgroup is developing draft legislation that includes issues such as confidentiality, mediation, dispute resolution, litigation, discovery, and patient safety. Also on the table is disclosure, i.e., informing patients when a serious medical event has occurred in a hospital setting.

Robert Dannenhoffer, a Roseburg pediatrician, told the workgroup that such a disclosure approach has been successful at Mercy Medical Center. Dannenhoffer, who is also CEO of the coordinated care organization Umpqua Health Alliance, explained that all medical staff and employees of Mercy Medical Center have participated since 2001, and are required to disclose serious events in a non-punitive hospital reporting system, while the hospital works in good faith with families to make them “whole.” Patients, he said, are not necessarily looking for money, but want their losses covered and want to make certain the same mistakes do not occur again.

Richard Boothman, a former trial attorney, reported to the workgroup on a disclosure program underway at the University of Michigan Health System since 2001. Its quality and safety division is closely tied to the disclosure program, with money invested in improving patient safety, Boothman said. As a result, medical malpractice claims have decreased from 53 to 31 per year, while the average cost per lawsuit has dropped from more than \$400,000 to around \$228,000, and the time to resolution has decreased from 20 to eight months. Physicians are very satisfied with the program, with 98% of 419 surveyed indicating their approval. Approximately 86% of plaintiffs' lawyers also approve, saying the transparency allows them to make better decisions about which claims to pursue.

In conclusion, Boothman said, “The long-term benefits are clear to us. We've seen some remarkable things happen.” He added that in July 2001, the number of pending claims involving the system totaled 262. Now, that number is down to 64, with only 10 claims ending up in court last year, despite the fact that clinical activity has doubled since then, and twice as many patients are receiving care. He cautioned, however, that many people are invested in the status quo, including judges and defense attorneys.

Robin Moody, of the Oregon Association of Hospitals and Health Systems, told the workgroup that most Oregon hospitals currently offer early disclosure. However, Moody also said she was “disappointed” that the section of the group's draft bill dealing with litigation was so short. Even in a “model” system like Michigan's, she said, several cases still end up in litigation.

Continued on next page

## Physician's Claim of Breach of Staffing Contract and of EMTALA Violation Dismissed

On July 11, 2012, the U.S. District Court for the District of Colorado granted a hospital's motion for summary judgment on a physician's allegations of breach of contract, tortious interference of contract, and violation of EMTALA (*Genova v. Banner Health*, D. Colo., No. 1:11-cv-1139, 7/11/12).

### The Facts

Ron Genova, MD, an emergency medicine specialist, was part of an emergency department practice group known as the North Colorado Emergency Physicians, P.C. (NCEP). NCEP contracted with Banner Health, an Arizona non-profit corporation doing business as North Colorado Medical Center (Banner), to serve as the sole emergency medicine group in the hospital's ED. At 10:30pm on January 21, 2010, Genova, an on-duty ED physician at the hospital, was informed that the hospital was facing a potentially serious crowding situation. An administrative representative indicated "all in-patient hospital beds and emergency department beds were full," and a nurse indicated "there were four ambulances out on calls, and that the hospital and emergency department had no physical capacity to take another patient."

Genova recommended that the administrative representative implement the hospital's plan named "Code Purple," designed to "maintain patient safety when the hospital population is at a critical level," and "[t]o provide a mechanism that will decompress patient volume." The administrative representative believed that Banner's Chief Executive Officer, Rick Sutton, would not divert ambulances, so Genova called Sutton to recommend that the plan be implemented.

While there was no dispute that the hospital was busy that night, a difference existed as to whether "Code Purple" was necessary. Following Genova's call, Sutton contacted the NCEP medical director, Dr. Campaign, to assess the situation that night. Campaign phoned another ED physician at Banner, Dr. Hutchison. Hutchison stated, "[y]ou know, we're busy, but we're getting through it." Campaign told Sutton that "neither ambulance divert nor ambulance advisory was necessary." Genova alleged, however, that Sutton "was concerned about losing patients to competing hospitals, and as a result, he refused to implement the Code Purple plan and divert ambulances to other hospitals."

Genova purported that as a result of his expressions of concern and recommendations to Sutton, Banner forced NCEP to forbid him from taking any further ED shifts in the hospital, effectively depriving him of his sole source of income. Genova filed the lawsuit, asserting three claims: 1) breach by Banner of its contract with NCEP; 2) tortious interference with Genova's contract with NCEP by both Banner and CEO Sutton; and 3) violation by both defendants of EMTALA. Subsequently, Banner filed a motion for summary judgment.

### The Ruling

#### First Claim: Breach of Contract

In responding to Banner's argument that it had no contract with Plaintiff, Genova stated that he can assert breach of the contract because "1) NCEP acted as his agent; 2) his contract with NCEP makes him a party to the contract; and 3) he is a third party beneficiary of the

Banner-NCEP contract." The Court determined that it need not address Genova's first or second claim, but agreed, "the NCEP group practitioners, including the group physicians, were the known and intended beneficiaries of Banner's obligations under the contract ... [thus] a group physician such as Dr. Genova has the right to sue for an alleged breach of the contract. However, one must take the bad with the good."

Section 3.2(m) of the contract specifies, "[e]ach Group Practitioner shall conduct himself/herself in a manner that is not contrary to the interests, reputation or good will of Banner or to the efficient and appropriate operation of the Hospital." On February 4, 2010, CEO Sutton delivered a letter to NCEP invoking section 3.2(m) of the contract. The letter concluded that Genova's conduct on three occasions, including the January 2010 night in question, was "unprofessional and inconsistent with the interests, reputation and goodwill of the hospital," and thus requested that NCEP immediately remove Genova from all duties at the hospital. The Court stated "[w]hether Dr. Genova's alleged conduct was unprofessional, and specifically, whether the three incidents or any of them were fairly and accurately portrayed, certainly would be matters of genuine factual dispute. However, such disputes are not material. Paragraph 3.2(m) of the contract effectively gives Banner carte blanche to request the removal of a physician whenever Banner determines that the physician has conducted himself in a manner that is contrary to Banner's interests."

Plaintiff then argued that provision 3.2(m) "should be declared void as unconscionable and contrary to public policy." However, in finding that the contract was a valid agreement between and among NCEP and Banner, who each mutually contributed to its drafting, the Court concluded, "Plaintiff provides no authorities suggesting that a court could void a contractual provision as unconscionable or contrary to public policy in such circumstances."

The Court called attention to the Banner-NCEP contract requiring that each group physician execute a "Joinder Agreement." The joinder agreement was a very broad waiver of Genova's right to sue Banner for breach of the contract, which in part reads, "*I hereby release Banner, the Hospital, the Medical Staff, the CEO, and their agents, employees and attorneys from any liability, claim, cause of action or demand connected with the termination of my Medical Staff membership and clinical privileges as herein provided. I further agree to indemnify and hold harmless Banner from and against all obligations, claims, costs, debts, demands, controversies, expenses, attorneys' fees, damages, losses and causes of action, of any kind whatsoever, whether known or unknown, arising from termination or non-renewal of the Agreement or the termination of my relationship with the Group.*"

Plaintiff contended that the waiver should not preclude his claim because the "Joinder Agreement is void as a matter of public policy." To the public policy point, the Court determined that "Dr. Genova argues that his services were discontinued for 'making recommendations he was required to make.' He analogizes this situation to cases holding that it is a violation of public policy to terminate an at will employee for refusing to perform an illegal act or for performing a public duty or exercising an important job-related right or privilege ... I accept the fact that

Continued on next page



Dr. Genova believes that he had an obligation to patients to recommend that the hospital invoke the Code Purple plan on January 22, 2010. I will presume that he had reasonable grounds for making that recommendation ... However, to void a contract, including the waiver provision in the Joinder Agreement ... on public policy grounds, the jury would have to find, based upon direct or circumstantial evidence, that Banner effectively discharged Dr. Genova because he exercised his right as a physician to request that the Code Purple policy be invoked. I conclude that even construing the evidence in plaintiff's favor for summary judgment purposes, he has not shown that there is a genuine dispute of fact requiring a trial."

Therefore, the Court granted the motion and dismissed the claim based upon breach of the Banner-NECP contract, but added "[t]his is not necessarily a result that the Court likes. I recognize that he is a fine physician, that he was arguably poorly treated, and that he and his lawyer have put a great deal of time and effort into this lawsuit. I have at least tried to write this order in a way that explains to him why I have come to the conclusions I have. Essentially, a contract is a contract."

### Second Claim: Tortious Interference with Contract

Claiming the tort of intentional interference with contractual obligations under Colorado law, Genova purported that Defendants "intentionally interfered with Plaintiff's agreement with his practice group by forcing Plaintiff's practice group to prohibit Plaintiff from providing any further emergency room services at NCMC (the hospital) or face termination of the group's entire agreement to provide services to NCMC." Finding that there was "no evidence that NCEP did not comply with that obligation or other obligations under this contract or under the Joinder Agreement between Dr. Genova and NCEP ... [and that] by executing the Joinder Agreement Dr. Genova waived and released Banner and CEO Sutton from any claim connected with the termination of his medical staff membership," the Court granted the motion for summary judgment and dismissed the Second Claim for Relief.

### Third Claim: EMTALA

The Court also rejected Genova's EMTALA claim. EMTALA contains a whistleblower provision for hospital employees who report violations of the statute. The Court suggested that Genova's claim "appears to be pursuant to this whistleblower provision, as he alleges that defendants retaliated against him for 'disclosing, objecting to and/or refusing to participate in an activity, policy or practice which Plaintiff reasonably believed was in violation of the [EMTALA].'"

The Court seemed sympathetic to Plaintiff's situation, stating that "[t]hese allegations, if true, describe conduct that is concerning. If true, there surely must be a means to report and remedy the problems. There may be a legal claim. Certainly the factual support offered in support of the allegations are sufficient to create a genuine dispute of fact that would preclude summary judgment if they were material to the resolution of the claim asserted." However, the Court concluded that Genova's allegations are not material to a claim under EMTALA. In failing to allege or show that a patient had not been properly screened and stabilized, i.e., the conduct that would violate EMTALA and would support a cause of action, no legal basis for the claim was asserted in this case.

Therefore, the federal district court entered its final judgment in favor of Defendants, dismissed Plaintiff's claims, and the civil action with prejudice, and awarded Defendants their reasonable costs.

The full text of the case is at: <http://docs.justia.com/cases/federal/district-courts/colorado/codce/1:2011cv01139/125790/79/>. ■

*EMTALA case synopsis prepared by Terri L. Nally, Principal, KAR Associates, Inc.*

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## Law and Emergency Medicine:

# EMTALA Gone Awry: Must We Admit Every Threatened Miscarriage?

Larry D. Weiss, MD JD FAAEM  
AAEM Past President



*Disclaimer: AAEM provides this article solely for the purpose of continuing medical education. Nothing in this article constitutes legal advice, as the specific facts in similar cases vary significantly. The article discusses general principles of the Emergency Medical Treatment and Active Labor Act (EMTALA)<sup>1</sup> in an effort to educate our members and to provide information for practice development.*

Many of our AAEM members in New England expressed shock and concern last year when a federal district court in Maine upheld a jury verdict finding that a hospital violated EMTALA when it discharged a pregnant woman with symptoms of a threatened miscarriage. One of our members told our home office that his hospital drafted a policy requiring the emergency department to admit every pregnant patient with symptoms of a threatened miscarriage. Of course, this violates strong national standards of practice. This article will review the Maine case, *Morin v. Eastern Maine Medical Center*, briefly review the EMTALA statute, and examine the reasoning of the court.<sup>2</sup>

### The Facts of the Case

Lorraine Morin entered the emergency department (ED) of the Eastern Maine Medical Center (EMMC) at approximately 4:30am on a Sunday, complaining of "contractions." She was 16 weeks pregnant. The emergency physician and the on-call obstetrician both performed a bedside ultrasound examination that showed a dead fetus. She had an uneffaced and non-dilated cervix. The obstetrician described what he thought were Braxton-Hicks contractions, discharged the patient, and advised her to follow up on Monday morning with a visit to her obstetrician.

The patient lived approximately one hour from the hospital. She strongly disagreed with the decision to discharge her to home. She delivered a stillborn baby at home, lost a considerable amount of blood, and saw her obstetrician on Monday morning. Her obstetrician admitted her to the hospital at that time "and performed an operation."

Ms. Morin filed suit against EMMC, alleging a violation of EMTALA. She specifically alleged a failure to stabilize an emergency medical condition. The jury rendered a verdict for Ms. Morin, awarding her \$50,000 in compensatory damages, and \$150,000 in punitive damages. The jury concluded the hospital discharged Ms. Morin while still having "contractions," before delivering her fetus, and with a risk to her health and safety (i.e., at risk of hemorrhage). The court upheld the jury's award of punitive damages because "EMMC's actions were so outrageous that malice toward a person injured as a result of that conduct can be implied."<sup>3</sup> The court also rejected EMMC's argument that EMTALA did not apply to a dead fetus.

EMMC requested a "judgment as a matter of law" in which a court will reverse a jury verdict in cases where no reasonable jury could reach a similar decision. The court refused EMMC's request. EMMC then filed an appeal. The AAEM board considered filing an amicus brief in this appeal, but in January 2012, EMMC settled with Ms. Morin and dropped their appeal. Because a court of appeal never rendered a decision this case, it has very limited precedential value. It may influence other district courts, but will only create limited precedence in Maine.

### EMTALA and the Reasoning of the Court

An article of this length cannot include a comprehensive review of EMTALA. Instead, I will attempt to briefly review EMTALA as it specifically applies to this case. When enacted in 1986, Congress stated its intention to address the problem of patient "dumping," whereby hospitals refused to examine and treat uninsured patients, often sending them to more distant public hospitals. While drafting this legislation, Congress heard testimony from many witnesses who alleged an inability to receive care from hospitals when they presented in labor. Some of these witnesses stated they delivered their babies in the back of ambulances while shuttling from one hospital to another.

As a result of this testimony, in EMTALA's final draft, Congress included strong protections for pregnant women in labor. EMTALA requires hospitals to screen, stabilize, and appropriately transfer patients who come to emergency departments. Specifically, if an individual comes to a hospital emergency department and a request is made on their behalf, EMTALA requires the hospital to provide an appropriate medical screening exam (MSE) within the capability of the emergency department, including all ancillary services routinely available, to diagnose emergency medical conditions.

With regard to pregnant patients, EMTALA specifically defines an emergency medical condition as "a pregnant woman who is having contractions (i) that there is inadequate time to effect a safe transfer to another hospital before delivery, or (ii) that transfer may pose a threat to the health or safety of the woman or the unborn child."<sup>4</sup>

Congress failed to provide a definition of an "appropriate medical screening examination," so federal courts gradually developed their own definition. According to this definition, a patient receives an appropriate MSE when the exam is comparable to similarly situated patients. Conversely, a patient receives an inappropriate MSE when the exam is disparate compared with similarly situated patients.<sup>5</sup> This definition reflects the fact that Congress enacted EMTALA as an anti-discrimination statute.

Continued on next page

In this case, Ms. Morin did not allege an inappropriate MSE, but alleged a failure to stabilize her emergency medical condition, claiming she was in labor and having active contractions. EMMC contended the patient was not in labor, but was having a miscarriage. One may argue whether the definition of labor includes second trimester miscarriages, but EMTALA only requires a plaintiff to show the presence of contractions. The opinion of this case does not provide precise evidence whether the obstetrician felt the patient had true contractions. At one point, the opinion states "Dr. Grover described what are called Braxton-Hicks contractions," but then states "Dr. Grover thought that she was having mild irregular contractions."<sup>6</sup>

The distinction between false contractions (i.e., Braxton-Hicks) and true contractions is critical to the outcome of this case. Braxton-Hicks contractions do not constitute an emergency medical condition. The duty to stabilize arises upon the diagnosis of an emergency medical condition.<sup>7</sup> If the physicians in this case diagnosed the presence of true contractions, then this created a duty to stabilize. In the case of a pregnant patient having contractions, stabilization requires delivery of the fetus and the placenta.

On the other hand, if the physicians diagnosed Braxton-Hicks contractions, then the duty to stabilize never arose. Even if a physician negligently fails to diagnose true labor, this does not create liability under EMTALA. A plaintiff in such a case would have a cause of action for negligence in a state court. EMTALA has nothing to do with negligence. An objective reading of this opinion leaves one uncertain as to whether the obstetrician thought Ms. Morin had true contractions. Either the jury concluded she had true contractions, or this issue was not adequately argued at trial. This would have been a vitally important issue on appeal.

### Lessons From This Case

This case highlights the importance of documenting whether a pregnant patient has "contractions" when presenting to an emergency department. Can a pregnant woman with first trimester bleeding be in labor or have true contractions? Can she have rhythmic contractions of her uterus leading to the delivery of a fetus? This certainly cannot occur before the eighth week of pregnancy, as an embryo does not become a fetus until that time. In most cases, after the eighth week and well into the second trimester, physicians cannot reliably detect rhythmic contractions of the uterus. Therefore, in most cases of first trimester bleeding, an emergency physician may accurately and honestly document "no evidence of contractions." In such a case, the emergency physician did not diagnose an emergency medical condition, and under EMTALA no duty existed to stabilize or admit the patient.

However, the reasoning of this court, especially if followed by other courts, highlights the risk of discharging patients with the diagnosis of incomplete or inevitable abortion. In these cases, a plaintiff may

successfully allege that the physician knew she was having contractions and losing her child and placenta. A court may reasonably interpret EMTALA and conclude that the plaintiff had an emergency medical condition requiring delivery of the fetus and placenta.

Finally, in a patient like Ms. Morin who presented in the second trimester or later, fetal monitoring with tocodynametry may detect the presence of true contractions. When detecting true contractions, EMTALA requires delivery of the fetus and the placenta, even in cases of missed abortions. However, in some cases, the contractions may resolve spontaneously or with treatment, thereby resolving the emergency medical condition.

Therefore, the Morin case does not require the admission of every patient with first trimester bleeding. Generally, most of these patients may safely go home with clear instructions and precise recommendations regarding follow-up care. Proper documentation should include the absence of contractions. However, the Morin case highlights the legal risk of discharging a patient with the diagnosis of inevitable or incomplete abortion, as well as patients in later trimesters who may have evidence of contractions either on physical examination or on fetal monitoring. A literal reading of EMTALA will require prolonged observation in those cases, until resolution of the contractions or delivery of the fetus and placenta. ■

*Dr. Weiss is a Professor of Emergency Medicine at University of Maryland School of Medicine.*

### References:

1. 42 U.S.C. §1395dd.
2. 779 F.Supp2d 166 (D.Maine 2011).
3. *Id.* at 189.
4. 42 U.S.C. §1395dd(e) (1)(B).
5. See, e.g.: *Summers v. Baptist Medical Center*, 91 F.3d 1132 (8th Cir. 1996); *Vickers v. Nash Gen Hosp.*, 78 F.3d 139 (4th Cir. 1996).
6. *Morin* at 176.
7. *Vickers* at 145.

## AAEM Antitrust Compliance Plan:

As part of AAEM's antitrust compliance plan, we invite all readers of *Common Sense* to report any AAEM publication or activity which may restrain trade or limit competition. You may confidentially file a report at [info@aaem.org](mailto:info@aaem.org) or by calling 800-884-AAEM.



# View from the Podium

Michael L. Epter, DO FAAEM  
Education Chair  
AAEM Board of Directors



It's never too early to start getting excited about Scientific Assembly — so let's do it! The highlights presented below culminate the work of a simply outstanding educational team and committee. This premier educational event will take place at the newly opened luxury resort — The Cosmopolitan — in Las Vegas, February 9-13, 2013. Here's a sneak peak at what promises to be a fantastic event that has come to define our organization.

Preconference course offerings on February 9 and 10 include:

- Resuscitation for Emergency Physicians (1.5 day course)
- ED Operations Management: Cracking the Code (2 day course)
- Introductory and Advanced Ultrasound
- Pediatric Emergencies: Children Are Not Little Adults! – jointly sponsored by CAL/AAEM
- Introduction to Wilderness and Operational Medicine – jointly sponsored by USAEM
- Pediatric Emergency Department Simulation: Critical Skills from Birth to the School Bus!

Given the successes of recent Scientific Assemblies and to increase the opportunities for networking, the 2013 program has increased by a half day and will begin on February 10 at 1pm.

The conference will have 11 robust plenary sessions with a mixture of clinical updates and topics addressing the changing landscape of health care, and the impact of these changes on our practice. Topics include:

- Affordable Care Act in My ED? ACO? What Does That Mean For Me?
- A 911 Emergency — Drug Shortages in Your ED – Joseph Lex, Jr., MD MAAEM FAAEM

Clinical Plenary Sessions with Preeminent Speakers Include:

- Best of the Best in Cardiology – Amal Mattu, MD FAAEM
- Best of the Best in Pediatrics – Ghazala Sharieff, MD MBA FAAEM FACEP
- Best of the Best in Resuscitation – Corey Slovis, MD FAAEM
- Best of the Best in Infectious Disease – Greg Moran, MD FAAEM
- Best Evidence: When Ultrasound Really Makes a Difference – J. Christian Fox, MD FAAEM
- Cases from the Front Lines of Shock Trauma: Pearls to Keep & Pitfalls to Avoid in Assessing & Managing the Trauma Patient in 2013 – Thomas Scalea, MD

Given its positive evaluations after premiering at Scientific Assembly 2012, "Ask the Experts" is making a return. In this unique, innovative session, panelists are presented with a challenging case with increasing amounts of information given as the case unfolds. Attendees will be able to see the thought process as experts such as Peter DeBlieux, MD

FAAEM, Corey Slovis, MD FAAEM, and Evie Marcolini, MD FAAEM, approach and solve cases in critical care, cardiology, and neurology. Amal Mattu, MD FAAEM, will serve as moderator.

In keeping with the spirit of providing attendees a cutting edge conference with up-to-date, results-oriented, and clinically relevant didactic sessions, the following new tracks have been added for 2013:

- Maximizing Your Scope of Practice: Critical Care Management in Your ED
- Mythbusters at Scientific Assembly
- No BMW'S Here: Cost Effective, Evidence Based Imaging
- Rare But Deadly: Call the Consultant Now!
- You Want Me To Do What? Show Me the Evidence!
- Draw Your Stethoscopes at Dawn! Hot Debates in Emergency Medicine
- The Clock Begins Now! Time Sensitive Critical Complaints

These New Tracks Complement the Timeless Attendee Favorites:

- When Kids Aren't Little Adults
- This is a Common Complaint: Let's Be Rational
- Let's Get Down to Business ... and Administration Of Course!
- When the Shift Hits the Fan! Cringe Inducing Triage Notes
- The Best of Morbidity and Mortality: We're Only Human, Learning From Our Mistakes

Specialty Tracks for 2013 Include:

- Prehospital Care: From the Field to Your ED
- International Emergency Medicine Comes to Las Vegas
- 2012 LLSA Review Track

If you think it couldn't get any better than the content listed above, IT CAN! The afternoon sessions on Tuesday, February 12, will feature three specialty tracks which are being piloted for 2013. The first of these three tracks focuses on YOU and is titled:

- Don't Roll the Dice: Maximizing Your Success Personally and Professionally

This track will feature sessions on financial planning (You've Earned It — Now Spend it Wisely! Financial Planning for the EP), resilience (Resilience: What Every EM Doc Should Know to Keep Going), and social networking (Social Media 101 & 102: Pearls & Pitfalls You Need to Know Now!).

The second track is an interactive track composed of small groups working to find best practices for common problems. These sessions will have an early sign-up given the workshop style format. The two content areas for 2013 are:

- Your Mid-level Provider Does What? Best Practices for Mid-level Providers
- Wake Up! It's Our turn to Grab the Ring — Maximizing Patient Satisfaction and Our Position in an Ever-Changing Healthcare Landscape

Continued on next page

The third specialty track represents the inaugural Diagnostic Case Competition.

Other annual favorites to round out the program include:

- Open Mic: AAEM members have the opportunity to expound on a cutting edge topic by presenting a 25-minute lecture on a subject of their choosing. The top speaker(s) will be invited to give a formal presentation at the 2014 Scientific Assembly in New York.
- Emergency Medicine Photo Competition
- AAEM/JEM Resident and Student Research Competition
- RSA-YPS Track — including the In-Training Exam Preparatory Course
- Medical Student Track — February 10, 2013

As customary for the conference, there is no registration fee for AAEM members (deposit is refundable). For more information, visit the website now: [www.aaem.org/education/scientific-assembly](http://www.aaem.org/education/scientific-assembly) — and don't forget to register for the preconference courses at the discounted rate.

Expect nothing less from your professional organization — the best emergency medicine CME, at no charge, in a prime location, presented by the top clinician-educators in emergency medicine. The AAEM Scientific Assembly — perpetually advancing emergency medicine for the expert clinician, and proudly, the premier educational conference in our specialty.

As always, contact me anytime ([mepter@medicine.nevada.edu](mailto:mepter@medicine.nevada.edu)) with your comments/suggestions as to how the Education Committee, Scientific Assembly, and the organization itself can be at the forefront in EM education; offering you content/resources that you rely on to treat the people that matter most — our patients. ■



# Register Online

## 19<sup>th</sup> Annual Scientific Assembly

- Registration is now open — Free for Members!\*
- Early registration deadline: January 8, 2013

\*Refundable deposit required

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## Dr. Arafat Awarded at the International Conference on Emergency Medicine



William T. Durkin, Jr., MD MBA FAAEM, presents the AAEM 2012 International Emergency Medicine Leadership Award to Dr. Raed D.A. Arafat, Undersecretary of State at Romania's Ministry of Health. The award was presented during Dr. Arafat's Disaster Medicine Session presentation at the International Conference on Emergency Medicine (ICEM) in Dublin, Ireland, on Saturday, June 30, 2012. Dr. Durkin noted that, "[Dr. Arafat's] personal dedication and sacrifice exemplify the mission and values of the AAEM. It is we who are honored to present him with this award and an honorary membership in AAEM." Read more about Dr. Arafat in the February 10, 2012, *New York Times* article titled, "Taking Care of His Adopted Country, One Emergency at a Time."

# Open Mic

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### 19<sup>TH</sup> ANNUAL SCIENTIFIC ASSEMBLY

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Top two speakers will be invited to give a formal presentation at the 2014 Scientific Assembly in New York, NY.

For general information about Open Mic opportunities, please contact Marcia Blackman at [mblackman@aaem.org](mailto:mblackman@aaem.org) or 800-884-2236.

# The 19th Annual AAEM Scientific Assembly

## February 9-13, 2013 — The Cosmopolitan of Las Vegas

The American Academy of Emergency Medicine invites you to attend the premier event in emergency medicine for clinicians — the 19th Annual Scientific Assembly! This event will take place at the newly opened luxury resort — The Cosmopolitan of Las Vegas, February 9-13, 2013.

### Conference Features

- Eleven robust plenary sessions with a mixture of clinical updates and topics addressing the changing landscape of healthcare, and the impact of these changes in emergency medicine practice.
- Seven new tracks to complement the timeless attendee favorite tracks.
- Three additional specialty tracks including a new interactive track, EMS specialty track, and the inaugural diagnostic case competition.

### Hotel Accommodations

The Cosmopolitan of Las Vegas  
3708 Las Vegas Boulevard South  
Las Vegas, NV 89109  
Phone: (702) 698-7000

Reservations by Phone: (855) 435-0005

(Reference "American Academy of Emergency Medicine" or the group code, "SCIEN13" to secure the group rate).

Online Reservations: <https://resweb.passkey.com/go/SCIEN13>

Reservation Deadline: January 8, 2013

AAEM encourages attendees to make reservations by this date. After January 8, 2013, regular room rates may apply and availability may not exist. Reservations should be made directly with The Cosmopolitan of Las Vegas.

Single/Double Occupancy - \$229.00 per night, plus applicable state and local taxes.

### Mobile App

We are also extremely pleased to offer a mobile app for the first time ever at Scientific Assembly! This app will provide participants with great features for the conference including:

- An event guide
- Speaker profiles
- Evaluations and surveys
- Banner ads/exhibitor listing
- Handout/PPT document access

### Register Today!

Registration for the Scientific Assembly is now open! You can register in one of the following ways:

1. Online. Visit the 2013 Scientific Assembly website, <http://www.aaem.org/education/scientific-assembly/registration>.
2. By Mail: Visit the 2013 Scientific Assembly website, <http://www.aaem.org/education/scientific-assembly/registration> and print out the registration form PDF. Complete the registration form and mail with payment to:  
AAEM Scientific Assembly  
555 E. Wells Street, Suite 1100  
Milwaukee, WI 53202-3823
3. By Phone: Call the AAEM offices at 1-800-884-2236 and ask for "Scientific Assembly Registration."

Attendance to the general assembly is free to all members. A \$200 deposit is required for members, which is refunded following the meeting unless the individual wishes to donate the deposit towards the AAEM Foundation or the AAEM PAC. Registration rates to the preconference courses vary.

### Accreditation Statement

The American Academy of Emergency Medicine (AAEM) is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians.

### Credit Designation Statement

The American Academy of Emergency Medicine (AAEM) designates this live activity for a maximum of 20.5 *AMA PRA Category 1 Credits*™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

While the app is under construction, you can still download the app by scanning the QR code to the right or by visiting <http://eventmobi.com/aaem13/>.



# 19TH ANNUAL SCIENTIFIC ASSEMBLY

## FEBRUARY 9-13, 2013



## Perpetually advancing emergency medicine for the clinician and proudly the premier clinical conference in the emergency medicine specialty.

### AAEM's 20th Anniversary Event

On Tuesday, February 12, 2013, AAEM will host an evening event for Scientific Assembly attendees to commemorate AAEM's 20th Anniversary. Visit the Scientific Assembly website for more information coming soon: [www.aaem.org/education/scientific-assembly](http://www.aaem.org/education/scientific-assembly).

### Preconference Courses

#### Preconference Courses, February 9, 2013

- Advanced Ultrasound
- Introductory Ultrasound
- Pediatric Emergencies: Children Are Not Little Adults!  
*jointly sponsored by CAL/AAEM*

#### Preconference Courses (Two-Day), February 9 & 10, 2013

- ED Operations Management: Cracking the Code!
- Resuscitation for Emergency Physicians

#### Preconference Courses, February 10, 2013

- Introduction to Wilderness and Operational Medicine  
*jointly sponsored by USAAEM*
- Pediatric Emergency Department Simulation: Critical Skills from Birth to the School Bus!
- Student Track



### 11th Annual Open Mic Session — Sessions Available

*Sponsored by the Young Physicians Section*

AAEM will again feature the Open Mic Session, which is a unique opportunity for attendees who have always wanted to speak at a national meeting. **Monday, February 11, 2013**, will feature an "Open Microphone" session in a 40-50 seat room at The Cosmopolitan of Las Vegas.

From 7:30am to 5:30pm, Assembly attendees will have an opportunity to present a 20-minute lecture (15 minutes for presentation, 5 minutes for questions) on any topic of their choosing, allowing 16 "new voices" to be heard and evaluated by AAEM Education Committee members and conference attendees. The top speaker(s) will be invited to give a formal presentation at the 2014 Scientific Assembly in New York, NY. Half of the time slots will be filled in advance by email. The remaining time slots will be filled on a "first-come, first-served" basis by signing up onsite. Those who presented at the 2012 Open Mic Session are not eligible to sign up. Speakers can choose any topic they wish; however, AAEM reserves the right to end a session if the content is not appropriate. Handouts, which are optional, must be provided by the speaker. An LCD projector and screen will be available for computer-based presentations.

Evaluation forms will be available for anyone who wishes to comment on what they've seen and heard. Timing will be VERY strict. Eight slots will be reserved for emergency medicine residents and Young Physicians Section members — four scheduled in advance and four scheduled onsite. The other eight slots are open for medical professionals who have been looking for an entry onto the speaking circuit. This is not an educational track, and there will be no CME for these sessions. Speakers certainly should not list the Open Mic Session on their CVs as "invited guest lecturer." To sign up for an Open Mic time, please contact Marcia Blackman at [mblackman@aaem.org](mailto:mblackman@aaem.org) or 800-884-2236. ■

THE COSMOPOLITAN LAS VEGAS, NV



# ABEM Elects New Leadership

John C. Moorhead, MD, has assumed the office of President of the American Board of Emergency Medicine (ABEM). Dr. Moorhead has been a member of the Board of Directors since 2004, and was elected to the (then) Executive Finance Committee in 2010. Since 1996, he has served ABEM in a variety of capacities, including as an oral examiner and item writer. Dr. Moorhead served on ABEM's Academic Affairs Committee, Communications Committee, Executive Committee, Maintenance of Certification (MOC) Committee, Test Administration Committee, and Test Development Committee. Dr. Moorhead also has represented ABEM on a number of external committees, including the Board of Directors of the American Board of Medical Specialties (ABMS), and its MOC CME Joint Working Group, Health and Public Policy Task Force, Exploring Future Relationships with BCBSA Design Team, and as chair of the MOC Committee. Additionally, he serves as the liaison to the American College of Emergency Physicians' Quality and Performance Committee.

Dr. Moorhead received his medical degree in 1975 from Queens University Medical School in Kingston, Ontario, Canada, and completed his residency in Emergency Medicine in 1978 at Royal Victoria Hospital, McGill University in Montreal, Quebec, Canada. He is Professor of Emergency Medicine, Public Health and Preventive Medical Education, and Health Policy, at Oregon Health & Science University (OHSU) in Portland, Oregon. To honor Dr. Moorhead's contributions to emergency medicine, OHSU established an endowment fund in his name.

The fund will sponsor leading educators in emergency medicine to shape and develop generations of emergency physicians for years to come.

James H. Jones, MD, has been elected to the office of President-Elect of the American Board of Emergency Medicine (ABEM). Dr. Jones has been a member of the Board of Directors since July 2005, and was elected to the Executive Committee in 2010. Since 1988, he has served ABEM in a variety of capacities including as examination editor, item writer, and oral examiner. He currently serves as the chair of the Academic Affairs Committee, the Test Development Committee, Finance Committee, and the Initial Certification Task Force. Dr. Jones has represented ABEM as a Delegate to the American Board of Medical Specialties and is a member of the Emergency Medicine Milestone Project Working Group. He also has been an editor and reviewer for a number of academic emergency medicine journals.

Dr. Jones received his medical degree from the Ohio State University College of Medicine and completed his residency training in emergency medicine in 1982 at Wright State University in Dayton, Ohio. He is Vice Chair of Medicine and is the Medical Director of the Wishard Memorial Hospital Emergency Department in Indianapolis, Indiana. His area of research is in emergent airway management.

At its July 2012 meeting, ABEM also elected the following directors to the 2012-13 Executive Committee: Richard N. Nelson, MD, Immediate-Past-President; Francis L. Counselman, MD, Secretary-Treasurer; and Barry N. Heller, MD, Member-at-Large. ■

## Thank You!

We would like to recognize and thank the following ED groups for participating in our 2012 100% ED Group Membership. We sincerely appreciate the enthusiastic and continuous support of these physicians and their groups.

### 100% ED Groups

- Amarillo Emergency Physicians – TX
- Campbell County Memorial Hospital – WY
- Cascade Emergency Associates – WA
- Chesapeake Regional Medical Center – VA
- Drexel University – PA
- Eastern Carolina Emergency Physicians (ECEP) – NC
- Edward Hospital – IL
- Emergency Specialists of Oregon (ESO) – OR
- Emergency Physicians at Sumner, PLLC (EPAS) – TN

- Florida Hospital East Orlando – FL
- Fort Atkinson Emergency Physicians (FAEP) – WI
- Fredericksburg Emergency Medical Alliance, Inc – VA
- Memorial Medical Center – IL
- Newport Emergency Physicians, Inc. – RI
- Northeast Emergency Associates – MA
- OSF Saint Anthony – IL
- Physicians Now, LLC – VA
- Salinas Valley Memorial Hospital – CA
- Santa Cruz Emergency Physicians – CA
- Southern Colorado Emergency Medical Assoc (SCEMA) – CO
- Space Coast Emergency Physicians – FL
- Temple University Hospital – PA
- University of Louisville – KY
- West Jefferson Emergency Physician Group – LA

### 2/3 ED Groups

- Bay Care Clinic LLP – WI

# Important Information Regarding Your ABEM Certification

Does your ABEM certification expire in 2017 or 2013? If your ABEM certification expires in 2017, you have ABEM MOC requirements that must be completed by December 31, 2012. These requirements are:

- Pass 4 Lifelong Learning and Self-Assessment (LLSA) tests
- Complete and attest to 1 Practice Improvement (PI) activity

If you have already completed these activities, you have met the requirements of your first 5-year activity period.

If you have not completed these requirements, you must do so by December 31, 2012. If not, you will not lose your ABEM certification; however, ABEM will designate and publicly report that you are “not meeting MOC requirements.” If you do not complete these and your subsequent five-year requirements by the time your certificate expires in 2017, you will lose your ABEM certification.

If your certification expires in 2013, you have ABEM MOC requirements that must be completed by December 31, 2013. These requirements are:

- Pass 8 LLSA tests
- Complete and attest to 1 Practice Improvement (PI) activity
- Pass the ConCert™ examination

If you do not complete all these requirements by December 31, 2013, your ABEM certification will expire; you will no longer be certified.

The key to meeting the PI requirement is to measure, benchmark/compare, implement an improvement/intervention, and re-measure. An example is shown below:

- An emergency department is tracking statistics for adherence to Core Measures for community acquired (bacterial) pneumonia (CAP) for the entire physician group.

- It is reporting physician adherence to the measures at department meetings or routinely posting this data in the ED.
- Comparisons are made to national or regional benchmarks, or even prior performance within the department.
- Suggestions are made or strategies are put into place to improve adherence.
- Performance is re-measured and reported to determine if adherence has been maintained or improved.

Other examples include PI activities related to any of the 16 PQRS measures, Core Measures, or other activities as diverse as sepsis pathways, asthma pathways, throughput time measures, door-to-doctor times, and most LEAN or Six-sigma projects. At least 10 of your patients must be a part of the measured group; fewer patients can be used for certain high-acuity, low-volume clinical issues (e.g., door-to-balloon times).

ABEM wants to help you maintain your certification. If you have questions, please call the ABEM office (517.332.4800 ext. 383), send an email ([moc@abem.org](mailto:moc@abem.org)), or visit the website ([www.abem.org](http://www.abem.org)) for additional information.

## IMPORTANT INFORMATION FOR

### Physicians with Certificates that Expire in and after 2013

Passing the ConCert™ examination will not automatically renew your certification. You must also pass your LLSA tests and complete and report completion of a PI activity. Any outstanding requirements will result in loss of certification. Please call or email the ABEM office with any questions. ■

## AMERICAN ACADEMY OF EMERGENCY MEDICINE



The American Academy of Emergency Medicine  
is *the* specialty society for emergency physicians.

**Renew with AAEM at** [www.aaem.org/renewaaem.org](http://www.aaem.org/renewaaem.org) [info@aaem.org](mailto:info@aaem.org)





# OIG Alerts Physicians to Exercise Caution When Reassigning Medicare Payments

The notice below from the HHS Office of Inspector General illustrates the dangerous position emergency physicians are in when they have no idea what is being billed and collected on their behalf. That is typical of several employment arrangements, most notably when emergency physicians work for contract management groups. Remember, you may be held liable for the actions of your coders and billers, even when asking to see what is billed and collected in your name can get you fired.

— The Editor

## Physicians May Be Liable for False Claims Submitted by Entities Receiving Reassigned Medicare Payments

Physicians who reassign their right to bill the Medicare program and receive Medicare payments by executing the CMS-855R application may be liable for false claims submitted by entities to which they reassigned their Medicare benefits.

OIG encourages physicians to use heightened scrutiny of entities prior to reassigning their Medicare payments. Physicians should carefully consider entities to which they choose to reassign their Medicare payments and ensure that the entities are legitimate providers or suppliers of health care items and services.

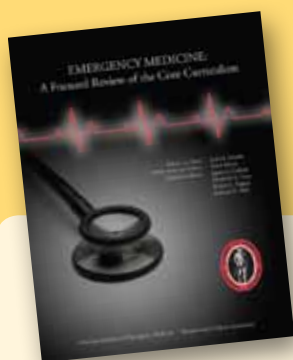
OIG recently reached settlements with eight physicians who violated the Civil Monetary Penalties Law by causing the submission of false claims to Medicare from physical medicine companies. Specifically, these physicians reassigned their Medicare payments to various physical medicine companies in exchange for Medical Directorship positions. While serving as Medical Directors, the physicians did not personally render or directly supervise any services. There was evidence that the

services the physical medicine companies claimed the physicians performed were not actually performed or were not performed as billed.

The failure of the physicians to monitor the services billed using their reassigned provider numbers resulted in individuals with little to no medical background serving as physical therapy “technicians.” These unlicensed “technicians,” including retail cashiers and massage therapists, rendered unsupervised in-home physical therapy services to Medicare and Medicaid beneficiaries. The physical medicine companies falsely billed Medicare using the physicians’ reassigned provider numbers as if the physicians personally rendered the services or directly supervised a “technician” rendering the services. Many of the owners and operators of the physical medicine companies were criminally prosecuted. OIG determined that the physicians were an integral part of the scheme and pursued their liability under the Civil Monetary Penalties Law.

Note: A physician who reassigns to any entity his or her right to bill the Medicare program and receive Medicare payments has the right to access the entity’s billing information concerning the services the physician is alleged to have performed and for which the entity billed Medicare. Physicians have unrestricted access to claims submitted by an entity for services that the entity billed using the physicians’ reassigned provider numbers to provide added assurances that the services for which the entity billed Medicare were, in fact, performed and were performed as billed.

This OIG Alert does not alter any individual’s or entity’s obligations under any other applicable Medicare statutes or regulations governing billing or claims submissions. ■



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AAEM-1012-051

*The Next Generation of Board Review—AAEM Resident and Student Association's:*

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- ConCert Exam
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## Upcoming Conferences: AAEM Sponsored and Recommended

AAEM is featuring the following upcoming endorsed, sponsored and recommended conferences and activities for your consideration.

For a complete listing of upcoming endorsed conferences and other meetings, please log onto <http://www.aaem.org/education/aaem-recommended-conferences-and-activities>

### January 4-6, 2013

- Florida Chapter of AAEM Scientific Assembly  
Orlando, FL  
[www.flaaem.org](http://www.flaaem.org)

### February 9-13, 2013

- 19th Annual Scientific Assembly  
The Cosmopolitan of Las Vegas  
Las Vegas, NV  
<http://www.aaem.org/education/scientific-assembly>

### February 9, 2013

#### PRECONFERENCE COURSES

- Pediatric Emergencies: Children Are Not Little Adults!
- Advanced Ultrasound
- Introductory Ultrasound

### February 9-10, 2013

#### PRECONFERENCE COURSES

- Emergency Department Operations Management: Cracking the Code!
- Resuscitation for Emergency Physicians

### February 10, 2013

#### PRECONFERENCE COURSES

- Introduction to Wilderness and Operational Medicine
- Pediatric Emergency Department Simulation: Critical Skills from Birth to the School Bus!
- Medical Student Track  
The Cosmopolitan of Las Vegas  
Las Vegas, NV  
<http://www.aaem.org/education/scientific-assembly>

### April 10-11, 2013

- AAEM Pearls of Wisdom Oral Board Review Course  
Las Vegas, NV  
<http://www.aaem.org/education/oral-board-review-course>

### April 20-21, 2013

- AAEM Pearls of Wisdom Oral Board Review Course  
Chicago, IL  
Dallas, TX  
Los Angeles, CA  
Orlando, FL  
Philadelphia, PA  
<http://www.aaem.org/education/oral-board-review-course>

## AAEM-Recommended Conferences

### January 15-17, 2013

- ICEM 2013  
Muscat, Oman  
[www.icemmuscat.org](http://www.icemmuscat.org)

### March 8-10, 2013

- The Difficult Airway Course: Emergency™  
Orlando, FL  
[www.theairwaysite.com](http://www.theairwaysite.com)

### April 5-7, 2013

- The Difficult Airway Course: Emergency™  
Las Vegas, NV  
[www.theairwaysite.com](http://www.theairwaysite.com)

### April 24-28, 2013

- 51st Annual Weil & UC San Diego Symposium on Critical Care & Emergency Medicine  
Las Vegas, NV  
<http://cme.ucsd.edu/weil>

### April 26-28, 2013

- The Difficult Airway Course: Emergency™  
Boston, MA  
[www.theairwaysite.com](http://www.theairwaysite.com)

### June 7-9, 2013

- The Difficult Airway Course: Emergency™  
New Orleans, LA  
[www.theairwaysite.com](http://www.theairwaysite.com)

### September 27-29, 2013

- The Difficult Airway Course: Emergency™  
Baltimore, MD  
[www.theairwaysite.com](http://www.theairwaysite.com)

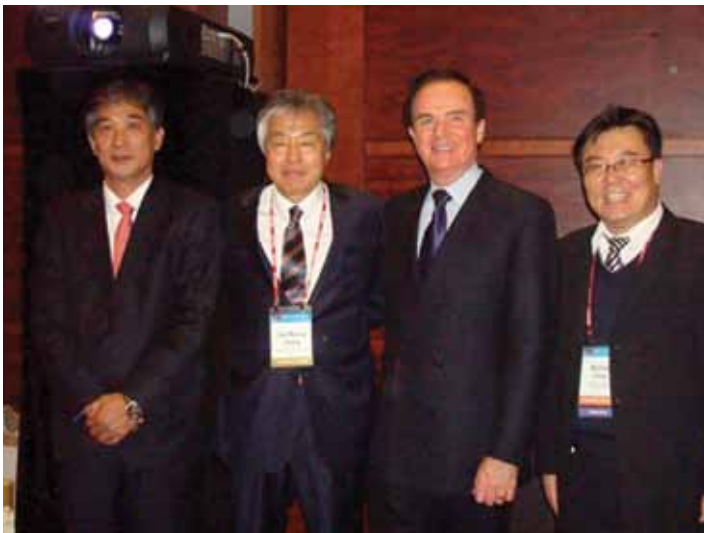
### November 22-24, 2013

- The Difficult Airway Course: Emergency™  
Las Vegas, NV  
[www.theairwaysite.com](http://www.theairwaysite.com)

Do you have an upcoming educational conference or activity you would like listed in *Common Sense* and on the AAEM website? Please contact Marcia Blackman to learn more about the AAEM endorsement approval process: [mblackman@aaem.org](mailto:mblackman@aaem.org).

All sponsored and recommended conferences and activities must be approved by AAEM's ACCME Subcommittee.

## Pan-Pacific Emergency Medicine Congress



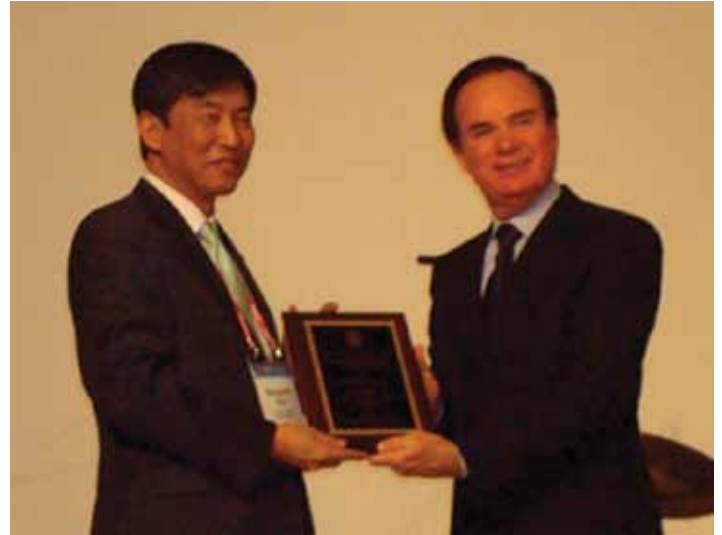
The Pan-Pacific Emergency Medicine Congress was held at the Coex Convention and Exhibition Center, in Seoul, Korea, October 23-26, 2012 with great success.



The Congress was a success with almost 1,300 delegates, speakers and sponsors from 35 countries. It offered opportunities for intellectual and social interactions amongst the participants.



# Pan-Pacific Emergency Medicine Congress



PEMC 2012 was born of partnership between the KSEM (The Korean Society of Emergency Medicine) and the AAEM (The American Academy of Emergency Medicine) to promote mutual exchange and to achieve academic advancement of emergency medicine in pan-pacific region.



Several AAEM members were able to attend and participate as speakers. ■



## COMMITTEE REPORT: Government and National Affairs

The Government and National Affairs Committee is charged with directing and coordinating AAEM's lobbying efforts in Washington, DC. Every day legislation and regulations are proposed and/or passed that significantly impact physicians. We work hard to advocate for emergency physicians, encouraging smart legislation and limiting unnecessary regulation.

Over the last several months, we have worked on the drug shortage issue from a variety of angles. We met with Hill staff to draft language for new legislation, endorsed the "Preserving Access to Life Saving Medications Act," attended "The Impact of Drug Shortages on Emergency Care" summit, worked with partners and industry organizations at the 2011 Drug Shortages Steering Group, and lobbied for successful passage of the FDA Reauthorization Bill.

As a committee, we use the AAEM Mission Statement to guide our advocacy. We continue to fight for fair and equitable practice environments for emergency physicians on a national level. Committee members are actively engaging federal regulators on the due process issue. We are supporting malpractice reform and balanced billing initiatives on

a state-by-state level. Medical liability reform remains a major concern of the membership, and the committee offers support to states that are considering legislation and constitutional amendments that address the issue.

The Medicare Sustainable Growth Rate (SGR) continues to be a problem, but we have endorsed the Burgess Bill, which was introduced in the House of Representatives this summer. It extends the current Medicare reimbursement rates through 2013. We continue to argue for a permanent SGR "fix."

If you are interested in participating in the Government and National Affairs Committee, we welcome your input. Be sure to sign up for updates at our Legislative Action Center on the AAEM website, and when you receive an email from us asking for you to contact your legislators, please do so! Your grassroots action is critical to passing important legislation. Visit: [www.aaem.org](http://www.aaem.org), and click on the advocacy tab. ■

Michael Ybarra, MD  
Chair, Government and National Affairs Committee

## COMMITTEE REPORT: Practice Management

The Practice Management Committee has been working on our track for the 2013 Scientific Assembly. We have chosen the topics that we feel can best be presented briefly in a lecture, while saving more complex topics for panel discussions. All the presentations should provide practical information that can be shared immediately with your respective groups and partners. We are excited to be covering timely and difficult topics for our members and hope to see this portion of the conference grow.

We have also been fielding questions and engaging in dialog with multiple groups that are struggling with their existing contracts, as well as a few emergency physicians who are looking to start their own democratic groups. As this is the Academy's heart and soul, we take great pride in providing rapid and useful answers to those who are seeking to advance independent and democratic emergency medicine.

Dr. David Lawhorn and several others on the committee are writing a textbook on starting a democratic group, which we hope to provide to interested members in electronic as well as hard copy formats. This is a project that Dr. Lawhorn has put countless hours into, and we think it will become an essential resource both to those in the process of starting a group, as well as those maintaining existing contracts.

This past spring, Drs. Durkin and Zun manned an exhibit booth at the American College of Healthcare Executives conference. They met with many executives in the health care field and educated them on AAEM and our principles. From those interactions, we are hoping to build more recognition amongst administrators and become a resource for hospitals.

Other areas of focus for the committee are quality, patient satisfaction, and changes in health care in the face of the PPACA, or Obamacare. Each of these topics is vitally important to independent emergency medicine groups. The game plan of waiting until the next Supreme Court decision, or the next election, or whenever the next issue comes up, is not a good strategy for any group. We hope to share innovative ways of handling these issues for smaller groups with limited resources. Please feel free to contact us if you have any comments or suggestions.

As always, to those who are interested, please reach out to us and participate in our committee and your Academy. That is what makes each of our groups better and makes our Academy the best that it can be. Thank you. ■

Craig Norquist, MD FAAEM  
Chair, Practice Management Committee

**new!**

### Procedural Sedation and Advanced Resuscitation Expertise Card

The Advanced Resuscitation Expertise Card now includes procedural sedation.

Access and download your card from your AAEM member account  
[www.aaem.org/myaaem](http://www.aaem.org/myaaem)

**Current news and updates**

can now be found on the AAEM website

[www.aaem.org](http://www.aaem.org)

## COMMITTEE REPORT: Operations Management

I would like to provide an update on the activities of AAEM's Operations Management Committee. The committee, though it had targeted a number of objectives early on, has refocused its energies to develop a workshop on improving ED operations by using innovative best practices; this will premier at the upcoming Scientific Assembly.

This workshop will be held as a preconference event Saturday, February 9th and Sunday, February 10th in Las Vegas, during the 2013 AAEM Annual Scientific Assembly. The workshop will focus on case studies from physician-engineers like Chris DeFlicht, MD, using clever out-of-the-box approaches to improving throughput in the ED, from places like Penn State Hershey Medical Center and the Ochsner Health System in New Orleans. Nationally recognized leaders in ED operations, such as Jody Crane, MD MBA, from Mary Washington Hospital in Virginia and Peter Viccellio, MD, from Stony Brook School of Medicine, will present their views on ED operations and the impact of impending changes in healthcare on our practices. Tom Scaletta, MD MBA FAAEM, from Edward Hospital in the Chicago area, will talk about

how all of this impacts customer service and patient satisfaction and what we can do to guarantee good patient experiences. Finally, Mark Graben, Joe Swartz, MBA, and Mark Jaben, MD MBA, will present their latest published work on using lean processes to achieve operational excellence. Each day ends with a round table discussion.

So, as you can see, we have been busy working (like good engineers do) on the long lead items required to put on this type of program. We are solidly on our way. It's going to be a power-packed workshop, giving participants both operations guidance from the country's most respected leaders in the field and practical examples of case studies that can be taken home and implemented.

Look for more information on this workshop in future Scientific Assembly announcements. We hope to see you there. ■

Joseph Guarisco, MD FAAEM FACEP  
Chair, Operations Management Committee

## CHAPTER REPORT: Uniformed Services AAEM

The last year has been a good one for the Uniformed Services Chapter of AAEM (USAAEM). We currently have 138 members, and we have continued to notice improved representation from all three branches of the military. Our chapter held another successful and well-attended preconference course before the Scientific Assembly in San Diego in 2012, and we have a new and exciting preconference course focusing on wilderness medicine planned for the 2013 Scientific Assembly in Las Vegas.

In addition, we started a USAAEM Facebook page primarily designed for medical students to obtain information on the Health Professional Scholarship Program (HPSP) and other opportunities that the services offer. We continue to offer a subscription to *The Western Journal of Emergency Medicine* for all members. ■

David Bruner, MD FAAEM  
Vice-President, Uniformed Services Chapter

## CHAPTER REPORT: Florida AAEM

We are pleased to be hosting our second annual Florida AAEM Scientific Assembly in Orlando, January 4-6, 2013. We expect an even better turnout this year given the beautiful weather in Florida in January. As before, there will be excellent speakers from across the state. Also, the LLSA Review Course that was very well received last year will be offered again, by popular demand.

Politically, this year we have made strides at collaborating with Florida

ACEP on lobbying the state government together. We plan on developing a joint legislative agenda for 2013 and will be participating in their EM Days in Tallahassee in March. We hope this mutual effort will be the start of more powerful and effective lobbying on emergency medicine issues. ■

Vicki Norton, MD FAAEM  
Associate Member Representative, Florida Chapter



### Second Annual FLAAEM Scientific Assembly January 5-6, 2013

**Hyatt Grand Cypress Resort & Hotel — Orlando, FL**

This activity has been approved for *AMA PRA Category 1 Credit(s)*™.  
Registration & Information at [www.flaaem.org](http://www.flaaem.org) or (800) 884-2236.



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## IMAGINE YOUR ARTICLE HERE!

**YPS is actively seeking new authors to publish articles in *Common Sense*.**

If your submitted article is selected for publication, you will receive a **\$25.00 Visa gift card\***, along with a complimentary 1 year YPS membership\*.

### Need a topic?

Topics listed below have been requested by our members and would be a great place to start. Original topics are still welcomed and encouraged.

- BP Management in Stroke
- Dermatologic Emergencies
- Hand Trauma
- Clinical Decision Rules for Pulmonary Embolism
- Low Risk Chest Pain Protocols
- Pediatric Conscious Sedation
- Updated Toxicology (ex: THC derivatives, bath salts)
- Vertigo
- Billing and Coding Tips
- Managing High Malpractice Risk Scenarios
- How to Deal with Difficult Consultants

Articles should be a maximum of 800 words and cannot have been previously published.

**Please submit all articles to [info@ypsaaem.org](mailto:info@ypsaaem.org).**

\* Limit of one

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Young Physicians Section**

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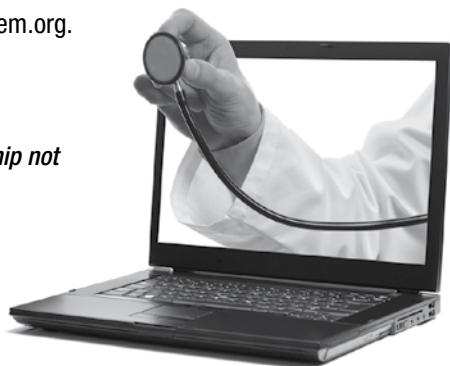
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### Rules of the Road

FOR YOUNG EMERGENCY PHYSICIANS

Chief Editor:  
David Hays, MD, FACEP  
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## AAEM/RSA President's Message

# A Young Emergency Physician Appreciates the History of U.S. Emergency Medicine Through the Lens of China's Emergency Departments

Leana S. Wen, MD MSc  
AAEM/RSA President



I'm a senior EM resident — a young emergency physician, part of the “new breed” that's always known emergency physicians to be residency-trained, and EM as a well-respected field. Being part of AAEM, I've heard our leaders talk about the struggles they had in establishing our specialty, but I didn't have a sense of what they actually went

through. Why is it that they so dislike the term “emergency room” and cringe at references to “ER doctors?”

It took a visit to China for me to even begin to understand the reasons. For the last month, I have been traveling the country to study the current state of medical education here. My trip traverses nine provinces and involves visits to 14 medical schools and over 50 hospitals.

As an emergency physician who is interested in health care systems, I was particularly curious to visit the EDs here. What I found is quite far from the EDs I know. Every hospital I visited, from rural provincial hospitals in Inner Mongolia to major inner-city teaching hospitals in Beijing, has an emergency ROOM. That's because patients are literally seen in a giant room, with beds pushed against walls and — if they are lucky — a curtain for privacy. Extra patients are lined up along hallways, often six-deep.

Many places have triage-to-service, meaning that patients are triaged to a specific area to be seen by specialists who come through the ER. Internists see patients designated as having medical problems, surgeons see patients thought to have surgical problems, etc. If the patient turns out to have a different problem than was initially suspected, a long discussion takes place before the patient is transferred to the correct part of the ER.

Since China is a densely populated country, many hospitals have serious issues with overcrowding. Not surprisingly, the biggest problem seems to be with patients waiting for a hospital bed — basically, boarding.

“Do you often see patients waiting for a bed for 24 hours?” I asked a doctor in a major Beijing hospital.

“24 hours? We are lucky if there's a bed in 72 hours!” He went on to describe the difficulties he had with admitting an elderly woman with CHF, diabetes, renal failure, and liver cancer who came in with respiratory distress. The heart failure service refused the patient, saying the problem was renal in nature. Renal declined, saying diabetes or cancer was the underlying problem. Oncology and endocrine stated the chief complaint was not mainly their issue. General medicine said the patient was too complicated. As a result, the patient stayed in the ED for the entirety of her care — a total of 30 days.<sup>1</sup>

The emergency physicians I met attributed the problem of boarding to the lack of respect for the specialty. Though EM is a specialty in China, and there are EM residency programs in some cities, it is considered to be a specialty of last resort — for those physicians cannot make it in other fields. Most “departments” are divisions that exist only under the auspices of “real” departments such as surgery and medicine. Attendings working in the ED are scorned by others, and fights over airway, chest tubes, and other procedures are frequent occurrences.

My fellow residents are (hopefully) wondering what kind of backwards environment I'm describing, but many reading this column are probably thinking that this description is not too far from the reality they knew. Indeed, the road to specialty recognition involves predictable stages, all described eloquently by our forefathers and AAEM leaders. My generation takes it for granted that we are part of excellent training programs and will be specialists in a well-respected medical field. But it wasn't long ago that our predecessors fought the same battles that China faces now, for specialty recognition, admitting privileges, scope of practice, etc.

Continued on next page

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We young residents and EPs need to thank those who came before us for making our specialty what it is and paving the way for us. For creating the emergency DEPARTMENT (rather than the ER) staffed by emergency physicians (rather than ER docs). For ensuring safer and better care for our patients.

We must also recognize that while many problems have been resolved, many remain. Overcrowding and boarding continue to be problems in EDs across the country. There are continuing challenges to our scope of practice, and other specialties still question our abilities (propofol for sedation, anyone?). Vocal groups still insist that there are other ways to become a "certified" EP through alternative boards. The corporate practice of medicine remains a real issue for practicing EPs.

It's imperative for young EPs like myself to continue to find value for our specialty. China's EM leaders have found creative solutions around their overcrowding and scope of practice problems, by starting "E-ICUs" (emergency ICUs) and transitional care units (transition from E-ICU to home) and staffing "emergency inpatient" and observation units. As we look to the future of EM, we should be aware of our history and work to overcome ongoing problems to make sure that we are advancing our specialty, both in our own country and internationally. ■

1. For more on EDs in Beijing, please see: Wen LS, Xun J, Steptoe AP, Sullivan AF, Walline JH, Yu XZ, Camargo CA Jr. Emergency Department Characteristics and Capabilities in Beijing. *Journal of Emergency Medicine*. 2012; in press.

*I would love to hear your comments on my columns! Please email me, [wen.leana@gmail.com](mailto:wen.leana@gmail.com) and follow me on Twitter, @DrLeanaWen, and my blog, <http://whendoctorsdontlisten.blogspot.com>. Along with Dr. Kosowsky, Clinical Director of the Brigham & Women's ED, I am publishing a book about patient involvement in healthcare, "When Doctors Don't Listen: How to Prevent Misdiagnoses and Unnecessary Tests." Please visit [www.whendoctorsdontlisten.com](http://www.whendoctorsdontlisten.com).*

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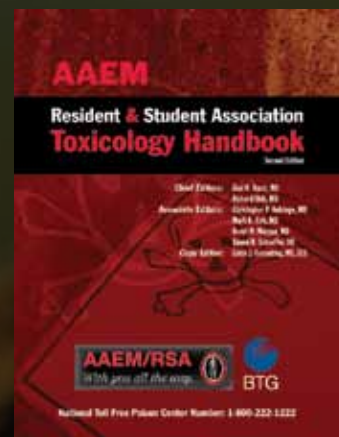
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AAEM-1012-051

# Dengue Fever in Florida: Time to Test?

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An 8-year-old Dominican boy presented to the emergency department (ED) after one week of sickness. The patient became ill with fatigue, decreased appetite, decreased activity, runny nose, rash, and mild fevers while on a trip to the Dominican Republic. He had visited a physician in the Dominican Republic and was diagnosed with otitis media and given amoxicillin. He returned to the United States after three days of illness and developed a fever of 104 degrees Fahrenheit at home, leading his mother to bring him to the ED. In the ED, he was found to have a negative influenza screen, negative rapid strep test, urinalysis without evidence of infection, as well as other unremarkable lab tests. He was given one dose of ceftriaxone and sent home to follow up with his PCP in 24 hours. He saw his PCP the next day, was given another dose of ceftriaxone, and sent home. Mom noticed continuous high fever with worsening poor appetite and vomiting, and therefore brought him back to the ED. Fever on arrival to the ED was 104.1 degrees Fahrenheit; repeat labs were unremarkable, and the patient was admitted for observation. During the patient's stay in the hospital, a throat culture was negative, and other lab tests were negative for CMV, EBV, parvovirus B19, RSV, Adenovirus, and mycoplasma. A test for IgM antibodies to the Dengue Fever virus was positive. The patient developed thrombocytopenia and petechiae, which spontaneously resolved over the next week.



Picture courtesy of Wikipedia Commons: Aedes albopictus mosquito

Dengue Fever is a potentially fatal, frequently missed diagnosis with fertile ground in Florida's mosquito-perfect climate. Currently, 40% of the world's population lives in areas at risk for transmission of Dengue Fever, and its geographic footprint is expanding. Infection with Dengue is one the leading causes of illness and death in tropical and subtropical areas, with up to 100 million people infected yearly. Although Dengue has previously been rare in the United States, it is endemic in Puerto Rico, Latin America, Southeast Asia, Indonesia, and sub-Saharan Africa, and has recently spread into Florida. The Florida Department of Health has confirmed both local and imported cases of

the mosquito-borne illness. Dengue cases in South America, Central America, Mexico, and the Caribbean quadrupled between 1989 and 2007 and continue to rise, reaching an all-time high in South Florida, Puerto Rico, and the U.S. Virgin Islands in 2010 (the most recent data available). The Centers for Disease Control and Prevention (CDC) recently released a study that revealed over 10% of Key West's population has been infected with the Dengue Fever virus.

Dengue is caused by a member of the flaviviridae, with four serotypes (DENV 1–4) and is transmitted by mosquitoes (*Aedes aegypti* and *Aedes albopictus*) found in tropical and subtropical areas. Infection with one of the four serotypes does not protect against infection with the other serotypes, and repeat infections increase the risk of more severe forms of Dengue (Dengue Hemorrhagic Fever and Dengue Shock Syndrome).



Picture courtesy of Wikipedia Commons: Aedes aegypti mosquito

There is currently no vaccine and no specific treatment for Dengue Fever (conventional anti-virals do not treat Dengue), and the best defenses are against the vector — mosquito prevention. There are an estimated 50–100 million infections per year with 500,000 hospitalizations due to severe disease, and a fatality rate of 5% — which is reduced to <1% by appropriate supportive therapy.

Early recognition of the disease and supportive treatment can substantially lower the risk of developing severe disease. Symptoms occur 4–7 days after the mosquito bite and last for 3–10 days. Classic Dengue Fever ("break-bone fever") has symptoms that include headache, high fever, muscle and joint pain, nausea, vomiting, and rash — similar to many other viral illnesses — and thus is often missed in the emergency department. Blood work often shows a low white blood cell count. The greatest dangers from Dengue Fever are forms of the disease called Dengue Hemorrhagic Fever (DHF) and Dengue Shock Syndrome (DSS). It is similar to other hemorrhagic fevers, with thrombocytopenia being the hallmark on lab testing.

Continued on next page



DHF is currently defined by the following four World Health Organization (WHO) criteria:

- Fever or recent history of fever lasting 2–7 days
- Any hemorrhagic manifestation
- Thrombocytopenia (platelet count of  $<100,000/\text{mm}^3$ )
- Evidence of increased vascular permeability

Dengue Shock Syndrome is the four above criteria and evidence of shock.

There are three phases of Dengue Fever. First is the febrile phase, lasting 3–7 days. Then the afebrile (critical) phase around the time the fever subsides when the patient may develop severe disease. Symptoms include severe abdominal pain, persistent vomiting, hypothermia, hemorrhagic manifestations, or a change in mental status (irritability, confusion, or obtundation). The patient may also have signs of shock. The last phase is the convalescent phase, leading to recovery.

In June 2012, the CDC announced a test for Dengue Fever. The CDC DENV-1–4 Real-Time RT-PCR Assay was announced as the first nucleic acid diagnostic device for detection and serotyping of the Dengue

virus approved by the FDA. The Dengue Fever assay detects DENV serotypes 1, 2, 3, and 4 from human serum or plasma. Although there are no vaccines for Dengue prevention and no medications specifically to treat the disease, timely medical care can reduce the possibility of death from 10% in DHF to 1%, and early identification is helpful in determining the best treatment plan. The assay will also be helpful in epidemiology and surveillance of the disease. ■

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## Resident Journal Review

# An Update on Airway Management in Emergency Medicine

Authors: Michael Allison, MD; Michael Scott, MD; Kami Hu, MD; David Bostick, MD; Daniel Boutsikaris, MD

Edited by: Michael C. Bond, MD FAAEM; Jay Khapde, MD FAAEM

There are few clinical skills as important to the emergency physician as emergency airway management. The field of airway management is constantly changing, and the practicing physician must keep abreast of the current trends in laryngoscopy, medication management, prehospital intubation, and the potential complications of intubation. Reviewed here are some of the key airway-related articles published over the past two years.

## Direct Laryngoscopy Compared to Video Laryngoscopy

**Tracheal Intubation in the Emergency Department: A Comparison of Glidescope® Video Laryngoscopy to Direct Laryngoscopy in 822 Intubations.** Sackles JC et al. *Journal of Emergency Medicine* 2012; 42:400-405.

**Difficult Airway Management in the Emergency Department: Glidescope® Videolaryngoscopy Compared to Direct Laryngoscopy.** Mosier JM et al. *Journal of Emergency Medicine* 2012; 42:629-634.

While most of the studies comparing direct laryngoscopy (DL) and GlideScope® video laryngoscopy (GVL) generally show GVL to be faster with higher success rates, the research settings are operating rooms and simulation labs. Platts-Mills et al. published the first ever study comparing DL and GVL success rates in the emergency department (ED) and found no significant difference between the two, supporting GVL as an alternative to DL.<sup>1</sup> Two studies out of the University of Arizona support GVL as not only an alternative, but as a potentially superior intubation technique.

In the earlier-published study, Sackles et al. performed a retrospective observational study using prospectively collected data including all patients intubated in a tertiary care university ED over a 24-month period, in which either DL or GVL was the initial device used. For every intubation, physicians completed a form that documented initial device, success rate, operator experience, airway characteristics, complications, reasons for failure, and performance characteristics of GVL, if applicable. Primary outcome was successful intubation on first attempt, an "attempt" being defined as insertion of the laryngoscope blade into the patient's mouth, whether or not passage of an endotracheal (ET) tube was attempted.

The authors found that GVL had a higher first-attempt success rate than DL (75% versus 68%,  $p=0.03$ ), and higher overall success rates in airways with two or more difficult airway predictors (70% versus 56%,  $p$  listed as 0.00). Failed DL intubations were reportedly due mainly to inability to visualize the airway, while failed GVL intubations were generally due to inability to direct the ET tube into the visualized airway. Interestingly, DL had a higher overall success rate in intubations requiring more than one attempt with the initial device (57% versus 38%,  $p=0.003$ ). The authors hypothesized this finding may be related to the previously mentioned reasons for device failure. Repositioning, blade adjustment, and other maneuvers can improve cord visualization in DL,

but there are few maneuvers the operator can utilize to improve ET tube passage through the cords if this is the reason for failure. Also, as most physicians are generally more comfortable with DL, it was hypothesized that they tend to make multiple attempts before abandoning DL, while GVL is more quickly abandoned for another device.

With regards to study limitations, the authors report that they may have a lower DL success rate than in the Platts-Mills study due to the "many rescue devices available" at their institution.<sup>1</sup> Other limitations include lack of randomization, no determination of data form inter-rater reliability, and inclusion of self-report bias, as the data forms were completed by each provider after the intubations were performed.

In the later study, the same researchers compare DL and GVL success in patients with difficult airways emergently intubated in the ED. They used the exact same patient population as their first study, and the study parameters were virtually identical: a retrospective review of prospectively collected data over a period of 23 months. A data form was completed by every physician post-intubation, documenting the indication for intubation, device used, presence of difficult airway predictors (DAPs), Cormack-Lehane view, complications, and GVL performance characteristics, if applicable. The same definition of attempt was used, and the primary outcome was successful tracheal intubation on first attempt.

The authors found that in patients with DAPs present, GVL had a higher first-attempt success rate than DL (78% versus 68%,  $p=0.007$ ), but their success rates were similar for rescue attempts. Looking at success of GVL over DL, the odds ratio (OR) for success in overall first-attempts was 2.26 (95% CI 1.62-3.15), with three or more anatomic DAPs, the OR was 2.72 (CI 1.73-4.29) for first attempts and 1.84 (CI 1.04-3.26) for rescue attempts. The authors noted that patients with GVL selected as the initial device had more predicted DAPs than those with DL selected as the initial device. They also found that certain DAPs (i.e., the presence of blood, a small mandible, obesity, and a large tongue) were independent predictors of intubation failure in DL as compared to GVL.

The limitations of this study are largely the same as in the authors' prior study: inclusion of possible self-report bias, uncertain inter-rater reliability with regards to patient DAPs or intubation characteristics, and the consideration that the Cormack-Lehane grading was created for assessment of patients prior to DL, but not video laryngoscopy.

These two studies are born from the same patient airway database. Their results indicate that GVL is superior at visualization, especially in patients with multiple DAPs (2+ in the first study, 3+ in the second) which often translates to superior intubation success, but not always. It is important to note that DL still has its role in both first-attempt and rescue attempts, and troubleshooting is much easier with DL than GVL.

Continued on next page

While not without limitations, these studies certainly provide data that indicate the superiority of GVL in certain settings, especially in patients with difficult airways, and set the stage for further research.

### Fiberoptic Laryngoscopy Compared to Video Laryngoscopy

#### GlideScope® Versus Flexible Fiber Optic for Awake Upright Laryngoscopy. Silverton NA et al. *Ann Emerg Med* 2012; 50:159-164.

When it comes to intubating critically ill patients, emergency physicians are generally well-versed in standard and rescue techniques required for the intubation of a supine positioned patient. However, there are certain conditions that make supine positioning less ideal due to the increased likelihood of rapid desaturation such as acute heart failure, angioedema, advanced pregnancy, and morbid obesity. Traditionally, upright awake intubations utilized flexible fiberoptic techniques which come with their own set of difficulties. Therefore, this study examined the possibility of utilizing the GlideScope® laryngoscope for this clinical problem, via the "tomahawk" position.

This was a prospective, randomized, crossover study in twenty-three awake volunteers, given local anesthesia followed by a face to face approach to laryngoscopy. The investigators compared the use of a GlideScope® video laryngoscopy via the blade held upside down "tomahawk" position versus flexible fiberoptic laryngoscopy. Exclusion criteria included age less than 18 years old, pregnancy, hypertension, heart disease, liver disease, epilepsy, diabetes, history of epistaxis, nasal problems, current infectious disease, an allergy to drugs used during the procedure or previous adverse reaction to the topical anesthesia. The primary end point of this study was time to a Cormack-Lehane grade II or better view based on the operator's report.

The study included 10 women and 13 men. A grade II or better Cormack-Lehane view was reported 95.6% of the time when the GlideScope® was used and 100% of the time when flexible fiberoptic laryngoscopy was used. The study was powered to assess for a 40-second difference between the approaches. On one volunteer, the best obtainable view was a grade III, and after three attempts the effort was terminated due to gagging. The median time to highest grade view for the GlideScope® video laryngoscopy was 16 seconds versus 51 seconds for the flexible fiberoptic approach. On average, the GlideScope® video laryngoscopy was 39 seconds faster than flexible fiberoptic laryngoscopy ( $p=0.049$ ). The number of attempts to attain a grade I/II view was similar between groups; however, the range of attempts was higher for the GlideScope® compared to fiberoptic ( $p=0.03$ ).

There are smaller studies looking at awake GlideScope® intubations; however, these were done in the supine position. This study is the first to look at its use in the upright patient in the face to face position. Although, this study does not necessarily demonstrate superiority of either approach, it does provide initial data to suggest this may be a viable option when flexible fiberoptic laryngoscopy is not available. The limitations to this study were its small size, in addition to the use of healthy volunteers, which clearly differs from the clinical population in which awake, face to face intubation would be attempted. Further, this study did not evaluate intubation, rather, only a view of the cords. This may be a viable option to awake intubations as well as diagnostic

laryngoscopy in the ED; however, this will require further investigation to assess its effectiveness and utility in the setting of acute illness necessitating intubation.

### Choice of Paralytic Agent in Rapid Sequence Intubation

#### Comparison of Succinylcholine and Rocuronium for First-attempt Intubation Success in the Emergency Department. Patanwala AE. *Acad Emerg Med* 2010; 18:11-14.

This study examines the effect of dose and type of paralytic agent used on first-attempt intubation success in the ED. This was a retrospective evaluation of information collected prospectively in a quality improvement database between July 1, 2007, and October 31, 2008, at an academic, tertiary care ED with a 3-year residency program. The database recorded all patients that were intubated in the ED with the physician having full access to a RSI (rapid sequence intubation) medication box that contained etomidate for induction and succinylcholine or rocuronium for paralysis. The physician did have other paralytics available, and choice was based on physician preference. Patients were excluded from the study if they did not receive RSI, did not receive etomidate for induction or succinylcholine or rocuronium for paralysis, if they were less than 18 years of age, or had any missing documentation in the database or medical record. An intubation attempt was defined as the laryngoscope being introduced into the mouth, regardless of whether the endotracheal tube was inserted or not.

A total of 327 patients were included in the final analysis. Of these 327 patients, 113 (35%) patients received succinylcholine and 214 (65%) patients received rocuronium. For succinylcholine and rocuronium, the first-attempt intubation percentages were similar, 72.6% versus 72.9% respectively, with a non-significant  $p$ -value of 1.0. The median number of attempts were also similar for succinylcholine and rocuronium ( $p=0.87$ ). The median dose used for succinylcholine was 1.65mg/kg (IQR=1.26-1.95mg/kg) and for rocuronium was 1.19mg/kg (IQR=1-1.45mg/kg).

The authors found that there was no difference between succinylcholine and rocuronium in first-attempt intubation success. It is important to note that the median dose of rocuronium used in this study was higher than what was previously reported in prior literature (1.19mg/kg versus 0.9 – 1.2mg/kg in previous studies).<sup>2</sup> There was an increased use of rocuronium in this study which the authors attributed to current practice at the institution.

The study included no information on complications or drug related adverse effects, information on the type of laryngoscope blade used, and no information was available regarding the time between drug administration and intubation attempt. Due to these limitations, possible unmeasured confounders may have led to the equality in success noted with rocuronium and succinylcholine. Despite these limitations, rocuronium, when dosed appropriately, appears to create a similar intubation experience to succinylcholine, in contrast to what earlier studies have found.

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## Prehospital Considerations in Airway Management

### Effects of Bag-mask Versus Advanced Airway Ventilation for Patients Undergoing Prolonged Cardiopulmonary Resuscitation in Pre-hospital Setting. Nagao T et al. *Journal of Emergency Medicine* 2012; 42; 162-170.

Management of the post cardiac arrest patient can be very challenging, and appropriate airway management is a critical component of their care. Unfortunately, there is little literature to guide when advanced airway techniques should be used in place of basic bag-mask ventilation (BMV), or in the setting of prolonged resuscitation or transport when BVM should be transitioned to advanced airway ventilation (AAV). There are significant advantages and disadvantages to both methods. Per the American Heart Association (AHA) 2010 statement, what is clear is that if an advanced airway is chosen, it must be performed by an experienced provider, and placed, ideally, in less than 10 seconds if placed during cardiopulmonary resuscitation (CPR). When this is not the case, unacceptably long pauses in compressions, airway trauma, hypoxemia from prolonged intubation attempts, and failure to recognize tube misplacement or displacement occur at unacceptably high rates. On the other hand, when quickly and successfully placed, AAV decreases the risks of aspiration and gastric inflation, may provide an additional route for medications, and allows for direct airway suctioning. The study by Nagao et al. addresses many of these questions.

This was a retrospective observational study done through a database review of Tokyo's Fire/EMS department. This study included 355 cardiac arrest patients from 2006-2007 with 156 receiving BMV and 199 receiving AAV. The transport time exceeded 30 minutes in both groups. The primary endpoint was survival to hospital discharge and favorable neurological status, with secondary outcomes being the rate of return of spontaneous circulation (ROSC) and rate of admission to the intensive care unit (ICU). The rate of admission to the ICU and ROSC were both higher in the advanced airway group (AAV) with  $p=0.035$

and  $p=0.009$ , respectively. There were no significant differences found between the two groups when comparing the rate of prehospital ROSC or favorable neurologic outcome. Patients were excluded if they were given epinephrine during the resuscitation, were less than 18 years old, or deemed to have suffered a non-cardiac etiology of arrest. Patients were not excluded if they underwent therapeutic hypothermia or percutaneous coronary intervention.

There are a few important points to this study that need to be highlighted, to better interpret these results. First, all patients per protocol received two minutes of CPR and BMV prior to the decision being made to place an advanced airway. AAV was left to the discretion of the EMT's, who were then granted approval via an on-call physician. Advanced airways in this study included laryngeal masks, esophageal-tracheal combitubes, and endotracheal tubes. Of the 199 AAV patients, endotracheal tube was chosen for just 10 patients, laryngeal mask for 147, and esophageal-tracheal combitube for 42. ROSC was obtained in 37 AAV patients, and of those, just one had an endotracheal tube placed. Although not statistically significant, there was a trend toward witnessed arrest in the AAV group compared with the BMV group (37.7% versus 28.8%,  $p=0.09$ ). Similarly, bystander CPR was initiated in 13.5% of the BVM group and 20.1% of the AAV group. Overall, ROSC and ICU admission was associated with the use of an AAV as well as a witnessed cardiac arrest. There was no difference in primary outcomes between the two groups.

Though the primary outcomes showed no difference based upon prehospital airway management in this study, there are some limitations to keep in mind. Only 10 patients in the AAV group were ventilated via endotracheal tube placement as the others received other supraglottic devices. The benefit of survival in this subgroup is not clear. A limitation to the random group assignment was that there was a trend toward more patients with witnessed arrests and patients receiving bystander CPR in the AAV; these groups of patients have been shown in previous studies to have more favorable outcomes. Patients who received epinephrine in the field were excluded from the study. This was done because only certain EMT providers in Japan were able to administer epinephrine, and excluding these patients eliminated a possible confounder for ROSC. Since epinephrine administration represents the standard-of-care for cardiac arrest, and no patients who received epinephrine were included in the study, the results must be interpreted with this limitation in mind. Finally, there was no difference in primary end points, which suggests that although AAV may allow for survival to the ICU it does not benefit overall outcome. At this point, additional research is required to determine the timing and role of AAV in the post cardiac arrest patient undergoing prolonged transport.

### Paramedic Laryngoscopy in the Simulated Difficult Airway: Comparison of the Venner® A.P. Advance and GlideScope® Ranger Video Laryngoscopes. Butchart AG et al. *Acad Emerg Med* 2011; 18:692-698.

This study examines the role of video laryngoscopy (VL) in prehospital medicine. This study examines the role of two particular devices in a simulated difficult airway mannequin. The GlideScope® Ranger utilizes

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a laryngoscope that is placed midline in the patient's oropharynx to visualize the vocal cords. A proprietary rigid stylet is used to pass an ET tube through the angle of the glottis through the cords. The Venner® A.P. Advance acts like a laryngoscope with a difficult airway blade and utilizes tongue manipulation to gain appropriate video-based visualization of the vocal cords. A laterally placed channel on the blade precludes the need for a stylet, acting as a guided track for ET tube delivery.

Thirty paramedics were studied in convenience fashion after a short demonstration. None had any experience with VL, and median prior experience was 60 lifetime intubations (range 20–300). The participants initially attempted intubation via direct laryngoscopy. Subsequently, participants were randomly assigned to start with one of the two airway devices and instructed to intubate a modified Grade III (Cormick-Lehane classification) mannequin with both the GlideScope® and Venner® devices. Primary outcome measures were time to secure tracheal intubation and an assessment of objective and subjective measures of airway trauma.

Time to tracheal intubation was shorter for both VL techniques when compared to DL. When compared head to head, the Venner® APA was faster than the GlideScope® in time to intubate (mean 25 versus 46 seconds,  $p < 0.0001$ ). Based upon assessment of discrete forward movements of the ET tube during intubation, the Venner® APA had less potential for airway trauma than the GlideScope®. A total of 83% of Venner® APA attempts had successful tube delivery on the initial pass, while 30% of GlideScope® attempts had similar first pass success ( $p < 0.0001$ ). After all intubation attempts, each study participant rated the force of laryngoscopy on a 10cm visual analog score. The Venner® APA was rated as less forceful than the GlideScope® or DL (1.6 versus 3.3,  $p < 0.001$ ).

This mannequin-based study adds to previous literature regarding shorter times to intubation with VL as compared to DL. This study also suggests that there are differences between specific VL devices, and track-based laryngoscopes may result in faster intubations with less trauma than rigid-stylet based devices. This study is limited by its mannequin-based design, as it is unclear how these results would perform in clinical practice. Although time to intubation may be a good surrogate measure of efficient laryngoscopy, it does not inform us whether patients' outcomes would be any different due to a 21-second difference in tube delivery. One of the investigators is a co-inventor and patent holder of the Venner® device (Venner Medical).

### Considerations in Tube Delivery

**Difficulties with Gum Elastic Bougie Intubation in an Academic Emergency Department.** Shah KH et al. *The Journal of Emergency Medicine* 2011; 41:429-434.

The Gum Elastic Bougie (bougie) has been used for years, but lately has gained more and more popularity and use as a rescue airway device in blind and semi-blind intubations. These authors designed a prospective, observational study to evaluate the rate of success of the bougie in intubations and to identify the most common causes of difficulty when using the bougie. All participants received a short training

course on bougie use prior to study participation. In any intubation where the bougie was used, the practitioner involved completed a form detailing their level of training, past experience with the bougie, grade of laryngeal view, and features of the bougie insertion, including reason for failure, if applicable. They also examined the percentage of bougie failure, defined as failure by first practitioner, and overall success, defined as successful intubation regardless of the number of attempts.

In a cohort of 88 patients, the bougie failure rate was 28.4%. The overall success rate was 79.6%. The most common cause of bougie failure was inability to insert the device past the hypopharynx in 53% of the failures, followed by inability to pass the ET tube over the bougie in 24% of failures, and esophageal intubation in 16% of failures. Of the 25 cases of initial bougie failure, seven were subsequently intubated using the device, yielding an overall success rate of 79.6%. Of the 18 full bougie failures, 14 were subsequently intubated by a more experienced emergency physician using DL. The authors also noted that practitioners less-experienced with the bougie accounted for a disproportionate amount of bougie failures — those operators with a history of three or fewer prior bougie uses constituted 55% of the participants but accounted for 64% of the GEB failures.

The authors note several limitations of their study, including a small cohort, the use of trainees and inexperienced physicians, and inability to know whether improper technique was the cause of the failure. The bougie is a useful airway device, but its success in emergency situations is not 100%. Inability to pass the hypopharynx and inability to pass the ET tube are two common points of failure.

**The Effect of Stylet Choice on the Success Rate of Intubation Using the GlideScope® Video Laryngoscope in the Emergency Department.** Sackles JC. *Acad Emerg Med* 2012; 19:235-238.

The use of video laryngoscopy has become increasingly common in the ED, especially in the predicted-difficult airway. Due to the angle of many video laryngoscopes, companies that produce these products often also produce a rigid stylet to be used in conjunction with their laryngoscope. This study sought to determine whether these rigid, specifically-designed stylets performed superiorly when compared to a standard malleable stylet (SMS).

In this retrospective study, the authors used a continuous quality improvement database to examine all intubations in their ED using a GlideScope® video laryngoscope, specifically looking to determine whether use of a SMS or a GlideRite rigid stylet (GRS) was superior. First-attempt success and overall success rates were the primary outcomes measured. The authors compared the two stylets with regard to the incidence of complications, which included oxygen desaturation, aspiration, and airway trauma. The two groups were similar, as the percentage of patients in each group with Grade I or II views and the number of pre-defined DAPs (e.g., c-collar, facial trauma, blood or vomit in airway, obesity, short neck, small mandible, large tongue, and airway edema) were similar between the SMS and GRS groups.

Data for 473 patients was evaluated. In the 322 patients intubated using GRS, the first-pass and ultimate success rates were 82.9% and

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93.5%, respectively. The success rates in the GRS group were found to be significantly higher than the SMS group which had first-pass and ultimate success rates of 67.5% and 78.1% ( $p < 0.001$ ). Furthermore, the mean complication rate in the GRS group was 25%, significantly lower than the 47% found in the SMS group ( $p = 0.003$ ). The authors report that this was mostly due to higher rates of desaturation in the SMS group (18% versus 31%,  $p = 0.0028$ ).

The limitations of this study include self-report bias; all the data was extracted by a single author. When using video laryngoscopy, it appears that using a rigid stylet specifically designed for use with the video laryngoscope provides significantly higher rates of success and lower rates of complications when compared to the use of a SMS.

### Ultrasound in Emergent Airway Assessment

**Pilot Study to Determine the Utility of Point-of-care Ultrasound in the Assessment of Difficult Laryngoscopy.** Adhikari S et al. *Acad Emerg Med* 2011; 18:754-758.

Predicting the difficult airway in the emergency setting is challenging. Traditional teaching focuses on features of the clinical history, and the head and neck exam to identify DAPs. To date, the use of ultrasound in emergency intubation has focused on confirmation of successful tube placement.<sup>3</sup> The authors of this study examined whether focused ultrasound can identify difficult airways, and set out to compare ultrasound measurements of anatomic structures to traditional screening tools such as the Mallampati score, thyromental distance, and interincisor gap.

This is a prospective observational study of patients undergoing elective surgical procedures. Study team members collected demographic information and performed difficult airway screening tests prior to elective intubations. Ultrasound was used to measure tongue thickness and neck soft tissue thickness at predefined locations. Comack-Lehane classification of the laryngoscopic view was recorded by anesthesiologists who were blinded to the predicted airway assessment.

Fifty-one eligible patients were included in the study, and six patients were found by anesthesiologists to have a difficult airway. The sonographic measurement of anterior neck soft tissue thickness was greater in patients with difficult airways at both measured locations. At the level of the hyoid bone difficult airways had significantly increased thickness (1.69, 95% CI = 1.19 to 2.19) compared with easy laryngoscopy (1.37, 95% CI = 1.27 to 1.46). A similar increased thickness at the thyrohyoid membrane was found in difficult (3.47, 95% CI = 2.88 to 4.07) compared with easy airways (2.37, 95% CI = 2.29 to 2.44). There was no significant correlation found between sonographic measurements and clinical screening tests.

Bedside ultrasound measurements may prove to be helpful in assessment of the difficult airway. This pilot study was conducted in patients undergoing elective surgical procedures, which gives the study poor external validity. There is time pressure in the emergency setting which may influence the ability to measure neck soft tissues and may contribute to inaccurate measurement of these structures. If validated in the emergency setting, ultrasound could be used as an adjunct to or in lieu of other clinical predictors of difficult airways.

### Take Home Points:

- Video laryngoscopy may be helpful in difficult airway scenarios, but direct laryngoscopy is still useful, especially in rescue attempts.
- There is no difference between succinylcholine and rocuronium in first-attempt intubation success when appropriate doses are used.
- Track-based or channel-based video laryngoscopes may provide faster intubation times with less trauma than video laryngoscopes utilizing rigid stylet-guided intubation.
- When using video laryngoscopy, greater success is achieved when using the appropriate stylet.
- Future studies may help identify whether soft tissue measurements of the neck with ultrasound may predict difficult emergency intubations. ■

### Additional References:

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# AAEM/RSA Members Take Capitol Hill

Megan Healy, MD  
Chair, AAEM/RSA Advocacy Committee

On September 12, AAEM/RSA members traveled to Washington, D.C., to lobby on important health care issues as part of the first ever AAEM/RSA Advocacy Day. The group met with legislative staff from six different congressional offices to garner support from both parties on topics of huge importance to the specialty of EM. Residents and students from Georgetown, Temple, and The University of Central Florida were joined by Teresa Ross, MD, Immediate Past President of RSA, and Mike Ybarra, MD, AAEM Government and National Affairs Committee Chair, for this inaugural event.

The day started with a morning roundtable session and introduction to advocacy. A panel of experienced health care advocates educated the group on timely issues including SGR reform, the creation of a federal narcotic tracking program, GME funding, and medical liability reform. The expert panel included Dr. Mike Ybarra, Dr. Leslie Zun (AAEM board member and RSA liaison), Dr. William Rogers (Medical Officer, CMS), and Ms. Terri Nally (AAEM public policy adviser).

The residents and students then spent time in both House and Senate offices discussing important pending legislation. The group implored representatives from both sides of the aisle to support H.R. 6142, the Assuring Medicare Stability and Access for Seniors Act of 2012, introduced by Michael Burgess (R-TX). This temporary measure will ensure physician payment stability through 2013, avoiding a looming 30% physician pay cut from Medicare as lawmakers try to develop a long-term solution to the SGR dilemma. The group also rallied support for another important bill, The Interstate Drug Monitoring Efficiency and Data Sharing Act (ID MEDS Act) (H.R. 4292/S. 2254), introduced by Representative Harold Rogers (R-KY). This act would establish standards to facilitate the sharing of prescription drug information between states, and therefore help combat narcotic abuse and accidental drug overdoses.

The group also expressed concern over planned pay cuts for federal GME funding, explaining the need for an increase in the cap on residency spots to alleviate the so-called "bottle-neck" and accommodate the expanding pool of medical school graduates. Cutting essential funding might otherwise force reductions in residency spots and therefore reduce patient access to medical care, especially in already underserved communities.

The residents and students were met with a warm welcome in the offices of Representatives Allyson Schwartz (D-PA), Dutch Ruppersberger (D-MD), and Daniel Webster (R-FL); as well as Senators Pat Toomey (R-PA), Bill Nelson (D-FL), and Richard Durbin (D-IL). Congressional staffers uniformly expressed the need for more physician involvement in government affairs.

AAEM/RSA hopes to expand events like this in the future to include other members of AAEM and YPS. To receive the latest information on the above legislation and other advocacy events via email, please visit the AAEM Legislative Action Center: <http://capwiz.com/aaem/home>. ■



Photo (R-L): Evan Scott, MD, Neal Shelley, MD, Bryant Lambe, MD, Megan Healy, MD, Teresa Ross, MD, Jim Miranda, MD, and Rachael Engle, DO

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## Medical Student Council President's Message

# Spotlight On Leaders in Emergency Medicine: Tom Scaletta, MD FAAEM

Interview by Mary Calderone, MS3

AAEM/RSA Medical Student Council President



*The "Spotlight On" Series re-started by Dr. Leana S. Wen, AAEM/RSA President, will be continued this year by Mary Calderone, AAEM/RSA medical student council president. The "Spotlight On" Series features interviews with leaders in emergency medicine. The seventh installment is a conversation with a leader in EM and AAEM: Dr. Tom Scaletta.*

*Dr. Scaletta is chair and medical director for Edward*

*Hospital ED in Naperville, IL, and served as AAEM's president from 2006-2008.*

### 1) What is your current position, and how did you get to it?

My first job was at San Francisco General (a county hospital/trauma center). We were a division of surgery and without our own EM residency program. I did work with many brilliant UCSF residents, watching their temporal arteries pulsate as they constructed elaborate differentials to explain a presentation of dyspnea. My job was to point out when it was time to stop talking and start intubating. SF General eventually approved an independent department of EM and started a highly-regarded EM residency program. Prior, I had moved back to Chicago to be closer to my family and became associate director of the ED at Cook County. Later, I became medical director at two high-volume community hospitals — initially West Suburban (Oak Park, IL), where we started the first EM group in the country to meet the AAEM fairness criteria — and now at Edward (Naperville, IL).

### 2) What challenges are unique to your position? What do you enjoy most about it?

Edward is a top performing ED, especially with regard to patient satisfaction. Leading is about forward thinking, problem solving, and project management. In the next five years we will be forced to greatly curtail the cost of health care through very judicious admission rates, a statistic where EPs vary widely. With this prediction in mind, I am identifying our outliers and helping them change. Consequently, I am caught between being respectful of practice autonomy and protecting job security in a future totally unforgiving of wastefulness. As an AAEM leader, I advocate for practice rights, but as a medical director, I encourage necessary change.

### 3) Tell us about your involvement in AAEM.

Getting involved in AAEM was a pivotal moment in my life. In 1996, when attending the Cook County trauma unit, a resident from the local osteopathic program explained that his program director held contracts at several inner-city, ambulance-receiving EDs where his residents moonlit alone overnight. Imagine being a junior resident tossed into a high acuity ED for \$50 a night shift in order to stay in the good graces of your program director. This was wrong on many levels — abuse of

power, inappropriate profiteering, and unqualified coverage.

I informed the president of Illinois ACEP that I wanted to do something, and he suggested writing a discussion paper. My first version included all the specifics, and a redacted version was to be sent out to board members. Inadvertently, Illinois ACEP mailed both versions. Two months later, I received a letter from a prestigious Chicago law firm representing the contract holder and threatening me with a defamation lawsuit, something not covered by malpractice or homeowners insurance. Let's just say there was a lot of explaining to do with my wife, as we had recently moved into the first house we ever bought, and she had just delivered our first baby. Incredibly, ACEP said I was on my own in sorting the issue out.

I contacted AAEM, and within 15 minutes was speaking with then President Bob McNamara. I'll never forget what he said. "Tom, this is great news! This is exactly what we're about. We can definitely help you." I was then put in contact with Joe Wood, the AAEM VP who was an MD/JD. Joe made it clear I would be OK. He emphasized that "the truth is a great defense," and that AAEM had a legal fund. I immediately joined and became progressively more involved. I went from chairing the Academic Affairs Committee to being elected to the board, and then moved all the way up to president from 2006-2008. AAEM was all about advocating for others. As president, I received a call every other week from someone unfairly treated by a contract holder and routinely engaged AAEM's resources to help.

### 4) What would you say to trainees and young EPs about why to get involved in AAEM?

AAEM is a totally authentic organization. The board facilitates EPs' ability to take great care of patients. AAEM is also agile. If you want to accomplish something within the organization, the organization will move as fast as you do. By putting in time and energy, you are rewarded by seeing the tangible benefits of your efforts. While a lot of other organizations try to shape their members and dictate what they do, AAEM is more like a piece of clay that its members can mold.

### 5) What has changed the most about emergency medicine since you entered the field?

When I started, the ED was the back door of the hospital. It served a necessary function but was not a place where growth was fostered. Later in my career, the ED became the front door for marketing since a great ED experience encourages use of other hospital services. Nationally, there are nearly two ED cases a year per five members of society. As a patient or visitor, more people are exposed to the ED than any other single hospital service. Right now, the ED is becoming the hub of the enterprise — the most important area influencing whether a



Tom Scaletta, MD  
FAAEM

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hospital fails or succeeds financially. This is why EPs must be adept at minimizing admissions and avoiding expensive tests without compromising patient safety.

#### 6) What are your specific areas of interest and why?

Patient satisfaction is my main area of interest. We are working on innovative ways to achieve high satisfaction, and I always enjoy speaking with other ED directors to share ideas. The skills necessary for an optimal patient experience are not adequately taught in residency (like empathy). In fact, some doctors are offended when their bedside manner is scrutinized. They feel satisfaction is mostly superfluous. To me, the best EPs have three primary attributes — they are fast, nice, and smart. By this, I mean they can move patients, satisfy patients, and provide high quality care. Being a great EP means connecting with the patient within two minutes, so that their trust in you persists for the next two hours. ■

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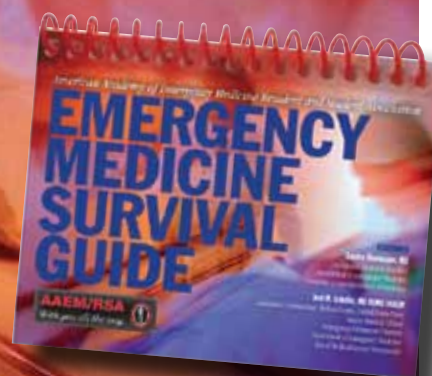
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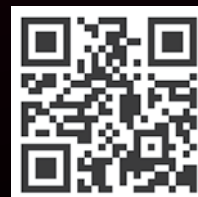
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