Editor’s forum

Welcome to the jungle!
An intern survival guide

Carson Penkava, MD, University of Alabama, Birmingham, AL, Secretary/EM Resident Editor-in-Chief

It’s that time of the year again. Around the nation, teaching hospitals become flooded with new ‘terns. As a new upper-level resident, I must say it feels pretty good to be at the top. During a trauma recess yesterday, the orthopedic intern came down for an open tib-fib on his first day of call. I could smell his fear as our famous “Trauma Mama” welcomed him to UAB in her own special way. More important than the sadistic pleasure of watching other interns squirm; however, now is a time to help our own excel. With that in mind, I offer some of my own words of wisdom.

The emergency room is your home. Luckily, it is also the most fun place in the hospital. Most days, I leave work thinking, “I can’t believe they pay me to do this!” Emergency medicine is also hard work, and you will have the occasional “Day From Hell.” Start off on the right foot by avoiding these classic pitfalls:

- **Tardiness:** The fastest way to peeve fellow residency-mates and disappoint your staff is being late. Your arrival is required for the departure of the other guy. Arrive on time, which is 15 minutes early in this profession.

- **Checkout:** Don’t ever take checkout lightly, no matter how much you like or trust the person you are relieving. Sometimes that “dispositioned” patient becomes problematic. Don’t be afraid to ask questions or to simply “start over” with the patient by doing your own focused history and physical! Your emergency room = your patient, no matter what. For instance, don’t let the patient languish there without pain meds or IV fluids.

- **Beating yourself up:** Emergency medicine is fast-paced and demanding; you will make mistakes. Yes, you. Most of the times, patients don’t die from this. Whether it is an error in an H&P, a procedure turned awkward, a film read incorrectly, or a final diagnosis that wasn’t exactly in your differential, turn your blunders into motivation to learn. Every time you reread about a disease or a procedure, you’ll pick up something new, making you less likely to miss it.

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2010 Scientific Assembly

We hope you will find the time to join us this September in Las Vegas, Nevada, for the 2010 ACEP Scientific Assembly. This is the largest gathering of emergency medicine physicians and residents in the country. Medical students interested in the specialty are also present in large numbers. Hosted by the American College of Emergency Physicians (ACEP), Scientific Assembly is known for its premier speakers, diverse topics, and the endless pearls shared by experts in the world of emergency medicine.

Every year, there are lectures and presentations geared toward emergency medicine residents and medical student enthusiasts. This year is no exception. EMRA has prepared multiple events including lectures that focus on residency and post-residency issues pertinent to your success. The following is a summary of EMRA events taking place at this year’s Scientific Assembly.

Tuesday, September 28
The day will kick off with the traditional EMRA Bloody Mary Breakfast. This hearty breakfast is an excellent way to jumpstart the day and hear what the rest of the week has in store for you. It is also a great opportunity to meet colleagues from other residency programs across the country.

This event is immediately followed by the EMRA Resident Forum. During this session, topics covered include developing leadership skills, fair business practices, contract issues, and finances. Some of the favorite sessions include Your Job Search: Identifying and Evaluating Real Opportunities, the Regional Breakouts of Job Seekers, and the free Networking Luncheon for Residents.

Later that evening, from 5:00 to 7:00pm, the EMRA Job Fair follows with more than 150 companies expected to participate this year – the largest in the nation! Find your region, community, fellowship, or academic setting of choice. Whatever your preference may be, you are bound to find the right gig, as this is the best job fair for emergency medicine physicians bar none.

And don’t forget the EMRA Public Hearing. For those that are interested in advocacy, health care issues, and organized medicine, this open forum allows EMRA members and program representatives to discuss our Representative Council resolutions before they are voted on by the Council the next day.

Wednesday, September 29
This morning begins with the annual EMRA Representative Council meeting – an event you won’t want to miss! Council meetings are your chance to participate in the governance and direction of EMRA and in the policy development for our specialty. Required for all program representatives, the day begins at 8:30am with an opportunity for you to meet and greet the candidates for the EMRA board of directors’ elections.

The Representative Council meeting convenes promptly at 9:00am beginning with liaison reports from major organizations within emergency medicine. Program representatives will then be presented with policy resolutions for deliberation and voting. The most highly anticipated event will be the annual EMRA elections, during which the candidates will first have an opportunity to address the membership. This will be your chance to select our national representatives for the next two to three years.

Whatever your preference may be, you are bound to find the right gig, as this is the best job fair for emergency medicine physicians bar none.

The EMRA Fall Awards Reception will be held later that evening from 6:00 to 7:00pm. Here, we showcase and recognize the excellent talent and achievements of those in emergency medicine. This is followed by the traditional EMRA Party – don’t miss this acclaimed event held at a local hotspot! You’ve heard the cliché . . . “What happens in Vegas stays in Vegas.” Grab your entourage, and join us for an evening in the city that doesn’t sleep!
Thursday, September 30

Standing committees meet at 10:00am and discuss ongoing projects and ways in which to expand our various educational endeavors. Each of the committees has a Chair who then reports progress to the board of directors in order to maintain a uniform plan for progress. Current standing committees include critical care, international emergency medicine, research, technology, and health policy.

Medical Student Events

Medical student events begin Saturday, September 25th with the Medical Student Governing Council (MSGC) meeting followed by the MSGC/EMIG (emergency medicine interest group) mixer.

We know that 3rd and 4th year medical students have a plethora of questions regarding their transition to an emergency medicine residency program. This is why on Sunday, September 26th, EMRA has compiled a panel of distinguished program directors, authors, and EM physicians to help you get those much needed answers. Topics include why emergency medicine, career paths in EM, getting into the residency of your choice, how to shine during residency, and interview day tips.

The medical student networking luncheon is also a phenomenal opportunity to mix and mingle with program directors in a more relaxed setting. Directors help answer questions regarding residency years and what to expect—a vital session EMRA medical student members do not want to miss.

The EMRA events at ACEP’s Scientific Assembly are specifically designed to meet the ever changing needs of residents and medical students alike in the specialty of emergency medicine. We hope you will join us to receive the valuable information we have prepared for you while meeting colleagues from around the country. As always, EMRA events are free of charge to medical students and residents. We look forward to seeing you at the 2010 Scientific Assembly which promises to be amazing!
Welcome to the jungle!
An Intern Survival Guide

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Secretary/EM Resident Editor-in-Chief

continued from cover
again. Read. A lot. Someone’s life is depending on it.

Unfortunately, as an intern, you’ll spend much of your time on off-service rotations. Some of them will make you crazy, but keep in mind you’re there for a reason. Focus on areas that will make you a better emergency physician. How might this patient present in the emergency department, and how would you manage his acute issues? Was there something other doctors missed? Every patient you round on might help you nail a diagnosis in the future, possibly saving a patient considerable time, pain, money, frustration, and disability.

During these off-service rotations, you are also serving as an ambassador for your program. Your competence and work ethic will reflect on the entire emergency medicine department. At the same time, you are making your own reputation in the hospital. Residents talk to each other. If you did a terrible job on your medicine rotation, other medicine residents will know who you are and question your admissions. Conversely, if you excelled, calling people you know from previous rotation for an admit can be fun.

When you talk to these consultants, their presentation preference will differ. Some want the formal style you learned in medical school—others want the bare bones. Remembering each person’s style is impossible. Regardless of whom I’m calling, I always try to give a selling point. For example, “I’ve got a 48-year-old, diabetic male who needs to come in for unstable angina.” Sound confident and be concise. If a consultant needs more information, he or she will ask you. Now and after residency, your reputation in the hospital will be based not just on your diagnostic ability, but also by how you present to admitting physicians.

Finally, nurses are there to help you do the best you can for your patients. Always be courteous. If nurses like you, asking them to do things will be a lot easier, and they are a lot more likely to do it quickly. If a patient asks for something simple and you are not elbow-deep in patient care, do it yourself. Nurses are impressed when they see you walking by with something like a blanket for a patient. It supports the camaraderie that makes the emergency room fun.

At the same time, you need to be respected and taken seriously. When that critical patient comes in, don’t be afraid to bark out orders and let other staff know when a patient isn’t getting the proper care. After a code or touchy patient situation is resolved, thank your nurses for their help. Everyone craves praise and recognition, and no one in the hospital may deserve it more than a nurse who has to put up with you on your first solo chest tube.

These next few years will be exciting. Every time I work with a medical student, I can’t believe how much I’ve learned in two years. Sometimes, it will be easy to lose perspective during trying times, but don’t ever forget who you are and who you want to become. Residency is a time of both personal and professional growth.
AN ABOVE AVERAGE APP
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EMRA Antibiotic Guide
by Salibad the Sinner –
Version 1.0.1 – Jan 22, 2010
“Excellent format and interface.”

Best of Class
by Sardamann –
Version 1.0.1 – March 23, 2010
“As an Infection Preventionist and a Microbiologist I find it an incredible source of information. Flow is very logical and essentials are readily available. Perfect work.”

Easier than Sanford
by Geekstrap – Update
“It’s easier to navigate and the suggestions actually seem more in line with actual practice.”

EMRA ABX GUIDE
iPhone App

Available on the App Store
or Download through your iTunes account on Apple.com
Every couple of months, you may see a “Call for Resolutions” advertisement in *EM Resident* or on the EMRA website. What does that mean, exactly? How are resolutions made? Well, resolutions are what keep EMRA going, and they come from you.

A resolution is a directive for EMRA to take a certain action or to make policy. Resolutions can be written by any EMRA member on any topic relevant to emergency medicine residents or to the specialty of emergency medicine. They can be submitted by individual members, residencies, or states.

The goal of a resolution is to assist the organization in addressing the needs of its members by directing our attention to particular areas of interest. Resolutions can be also used to change EMRA bylaws, representative council procedures, or prior adopted policies.

So, how do you write a resolution? First, identify and research an issue you feel the organization should address. Find out what has been done, and more importantly, what needs to get done. Write down the established facts relating to the topic. These will be your “Whereas” clauses, which give background information to the reader of a resolution. Basically, these clauses paint a picture of why the subject should be considered.

Whereas clauses should flow in a logical order. Statements of fact should be cited with the appropriate references. Whereas clauses are not voted upon by the Council, but they set the stage as an explanation and rationale for the resolution.

Once the facts are in place, it is time to state what you want. This statement will be your “Resolved” clause, which can either instruct EMRA to do something or propose a new policy or belief of the organization. Multiple clauses may be included in the same resolution.

These clauses are what will be debated on the Representative Council floor; be sure each makes sense when read on its own. If approved, the Resolved clause will represent the policy that is adopted, and functionally become EMRA “law.”

All resolutions must be submitted by a deadline determined by the EMRA Representative Council Procedures, typically 45 days before the upcoming Representative Council meeting. Resolutions submitted after this date may be considered as a late or emergency resolution, depending on when they are submitted. They will require an additional vote to be considered by the Representative Council.

Once submitted, resolutions are published online for all members to view. One day prior to the Representative Council meeting, the resolutions are forwarded to the Reference Committee to be discussed at their public hearing. Members of the Committee hear testimony on each resolution in an open and informal debate. The author is encouraged to attend the public hearing to answer any questions. The Reference Committee then formulates a summary of the proceedings and their recommendations.
“So, how do you write a resolution?”

The next day at the Representative Council meeting, the Reference Committee will present their recommendations. The author and the EMRA membership are again given the opportunity to offer comment on the resolution. The Representative Council will then decide one of the following: to adopt the resolution, adopt as amended, or not adopt. They may also refer the resolution to the EMRA Board, a committee, or a task force.

Whatever the outcome, authoring a resolution can be a wonderful way to get involved in EMRA. By bringing light to emergency medicine issues and resident concerns, you truly are making a contribution to our specialty at large. If you are interested in writing a resolution, it is not a tedious task. Check out www.emra.org to view samples of prior resolutions or to submit your resolution online. For additional help, contact your Council Officers, Kaedrea Jackson at speaker@emra.org, or Angela Fusaro at vicespeaker@emra.org. We look forward to hearing from you.

Get involved with EMRA’s Conference Committees

We are currently recruiting volunteers for the 2010 ACEP Scientific Assembly EMRA Representative Council Conference Committees. These committees are a great way to get involved, see how EMRA operates, and meet the board and staff. Come help us effectively run our Representative Council meeting as a member of one of the following: Reference Committee, Credentials and Tellers Committee, or Sergeant-at-Arms. Positions are for this conference only.

Contact Angela Fusaro at vicespeaker@emra.org for more details. Deadline for applications is August 30, 2010.

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Interested in advocacy?

Consider becoming the next Legislative Advisor! After three years in this post, it is time for me to step aside and invite the next leader of our advocacy efforts to step up and take the reins. At ACEP’s Scientific Assembly in Las Vegas this September, we will be electing the position of Legislative Advisor for the first time. The individual who takes the position will lead our organization’s efforts over the next two years. Think you might be interested? The details of the position are described below.

**Education**

The Legislative Advisor (LA) works to improve resident education on advocacy topics. One project is creating an interactive program for the Resident and First Timer’s Track at the ACEP Leadership and Advocacy Conference. The LA is also responsible for developing a robust online advocacy toolkit, as well as maintaining the Advocacy Lecture Series online. Additionally, the LA works to broaden the appeal of our advocacy resources to residents and make EMRA synonymous with resident education on advocacy.

**Outreach**

Working with the American College of Emergency Physicians to jointly address residents is an ongoing effort. You will work with the Washington, D.C. office of ACEP, the Federal Governmental Affairs Committee, and the Board of Directors to reach out to residents on important advocacy topics. These topics include changes to Medicare, residency realignments, and a multitude of other issues. Cooperative efforts with the Society of Academic Emergency Medicine, Council of Residency Directors, and other organizations are constantly evolving.

**Travel**

Much like the army advertises, we have exciting travel opportunities. As part of the Board of Directors, you will attend more meetings than you can imagine. With Scientific Assembly in the fall, the Board Retreat in the winter, Leadership and Advocacy in the spring, and SAEM in the summer, exotic destinations await. It is a hefty commitment as a resident, often requiring sacrifice of personal vacation and time off, but is well worth it. Without you, an important voice would be missing!

**What you make it**

Only a few leaders have held this position over the decade since its creation, and each has taken it in diverse directions. As long as the LA meets the goal of promoting our advocacy efforts, the role can be what you want it to be. Your inspiration, passions, and leadership will help guide where the next LA, in addition to the entire EMRA organization, will move. If you have the passion and the interest, get involved. Do not hesitate to contact me for more information on the position and the potential. Applications are due soon, so now is the time! ■
Don’t just do something. Stand there!

“Sir, we’ve got inbound.”
“Fine, what is it? And what’s the ETA?”
“Local National, Sir. Snake bite to the face.”
Uh-oh.

An act as innocuous as opening a sack of grain for the morning meal initiated a sequence of events that tested the boundaries of our moral obligation as human beings and the harsh realities of wartime medicine. As our nation continues to debate the basic “right” of healthcare on the political front lines, it is left to the individual physician to resolve the ethical battle on the battlefield front lines.

The case I had a few days ago was a 5-year-old, Afghan boy who was bit in the face by a Haly’s viper while opening a sack of grain. His father brought the child to the only medical facility in the area—a Marine Corps Forward Operating Base.

No antivenom was available, and although the Marine Corps medical rules of eligibility did not include the care of non-combat-related injuries, the local commander deployed his resources to scour the local markets and area for the medication. The nearest source was 150km away at a British hospital, which might as well have been back in the United States when travelling by land in this unforgiving terrain.

An air MEDEVAC was requested, but the air controller would not release the helicopters from their current missions. The patient did not meet eligibility requirements, and would take the “bird” out of place for a quick response should one of our troops be wounded.

Finally, after back and forth arguments on our communications board, one simple and straightforward statement was written in all capital letters: “THIS CHILD WILL DIE WITHIN THE HOUR IF YOU DO NOT SEND A MEDEVAC!”

I do not envy the air controller. The question was simple: do you disobey protocol or let a child die?

The helicopters were sent. As the plan developed, the little boy would be transported halfway to my location at Camp Dwyer, and the antivenom would meet him there. The field Corpsman placed a nasopharyngeal airway; upon arrival, the boy was maintaining a normal oxygen saturation without labored breathing. Marked facial swelling was noted with wounds on the upper lip and epistaxis from the NPA placement. After prying his eyelids apart, I could see the frantic eyes of a 5-year-old child looking back. A rush of questions flooded my thoughts:

Do I give the antivenom? I don’t have labs to determine his coagulation status or CBC.

What if he has an anaphylactic reaction? How do I make an epi drip from what I have?

Do I intubate? We don’t have a pediatric ventilator.

I don’t know his coagulation status. If I don’t intubate him, and he crashes mid-flight, will a cricothyrotomy be disastrously bloody?

If I use the antivenom on this child, what if a Marine, Sailor, or Soldier also gets bitten? I won’t have any left.

Let me jump to the end and tell you the little boy was ultimately intubated and later extubated after receiving the antivenom. He is eating ice cream for the first time in a nice air-conditioned hospital room. Fortunately, no one else was bitten on my watch that day.

I have sat through countless lectures related to triage in the practice of Emergency Medicine. Not a single one helped me resolve this conflict in medical planning, when I had plenty of manpower, but a very finite amount of helicopters and a life-saving medication. Each time a call for help is sent from one of the Afghans, the “what if” game still continues. Will “winning the hearts and minds” of our host nation and its people be at the expense of our own countrymen?
Android Apps

With the increasing demand for Android-powered smart phones during the past year, Google’s mobile operating system is quickly gaining market share. More than 9,000 new mobile applications were added to the app store in March of this year alone! Hopefully this trend will continue, resulting in a greater array of medical applications making their way to the Android platform.

Many of you have been wondering what applications are available for Android and which of those are useful to you as emergency medicine residents. I have selected five applications that are popular amongst the medical community and will be useful to you throughout your career.

**Skyscape**

Skyscape Medical Resources can be downloaded from the Android Market and comes bundled with three valuable resources: RxDrugs, Outlines in Clinical Medicine (OCM), and Archimedes Medical Calculator.

*RxDrugs* provides a straightforward interface for gathering pharmacologic data. You can search for a drug by typing its name into the search box. It takes at least two taps to get to the drug’s indications, dosing and pricing. This makes it time consuming if you use it more than a few times a day.

*Outlines in Clinical Medicine* contains a large database of diseases with concise descriptions of each. It is a good resource to brush up on a disease but you’ll need to turn to other resources for more in-depth information.

Skyscape is a useful resource since it also has a large number of textbooks such as *Johns Hopkins POC-IT ABX Guide*, *Harrison’s Manual of Medicine*, and *5-Minute Clinical Consult*, as well as 180 other resources. The interface as a whole, however, leaves a lot to be desired. The tapping area for a given item is much smaller than it should be for a touch screen phone (about 50 percent smaller), which can cause inadvertent taps and frequent slowdowns.

**Epocrates**

Epocrates RX Free is also available for the Android Market. It is currently in open beta mode, which means that anyone running a current version of the Android operating system can install it and use most of its functions. However, there are some performance and input issues.

Compared to Skyscape’s *RxDrugs*, Epocrates provides a simpler and faster interface for drug data, drug interactions, and pill identification. On start-up, you can choose to search for a drug by typing in its name. Once you’ve chosen a drug, you can quickly choose between dosing, contraindications, adverse reactions, pharmacology, and pricing with one tap and a swipe of the finger.

The EMRA Board of Directors recently approved funding to expand the EMRA ABx Guide to the Droid and Blackberry platforms. Look for the 2011 edition to be released later this year.
“More than 9,000 new mobile applications were added to the app store in March of this year alone!”

Another useful feature of this application is its pill identification function. This feature is helpful when a patient does not remember the name of a medication, but can readily describe it. It is invaluable in an overdose situation as well, when EMS personnel bring in a handful of pills they found on the floor.

QxMD
QxMD is a set of five calculators: cardiology, gastroenterology, hematology, nephrology, and due date/gestational age. All are available for free on the Android Market. Although you need to install each calculator separately, you can interact with all of the calculators through one interface.

This set of calculators is easier to use than Skyscape’s Archimedes because it was designed for Android powered touch screens. The tapping area for a given item is wide and as a result, is more forgiving for those of us with wider fingers.

PubMed mobile
PubMed Mobile is a free application available from the Android Market. Searches using this application are similar to PubMed website queries. Once a query has been entered, users are given a list of article abstracts that can be printed, emailed or saved for future reading. The more technologically and socially aware users can also share their searches via Twitter and Facebook.

Its inherent simplicity makes it work well every single time. You never know when it will come in handy to quickly read an abstract and impress an attending with the latest literature!

PEPID
PEPID’s ED Platinum Suite is now available for Android. Unlike the other four applications listed in this article, PEPID provides a free 14-day trial for the Suite and is discounted for EMRA members.

PEPID’s ED Platinum Suite provides a large amount of information in an intuitive format. The outline format is simple to understand and follow. There are no weird effects or interactions to distract you when browsing for that nugget of information.

The PEPID program itself provides a sidebar to the right of the screen giving users a quick view of the subsections available for that particular topic – be it pediatric vaccinations or acute otitis media. The sidebar allows users to jump to the relevant ICD-9 codes, indications, pathophysiology, and many other topics with a swipe and a tap.

One of the drawbacks of this application is that its performance lags in comparison to many other applications and routinely becomes unresponsive to taps causing you to wait unnecessarily.
By far the most dangerous foe we have to fight is apathy - indifference from whatever cause, not from a lack of knowledge, but from carelessness, from absorption in other pursuits, from a contempt bred of self satisfaction." - William Osler

Throughout the course of my term as the ACEP representative, many people have asked me why I ran for the position or why I continue to remain active in EMRA and/or ACEP. Some ask because they are curious about the spark that fuels my fire. Others ask because they want to know how to get involved. But last week, just before I left to attend the annual SAEM meeting, I was left speechless when one of my senior colleagues told me “when you look back on it, you will regret that you wasted all of your time on that stuff.”

As defined in The American Heritage Dictionary of the English Language, apathy is the “lack of interest or concern, especially regarding matters of general importance or appeal; indifference.” While many would view current issues such as health care reform, EMTALA, tort reform, or the workforce shortage as the biggest challenge the specialty of emergency medicine is facing today, I would have to respectfully disagree. Although all of these issues are certainly important, the biggest challenge facing our specialty is apathy.

Next time you are sitting in a lecture, look around at all of your peers and colleagues. How many of them belong to EMRA and ACEP? If your residency is like many around the country, chances are most or all of your fellow residents are members. But how many of them know what benefits come with their membership? Most would be able to name some of the EMRA benefits like the EMRA Antibiotic Guide, EM-RAP, and EM Resident. But how many of them can name three (or even one?) way in which ACEP has advocated on their behalf in the past year? Finally, look around again and ask yourself, “How many of these people will remain members in the first year after graduating residency?” Or the fifth year? Those numbers will certainly be far fewer.

So why do so many people not renew their membership? And why, even for those who do choose to maintain their membership, are there so many people who remain blissfully unaware of all the work that ACEP does on their behalf?

The answer to this is apathy. Though everyone’s experience is different, a large number of our colleagues remain rather apathetic in regards to some of the major issues facing our specialty today. They seem to think that it is someone else’s problem to fix for them, while they sit on the sidelines watching the game. And some, such as my senior colleague, truly just don’t care at all—failing to see any value in the time devoted to and the benefits derived from ACEP membership.

Over the past year alone, ACEP successfully lobbied to have access to emergency medical care included as an essential medical benefit in the new health care reform bill and continues working towards a permanent fix to the SGR. Given the battles around the country about balanced billing and board certification, it is hard to believe that any practicing emergency physician would find these issues trivial.

Throughout the past two years, I have devoted an endless number of hours and travelled many thousands of miles in carrying out my role as your ACEP representative. I’ve attended meetings, participated in conference calls, and lobbied on Capitol Hill. But I have never considered any of it to be a waste of my time.

And so I make this plea to you—rather than be one of the apathetic majority, be active and take a stance. Every little bit helps, and even a single voice can be enough to make a tremendous difference.

Helen Keller once said “Science may have found a cure for most evils, but it has found no remedy for the worst of them all—the apathy of human beings.” Perhaps now is the time to look even harder for the cure.
When I went into the hospital today, a new, yet familiar, sensation filled the hospital. Everywhere I looked, residents had a simultaneous look of excitement and terror in their eyes. Yes, it’s July 1st again! It’s that time of year when junior residents are promoted to senior status and medical students become brand new physicians. As I was about to start a shift in trauma and critical care, I introduced myself to the new intern who would be working with me. The first question I was asked was “The nurse asked for a Tylenol order, and I ordered two. Is that ok?”

As I enter into my fourth and last year of residency, I reflect back upon what I have learned and encountered over the past three years and about what advice I would have wanted a senior resident to impart upon me as a physician. As a brand-new intern, the realization that you are now actually responsible for the care and well-being of patients can be a very frightening, but exciting, experience. As an emergency medicine resident, we are exposed to the intimate details of illness, birth and death. The experiences I have obtained during residency have been to the extremes of exhilarating, terrifying, and irreplaceable.

Emergency medicine residents must also function within a system designed for the inpatient teams that will eventually take care of the patients. Within a large hospital system, the nuances of how to admit a patient efficiently to a particular service can take years to master. Practicing within emergency medicine also presents the challenge of caring for patients we have never met before. We must make quick decisions based on limited data; consequently, we may feel that we are practicing in a “fishbowl” and are second-guessed by our inpatient colleagues.

Since emergency medicine is a relatively new specialty, residents may feel a lack of support from hospital administration; however, this environment actually helps to create the art of emergency medicine. We are trained to quickly assess a brand new patient, determine how ill they are, and make decisions within moments. This skill separates us from other physicians.

Finally, I would impart to new physicians the importance of respecting the challenges imposed by shift work. Our colleagues in other specialties may envy this structure of fixed hours and no call. Shift work, however, presents many challenges.

Disruption of circadian rhythms may lead to chronic sleep deprivation. Shift work also creates challenges with finding time to study, taking care of personal needs, and maintaining social relationships. It is important to schedule time for yourself to maintain a well-rounded life.

As I think back about the excitement associated with starting my first year of residency, I am honestly rather nervous about starting my final year. Soon I will start working on my future after residency! I will also be responsible for supervising the new residents, which requires attention to both teaching and patient safety. Though I am excited about the year ahead, I cannot believe it’s already July 1st again!

References
**Bouncebacks!**

**A brilliant diagnosis dims**

*Editor’s Note:*
*Bouncebacks*, in which we recount scenarios of actual patients who were evaluated in and discharged from an emergency department and then “bounced back” for further treatment, will appear in every other publication of EMRA’s *EM Resident*. Articles will be based on cases from the book *Bouncebacks! Emergency Department cases: ED returns* by Michael Weinstock, Ryan Longstreth, and Greg Henry. The book begins with a unique patient safety technique and a review of bounceback literature, then presents 30 cases in a medical ‘who-dun-it’ format with case-by-case, risk-management commentary by Gregory L. Henry, past president of The American College of Emergency Physicians (ACEP) and discussions by other national EM experts (2006, Anadem Publishing). Available in the ACEP bookstore at [www.acep.org](http://www.acep.org).

**It is an honor to write a column for EMRA’s *EM Resident* and only fitting for the first column to be based on the first chapter from my book *Bouncebacks!* I will blow the surprise early; no one dies. No one loses a limb. No one loses a lawsuit. But this case demonstrates some very basic principles of diagnosis and patient safety. The documentation reproduced below is the actual chart (shortened) complete with poor grammar and punctuation errors… it is the evidence a lawyer would base his case on.

On the surface, the patient is one we see every day; an 18-year-old with a hand laceration repaired and sent home for follow-up. But is it only as it seems? Monday morning quarterbacks unite; what would you have done differently? Would you feel comfortable defending this chart if there was an adverse outcome?

**An 18-year-old male with right hand pain - initial visit**

<table>
<thead>
<tr>
<th>Time</th>
<th>Temp</th>
<th>Pulse</th>
<th>Resp</th>
<th>Syst</th>
<th>Diast</th>
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<tbody>
<tr>
<td>11:12</td>
<td>96.6</td>
<td>66</td>
<td>16</td>
<td>110</td>
<td>68</td>
</tr>
</tbody>
</table>

**History of present illness (at 11:20):**

18 year old male without a significant

PMH presents with complaints that he was messing around with some friends the night before and they were close to a brick wall and a brick was loose and came down and landed on the dorsum of his right hand over the third MCP joint. The injury occurred 15 hours prior to the ED presentation. He complains of edema and redness and a laceration. Also c/o limited movement of the finger with pain with flexion and extension. No c/o fever, chills, night sweats. No allergies. Tetanus unknown.

**Past medical history/triage**

**Medication, common allergies:** None

**PMH:** None

**PSH:** None

**Exam (at 11:23):**

**General:** Alert and oriented, no acute distress

**Ext:** 1 cm laceration over the third MCP joint on the dorsum and edema and erythema and swelling between the second and fourth metacarpal to the base of the metacarpals; even passive ROM of the third MCP causes pain with both flexion and extension

**Skin:** No red streaks

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*Michael Weinstock, MD*

Clinical Associate Professor of Emergency Medicine
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“**To obtain an accurate history in a less-than-accurate patient, use open-ended, non-judgmental questions and involve family and friends. Having a high index of suspicion for the worst scenario will allow for comprehensive care.”**
Neurovasc: Cap refill brisk. Sensation WNL

Orders/results (at 11:58): XR negative for fracture

Progress notes (at 12:45): Anesthetized with 0.5% Marcaine, prep, drape, thorough irrigation with sterile saline and explored. The extensor tendon was intact, but the tendon sheath was frayed. Cleaned again with 10% betadine solution. Two loose 4-0 ethilon sutures were placed to the skin. Ancef 1 g IM and dT. Wound dressed with polysporin, adaptic and a volar OCL splint.

Diagnosis: Right hand laceration, 15 hours old, with cellulitis

Disposition: Discharged to home ambulatory at 13:37. Rx for Keflex. Referral to a plastic surgeon to follow up in a couple of days and return to the emergency department with worsening symptoms or if unable to get in to see Plastic Surgeon.

Phone call to emergency department the next day: Complaints of swelling of the hand and fingers and pain. Has been taking Advil because he cannot afford Rx. Advised to return to the emergency department to be checked.

Discussion of documentation and risk management issues

Error #1: Believing the patient.

Discussion: The dog ate my homework… I can’t be pregnant… A brick fell on my hand… Failure to recognize a laceration over the MCP as a likely clenched fist injury (CFI)/’fight bite’ colors subsequent management. To obtain an accurate history in a less-than-accurate patient, use open-ended, non-judgmental questions and involve family and friends. Having a high index of suspicion for the worst scenario will allow for comprehensive care.

Teaching point: Nothing substitutes for an accurate history

Error #2: Failure to consider tenosynovitis or deep fascial space infection of the hand.

Discussion: The patient states the injury occurred only 15 hours prior to presentation, yet he had already developed erythema of the second through fourth metacarpals, with associated limited finger movement. The physician documented pain with passive flexion and extension of the third MCP and an associated frayed tendon sheath. The time frame presented suggests a rapidly progressing infection. The exam suggests more than simple cellulitis. Kanavel first described the four cardinal signs of flexor tenosynovitis in 1939: 1) pain on passive extension, 2) tenderness along the flexor tendon, 3) symmetric edema of the involved finger, and 4) flexed resting posture of finger'. Early in the course, a patient may not exhibit all four signs; our patient initially had at least two.

Teaching point: Deep space hand infections are high risk and must be aggressively managed.

Error #3: Primary closure of an infected wound.

Discussion: All CFIs should be left open, dressed, and splinted in position of function. CFIs have high rates of associated tenosynovitis (22%), septic arthritis (12%), and osteomyelitis (16%)'. When cellulitis or tenosynovitis is present admission for IV antibiotics and evaluation by a hand surgeon is prudent.

Teaching point: Leave CFI lacerations open to heal by secondary intention.

Error #4: Failure to prescribe the appropriate antibiotic.

Discussion: Most infected CFIs are polymicrobial, requiring both aerobic and anaerobic coverage. Staphlococcus and Streptococcus are still the two most common causes, but other bacteria, including Eikenella, may also be cultured'. This patient was prescribed Keflex (cephalexin), inadequate coverage for oral flora; Amoxicillin/clavulanic acid (Augmentin) is a better choice'.

Teaching point: Choose an antibiotic appropriate for the specific type of wound.

Error #5: Failure to address pertinent social issues.

Discussion: The patient called the emergency department the next day because he could not afford his antibiotics. A good patient disposition includes assurance that the patient can follow your recommendations. If the patient does not have means to obtain their medicine, explore other ways for treatment to occur. When there is question about follow up, returning to the emergency department is the best option.

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A brilliant diagnosis dims

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Teaching point: A brilliant diagnosis dims when the prescription is not filled.

Emergency department return visit—five days later

- **HPI:** Returned five days later with chief complaint of increased hand pain and drainage after his girlfriend kicked his wound. He had not filled his Keflex.

- **PE:** Temperature was 100.3 and he seemed “very uncomfortable,” with a grimace on his face. There was purulent drainage from the wound with extreme pain on range of motion of the metacarpophalangeal (MCP) joint and pain along the tendon.

- **ED course:** IV Unasyn (ampicillin and sulbactam) was administered and he was admitted to plastics with a tendon sheath infection vs. septic arthritis.

- **Hospital course:** Taken to the operating room the next morning and he was found to have a large extensor tendon laceration with exposed joint and pus within the joint space which cultured *Eikenella* species and *Strep viridans*, suggesting human bite wound.

**Legal perspective**

Would a plaintiff’s lawsuit win in this case? Certainly a jury would be sympathetic to a doctor who was an innocent victim to a vicious patient’s lie! Case No. CV87/002178S from New Haven, CT may shed some light:

**Allegation/cause of action:** Negligent failure to timely diagnose infection resulting in extensive scarring and permanent severe constriction of the fifth finger.

**Martin Prout vs. Robert Kerin, MD**

- 23 year-old-male plaintiff presented to Milford Hospital emergency department with complaint of contusions and lacerations to both hands resulting from an altercation the previous day. The emergency department physician determined there was no infection and recommended follow up in the orthopedist’s office the next morning

  - The next day the orthopedist diagnosed early infection in one hand, cultured the wound and started cephalexin.

  - Patient returned three days later with worse infection and was referred to a hand specialist but did not follow up as instructed.

  - Returned six days later with severe infection

  - Required surgery with resultant extensive scarring and severe constriction of 5th finger.

- **Plaintiff allegation:** The defendant deviated from the standard of care in his treatment of the plaintiff in failing to take a proper history from the patient, as a result of which the defendant was not made aware that the plaintiff had suffered a human bite to the hand. Had the plaintiff been hospitalized and treated with IV antibiotics, the damaging infection would have been prevented and pt. would be able to continue working as laborer

- **Defense:** The defendant did not make the emergency department physician aware of the mechanism of injury and did not take the antibiotic as prescribed (though alleging he did take the antibiotic, the pharmacy did not show record of defendant filling the prescription)

- **Jury verdict:** In favor of emergency department physician

**Summary of case and risk management principles**

Index of suspicion is often borne of experience, but even if the mechanism of this injury was missed, there were other opportunities to ‘get it right’ including not closing an infected wound, ensuring resources for medication, and appropriate follow up. Most importantly, all patients should know that if their injury does not improve or worsens, they should return to the emergency department for re-evaluation.

**References**

1. Kanavel AB. Infections of the Hand. 1939;17-410
A warm southern welcome

It is with great honor and excitement that I write my first article for *EM Resident* as Chair of the Medical Student Governing Council. I have been involved with EMRA for the last two years, first as a regional representative on the Medical Student Council and then as West Coordinator on the Medical Student Governing Council. I am privileged to spend yet another year working with EMRA.

First, I would like to send a big “Thank you!” to the outgoing council members, namely the outgoing chair, John Anderson (now Dr. John Anderson!) John led one of the most successful councils to date with integrity and foresight, not to mention humor. I wish John and the rest of last year’s council great success in their new adventures.

My previous experiences with the Council and EMRA have provided me the opportunity to learn incredible lessons in leadership, mentorship, and friendship. As a lost, little, first-year medical student, I was encouraged to get involved in EMRA by my mentor, Dr. Sam Luber.

Now, as I prepare to enter my fourth year, I realize that becoming involved has been an invaluable experience and opportunity that has shaped me into a better physician-to-be. I have also seen this in the many friends I have made over the years through EMRA, irrespective of the specialties they ultimately chose.

As this year’s Medical Student Council revs up, we look forward to exceeding the expectations set by previous councils. It is our continued goal to provide the outstanding opportunities available through EMRA to as many students as possible. Because of the experience I have had, I feel strongly about opening the door for any medical student looking to get involved.

From first years to fourth years, the EMRA website (www.emra.org) is a great place to start. In addition to mentorship opportunities for all, the website resources range from clinical pearls to interview tips and everything in between. I would also like to encourage medical students to contact any council member with questions or ideas. Our email addresses are available on the EMRA website under Medical Student Governing Council.

This year’s council is a talented, motivated and diverse group of medical students from all across the world; our different perspectives will ensure that student interests are well served. I look forward to working for you and with you as we take on the new adventures of this year!

*Shae Patyrak, MSIV*  
**UT Southwestern Medical School**  
**Dallas, TX**  
**Medical Student Governing Council Chair**

“Now, as I prepare to enter my fourth year, I realize that becoming involved has been an invaluable experience and opportunity that has shaped me into a better physician-to-be.”

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### Medical Student Professionalism and Service Award

One award available for each medical school OR emergency medicine residency program based on selection by school or residency program.

**Selection process**

Select one medical student per medical school or EM residency program for student who:

- gives outstanding care to patients in professional/humanistic manner;
- has active leader service to medical organizations and community;
- grades and board scores are NOT a requisite

**Submission process**

Only one nominee per medical school or EM residency program. Submit name of local award recipient to ACEP using online submission form.

**Application deadline**

October 29, 2010

**Awards**

- a certificate from ACEP
- reception at ACEP’s annual meeting
- any monetary award to be decided at the local level

**Announcement**

- publication of names in an ACEP publication.
- encourage presentation of award at your medical school’s award ceremony or graduation ceremony.
Moving on, giving back

As I was driving home from an overnight shift in the emergency department last week, I pulled to a stop behind a car with a prominently displayed bumper sticker: “If you can read this, thank a teacher,” it urged. As medical students early in the course of our careers, we tend to focus on supplementing our fund of clinical knowledge by memorizing diagnostic algorithms and physiologic pathways while learning to interpret data in the context of patient care.

With such an emphasis on the acquisition of medical knowledge, it is easy to overlook the fundamental role of more senior practitioners in providing instruction, mentorship, and guidance to the next generation of physicians. At this time of transition, when medical students enter the world of residency and residents become new attendings, it seems prudent to reflect upon the role of mentors in shaping our careers. In turn, we can take advantage of our new knowledge to provide a similar service to the next generation.

A quick disclaimer: I am far from an authority on the subjects of clinical instruction and medical advising. They are, however, areas of great personal interest. Through recent personal attempts to expand the Emergency Medicine Interest Group at my medical school, I have come to appreciate the value of strong teaching and mentorship. Herein, I’ve compiled several tips to encourage everyone in emergency medicine – from senior medical student to new attending – to become actively involved in advising and teaching the next generation of emergency medicine physicians.

1. Connect with your institution’s Emergency Medicine Interest Group (EMIG). Ideally, EMIG leaders will come to you to solicit advice or help with workshops, but it can never hurt to actively volunteer. Offer to attend a meeting to answer questions or speak about life as a senior medical student, resident, or attending. You are an invaluable source of information for students in the early stages of their training! The EMRA website has a database of EMIGs listed by state with associated contact information.

Many medical schools will also run “Careers in Medicine” specialty days, during which first-year students are introduced to the various medical specialties during one-hour-lunch sessions. These are usually staffed by senior members of the respective specialty departments.

Students will also have practical questions about the current training experience, which are most appropriately addressed by residents and younger attendings. Consider speaking with the head of your department about the possibility of contributing to these sessions, generally held in the early fall.

2. Run a Skills Workshop or lead a Journal Club. After countless hours spent in lecture, students are enthralled at the prospect of learning basic procedural skills! IV insertions, blood draws, splinting, and suturing are all exciting and practical skills to have. Many EMIGs organize regular procedural workshops, but often struggle to identify faculty or residents to run the sessions. This is a wonderful opportunity not only to teach essential skill, but also to interact with students and to discuss EM in a casual setting.

Similarly, Journal Clubs are the perfect venue for informal interaction between
backcountry emergency medicine

Imagine your emergency department. See all the nurses, physician assistants, and respiratory technicians; imagine the CT scanner down the hall, your portable ultrasound machine, the 24-hour lab, the trauma bay, and the ambulance bay and waiting room filled to the brim. Now, get rid of the waiting room and ambulance bay, forget about the support staff, stash away the ultrasound machine and CT scanner, turn the volume way down, and push aside the trauma bay; in fact, let’s dissolve away all the walls. Oh yeah, all those meds? You get to keep about 25.

From all that is left, pick out your “essentials” and bring them to the Talkeetna airport in central Alaska to load on a plane bound for the Denali base camp. Or bring it on your row raft on the Colorado River. Or stick it in the lid of your pack before putting on your snowshoes and heading out on a traverse of the White Mountains in New Hampshire.

Wilderness medicine is the field of medicine that focuses on the prevention, diagnosis, and management of illnesses in the wilderness setting. What excites so many people about wilderness medicine is the challenge of managing patients without many of the tools available in the ED. This requires specific knowledge, a particular set of skills, and creativity. Perhaps what makes wilderness medicine most attractive is the setting: mountains, rivers, oceans, glaciers, caves, rainforests, and deserts.

The types of injuries and illnesses encountered in wilderness settings vary depending on location and activity. Expedition physicians on Everest see different pathology than scuba diving guides in Australia. The most common conditions encountered in the wilderness include water and insect-borne infections, musculoskeletal injuries, dehydration, blisters, hyper/hypothermia, lacerations and abrasions, burns, contact dermatitis, and bites/stings. While many conditions can be easily managed in the backcountry, others—including serious altitude illnesses, significant trauma or
Backcountry emergency medicine

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hemorrhage, anaphylactic reactions, and cardiac events—require emergent evacuation.

Back to your expedition on Denali. One of the climbers starts complaining of headache, difficulty sleeping, and nausea. What’s on your differential? Do you recommend they continue, stay put, or return to Talkeetna? On another expedition, a river guide develops severe diarrhea. You start IV fluids, but what’s next? Your snowshoeing partner falls and complains of leg pain. What’s your plan? Did you pack the right supplies?

What exactly are you supposed to pack when you go on your adventure? Of course, it depends on your setting, but duct tape seems to be an item that some consider indispensable. If you have blisters, just cover them with duct tape. If you need to fasten together a splint, you can use duct tape. Hungry? Duct tape!

While opinions vary, a 1997 article published in Wilderness and Environmental Medicine provided data-driven recommendations for first-aid kit contents for the typical hiking trip, including:

**Dressings and wound care**
- Adhesive bandages (12)
- 2-inch adhesive tape (2 rolls)
- Conforming gauze bandages (2 rolls)
- Elastic bandage (1 wrap)
- Moleskin (two 15.5-square inch sheets)
- Second Skin (4 pads)
- Sterile gauze compresses (6)

**Equipment**
- Scissors (1 pair)
- Thermometer (1)
- Tweezers (1 set)

**Oral OTC preparations**
- Antacid (6 chewable tabs)
- Diphenhydramine (6 tabs)
- Bismuth subsalicylate (6 chewable tabs)
- Ibuprofen (6 tabs)

**Topical OTC preparations**
- Alcohol swabs (10)
- Antibiotic ointment (6 packets)
- Hydrocortisone (one 30-g tube)
- Providone /iodine solution (8 individual swabs)
- Tincture of benzoin (one 30-ml bottle)

If you find this intriguing, there are numerous ways for medical students to get involved in wilderness medicine. Become a member of the Wilderness Medical Society and attend a conference. Start or join a wilderness medicine interest group. Get involved in wilderness medicine research or organize a wilderness medicine trip at your school.

Some students have even had the opportunity to join mountaineering expeditions on Denali, join National Geographic treks in the Amazon, and teach wilderness medicine courses. After residency, you can pursue further training as a fellow in one of the many wilderness medicine fellowship programs across the country.

Whether you prefer backpacking, scuba diving, skiing, spelunking or climbing, or if you just enjoy being outside, wilderness medicine is a fun and exciting field. So get out there and enjoy the wilderness, but be sure to pack your first-aid kit with the right stuff, keeping in mind the nature of your adventure. Happy trails!

**References**
The United States becomes more and more culturally and ethnically diverse every day. Accordingly, we are seeing more multilingual patients in the nation’s emergency departments. While some cities have always housed substantial language minorities, for much of the US, language barriers present a new and unforeseen challenge. As the de facto front door of the hospital for many patients, the emergency department naturally bears the brunt of the burden of multilingual communication.

In the hustle and bustle of the emergency department, physicians, students, and staff alike often forget that Limited English Proficiency (LEP) patients have a legal right to communicate and to be heard in the language that is most appropriate for them.

Failing to offer suitable communication through interpreter services or fully bilingual staff is considered equivalent to discrimination, is a violation of Title VI of the Civil Rights Act, and has resulted in patient deaths and litigation. To comply with Title VI, hospitals have employed a variety of services ranging from the in-person medical interpreter (the gold standard) to remote telephone interpretation.

A new nationwide certification system is gradually being phased in to promote the professionalization of the field of medical interpreting. Meanwhile, many hospitals are offering linguistic competency tests for staff who wish to communicate with patients in languages other than English. If you speak another language, you should check with your hospital’s interpreter program to determine whether you should take a competency test.

Technology has been rapidly developed to assist staff in the emergency department, where time pressures make waiting for an in-person interpreter impractical. At the Massachusetts General Hospital (MGH) emergency department, new Interpreter Phone on a Pole (IPOP) devices have recently been implemented to reduce these delays. The IPOP—a conference speakerphone mounted on a portable IV pole—eliminates the problem of passing telephone handsets between users and allows the provider and patient to look at each other during the encounter. It is advantageous in the emergency department to watch a patient’s grimace or body language, which might provide clues to the diagnosis.

“The IPOP is absolutely crucial and also convenient when an interpreter is not available, and in particular for languages that we don’t see commonly in the emergency department,” observes Christopher LeMaster, MD, PGY4 at MGH. While less than three years old, the IPOP is set to become antiquated soon as portable video-conferencing devices become available, finally making instant face-to-face contact among provider, patient, and interpreter a reality.

How can you make a positive difference for your LEP patients? If you see a patient who is struggling to communicate in English, seems to be only nodding or saying “yes” in response to questions, or is speaking through a family member, make sure that the patient has been offered an interpreter. When there is a language barrier, don’t hesitate to use your emergency department’s telephone interpretation service to quickly ask questions in the patient’s language.

Do not count on an untrained staff member to interpret for you and don’t assume that your attending or other emergency department staff has already offered the patient an interpreter. Make sure to document the interpreter’s name or employee number in the medical record, even for phone interpretation. Patients may opt to communicate in broken English or through a family member, but they should at least be offered the option of an interpreter. Providing appropriate language services will protect you and your hospital from legal challenges and will help safeguard your patient’s life!
Revering research

The most important achievement of our residency training is the proficiency in our chosen profession – attained through study, skill development, practical clinical work, and the caring guidance of our counselors, professors, and mentors. For some of us, these years gave life to a nascent interest in research. For others, the intensive training, both grueling and rewarding, has led to an everyday opportunity to improve (and many times, save) the lives of others. The knowledge in our brains, the skill in our hands, and everything we will accomplish in our individual practices all stand firmly on the foundation of those who came before us.

Where would our specialty be without the foundational training that came, not just from one predecessor, but from many. So much of what we do depends on the trailblazers, the inventors, and the diligent souls who carefully gathered the evidence and then, just as carefully, recorded it for the benefit of those who would follow. They wrote it down with wonder, recognizing the value that information held. They wrote it down with courage, knowing it would be challenged, modified, and re-written as new and better evidence was discovered.

Without research, we stagnate. Even more importantly, our patient suffers…not just from what we fail to do, but also from what we do unnecessarily. The undeniable truth is that, in a time-sensitive endeavor such as emergency medicine, research is not only pure bench science or applied knowledge translation, but also health services and health policy research. What this research uncovers may be interesting, and even exciting, to the researcher, but to the patient in need of immediate and critical care, it can be a lifesaver.

Do we need lights and sirens? Does boarding kill, and if so, how often? Does the four-hour-antibiotic rule for pneumonia really matter? Can that four-hour rule harm those who have to be moved further back in the queue? Is medical liability (both claims and insurance costs), eating up precious dollars that could be better spent protecting patients in another manner? Was it misinformation or ignorance that led politicians to believe (falsely as it turns out) that the uninsured use the emergency department more than the insured?

Will gathering the data and publishing the effects of changes in health services (e.g., Massachusetts Health Care Reform legislation) prove that coverage does not necessarily equal access?

Emergency medicine is at the confluence of the immense challenges faced by both medicine and society. We need the evidence – the research to do the best for our patients – to add credibility to what seems obvious to us. This research depends on your investment in the process of crafting the right questions and in translating the knowledge gained into actionable answers. Your future, and that of your patients, depends on the successful outcome of this effort.

We know that in less than 50 years, emergency medicine has evolved from primitive beginnings into a modern specialty. Research proves our point and assures our place as a valuable profession in the struggle to mitigate pain and illness. Research allows us to use our present activities to directly craft a better future. EMRA and research are natural partners, for both have their hopes and dreams inexorably linked to improved emergency health care for all.

Let’s keep the fire in our gut and place our bets on the future. Every dollar that you contribute to the Emergency Medicine Foundation makes a difference, and thanks to the coverage by ACEP of all administrative costs, every cent you contribute goes directly into research. On behalf of the Emergency Medicine Foundation and all of the current and future beneficiaries of your generosity, I thank you.
Congratulations to the 2010-2011 EMF/EMRA Resident Research Grant Awardees
(All grants are $5,000)

Brian Roberts, MD
Mentor: Stephen Trzeciak, MD, MPH
Cooper Health
Therapeutic Hypothermia and Vasopressor Dependency after Cardiac Arrest

Arjun Venkatesh, MD
Mentor: Jeremiah Schuur, MD
Harvard Medical School
The Impact of Observation Care on Preventable Admissions and ED Revisitation

Melinda Morton, MD
Mentor: Richard Rothman, MD, PhD
Johns Hopkins Department of Emergency Medicine
Clinical Decision Guidelines for Mild Traumatic Brain Injury: Current Practice and Obstacles to Implementation (A Pilot Study)

Margaret Samuels-Kalow
Mentor: Stephen Porter, MD, MPH
Brigham and Women’s Hospital
Discharge and Care Outcomes

Stacey House, MD, PhD
Mentor: David Ornitz, MD, PhD
Washington University, St. Louis
Role of Heparins on the In Vivo Bioavailability and Cardioprotective Properties of Human Recombinant Fibroblast Growth Factor 2: Development of a Novel Therapeutic for Acute Myocardial Infarction

Call for Proposals
The 2011-2012 Grant Cycle will be posted on EMF’s website in August 2010!

EMF/EMRA Resident Research Grants-Up to 3 will be awarded

NEW!
EMF/Medical Toxicology Foundation Resident Research Grant
One grant with an emphasis on toxicology will be awarded

www.emfoundation.org
(800) 798-1822 x3216
Going independent? – Get the tax facts!

I often find myself advising independent contractors (IC) after the fact. Many physicians accept positions as ICs and then try to figure out what it means. Following are the pertinent considerations for the most common types of IC practices. Please note that this article contains brief guidelines only and you should always discuss your individual situation with your tax, legal, and financial council.

Types of Practice
The three types of entities most common for Independent Contractors are
- Sole proprietorship (or Single-member LLC)
- S-corporation
- C-corporation

Taxes
Sole Proprietorship or Single Member LLC
Pros
- Simplicity of record keeping compared to other entities
  - Reduced payroll tax filings
  - Reduced income tax filing requirements
- Can employ spouse full-time to provide legitimate services to entity. Combined medical insurance premiums can be deducted which reduces both income tax and self-employment tax.

Cons
- All net income from entity is subject to FICA and Medicare tax (self employment tax).
- Slight increase in exposure to audit by the IRS. This is because the IRS has additional agents available to examine individual returns compared to the agents available to audit business returns.
- There is no tax withholding, so you will be required to pay quarterly estimated taxes. This will require closer monitoring to avoid underpayment penalties.

S-Corporation
Pros
- Payments to the physician as dividend distributions are NOT subject to FICA/Medicare tax. Payments paid to an employee–shareholder as wages ARE subject to FICA/Medicare taxes. With careful planning and consideration of reasonable compensation to the physician, this structure can be utilized to reduce FICA/Medicare taxes.
- Employer-paid retirement plan contributions and health insurance are a company benefit and not subject to FICA and Medicare tax.

Cons
- Must monitor reasonable compensation throughout year.
- Requires payroll tax filing for the physician and a separate income tax return to report the business income.

“The type of entity that you choose can impact your flexibility to deduct benefit plans, make retirement contributions, and protect your income through disability insurance.”
These added compliance costs may outweigh the potential tax savings.

- W-2 compensation paid to the physician is subject to Federal and state (if applicable) unemployment taxes.

**C-Corporation**

*Pro*
- The physician is eligible to participate in benefits such as health insurance, flexible spending, and medical reimbursement plans to pay for out-of-pocket medical expenses.
- Employer-paid retirement plan contributions and health insurance are a company benefit and not subject to FICA and Medicare tax.

*Cons*
- Has the same cons about payroll tax filing and W-2 compensation as an S-Corporation.
- Entity is considered a personal service corporation and any net income left in the corporation is subject to a flat 35 percent federal tax rate.
- Possible double taxation of income. This occurs when the net income of the company is subject to tax at the corporate level and then later paid as a dividend to the shareholder-owner. The shareholder will be subject to income tax on the dividend.
- Generally requires more attention and planning at the year-end in order to zero out corporate taxable income.

**Strategies**

1. Practicing as an independent contractor offers many opportunities. Consider establishing a SEP or solo-401(k) and defer up to $49,000 to your retirement, pre-tax. If your spouse is an eligible employee, you may be able to defer $98,000 between the two of you in a solo 401(k). If you need additional tax deferral, establish a defined benefit or other supplemental retirement plan, likely accommodating as much money as you can afford to defer!

2. Take advantage of employer-funded cash programs, currently paying 5.05 percent.

3. Talk to your CPA about the pending tax increases. Consider changing your practice structure now if it will reduce your future tax liability.

4. Retain a bookkeeper or CPA to establish proper accounting records via QuickBooks, the business accounting software. Establish a business checking account and business credit card so that all expenses can be accurately accounted for maximizing deductions!

The type of entity that you choose can impact your flexibility to deduct benefit plans, make retirement contributions, and protect your income through disability insurance. I encourage you to develop an advisory team of financial, tax, and legal professionals. This team can advise you how to properly set up your practice so that you can make the most of the time and money that you invest in your career.

Shayne Ruffing, CLU, ChFC, AEP is the creator of the Confident Transition Plan™ for medical residents, the Physician Disability Income Analyzer™ and the Physician’s Financial Navigator™. Shayne specializes in executive benefit planning for physicians and medical practices. He can be reached at 800.225.7174, or via e-mail at shayne@mybpginc.com or on the web at www.IntegratedWealthCare.com. Shayne is a Financial Advisor offering Securities and Advisory Services through NFP Securities, Inc., a Broker/Dealer, Member FINRA/SIPC and Federally Registered Investment Advisor. The Benefit Planning Group is not an affiliate of NFP Securities, Inc.
An uncommon cause of chest pain during pregnancy

Case

A 19-year-old, G1P0 female at 36 weeks gestation presents to the emergency department complaining of substernal chest pain. She reports that the pain has been worsening over the last few days, with mild shortness of breath, and denies any pain radiation. The patient reports that she experiences a pressure sensation directly beneath her sternum, which is relieved slightly by sitting forward in bed. Review of systems elicits no recent illnesses, fever, chills, nausea, vomiting or diarrhea. She reports a benign gestational course to this point. There is no significant past medical history, medications, or allergies.

On examination, the patient is alert and oriented, in mild distress. Vitals are as follows: temperature of 98.9 F, heart rate 108 bpm, blood pressure of 110/72, respiratory rate 18, and oxygen saturation of 99 percent on room air. Lungs are clear to auscultation bilaterally with no apparent wheezes, rhonchi, or rales. Cardiac exam reveals a regular rate and rhythm with no extra heart sounds. No distal edema or jugular venous distention is present. The remainder of the exam was unremarkable.

Laboratory data, including CBC, BMP, and troponin, were all within normal limits. EKG showed a sinus tachycardia with no ST or T wave abnormalities. Chest X-ray showed a slightly large cardiac silhouette with no airspace disease. D dimer was elevated at 456. CT angio of the chest showed no evidence of PE, but did show an enlarged heart with some evidence of pericardial effusion.

Discussion

Peripartum cardiomyopathy (PPCM) is an important cause of maternal morbidity and mortality in the peripartum period. Little is known about this uncommon pathology. Even so, early recognition of this disease is important for initiation of treatment and optimum outcome for both mother and fetus.1

The cause of PPCM is poorly understood, and there are several theories that attempt to describe it. Overall, there appears to be more evidence supporting an infectious or autoimmune etiology.2 Viral myocarditis has been implicated in PPCM; however, studies using endocardial biopsy to confirm myocarditis have been inconsistent. Rates of biopsy-proven myocarditis in patients with PPCM have ranged from 76.6 percent to as low as 8.8 percent, which is consistent with the expected baseline incidence in the background population.3,4 Other less supported theories include maladaptive changes to the physiologic changes of pregnancy, as well as environmental and genetic factors.

Peripartum cardiomyopathy is relatively uncommon in the United States, and quantifying its incidence has been difficult. It occurs in one out of 3000 to 4000 live births, though the incidence varies in other parts of the globe, lower in Europe and higher in parts of Africa.5

Risk factors include advanced maternal age, hypertension, multiple gestational pregnancies and history of eclampsia. Race and multiparity had previously been regarded as risk factors, though recent research has called this into question.6
By definition, PPCM is the rapid development of congestive heart failure in the last month of pregnancy, or within five months following delivery, with absence of cardiac disease prior to the last month of pregnancy.5

Diagnosing PPCM can be difficult, as symptoms of heart failure, such as shortness of breath, lower extremity edema, and fatigue are common symptoms in a normal, third-trimester pregnancy. Severe symptoms such as orthopnea, chest pain, jugular venous distension, or evidence of pulmonary edema should raise a physician’s index of suspicion of heart failure.

Of course, other causes of chest pain and shortness of breath, such as pulmonary embolism, should be ruled out. Ultimately, the diagnosis is one of exclusion supported by finding echocardiographic evidence of left ventricular dysfunction.

Treatment of PPCM, like treatment of other causes of congestive heart failure, centers on volume control via salt restriction and diuretics and blood pressure control. In pregnant patients, delivery of the fetus will ultimately decrease the stress on the heart.7

Hydralazine is generally the first line agent for blood pressure. Amlodipine has been shown to be beneficial in other forms of CHF and can be used in PPCM as well. ACE inhibitors should be avoided until the post-partum period because of the possibility of teratogenicity.

For acute failure, vasodilators, such as nitroglycerin, can be used. Use caution with nitroprusside, as toxic metabolites can accumulate in the fetus. Inotropes such as dobutamine may be useful acutely; digoxin may be useful as outpatient therapy.

Patients with PPCM appear to be at increased risk of thromboembolic disease and may benefit from anticoagulation with heparin.2 In severe cases, positive pressure ventilation, invasive monitoring, and admission to the ICU may be warranted. In the most severe cases, left ventricular assist devices and even cardiac transplantation may be indicated. In all cases, there should be a team approach to treatment, involving cardiology, obstetrics, and perinatology.5

The prognosis for patients with PPCM depends on the extent of recovery of left ventricular function. About 50 percent of women have LV function return to baseline within six months.5 In a few small studies, those women who had persistent LV dysfunction had much higher cardiac mortality rates, as high as 85 percent over five years.

It appears that even in those who have full recovery, patients may have abnormalities on stress testing and may have decreased exercise tolerance.8 Whether or not women should attempt subsequent pregnancies is currently debated.5 There is concern of recurrence and worsening LV function, and women should be carefully counseled regarding the risk in future pregnancies.

Case conclusion

In our patient, echocardiography revealed dilated cardiomyopathy with an ejection fraction of 20-25 percent consistent with peripartum cardiomyopathy. The patient went on to have a cesarean section the next day. After surgery, the patient required pressor support and was placed in the ICU. She is currently undergoing evaluation for heart transplant.

References
The authors of this study have created and validated a rule identifying children at very low risk of clinically important traumatic brain injury (ciTBI) and propose an algorithm for the management of pediatric blunt head trauma patients.

Need for this study
This study may help to avoid unnecessary neuroimaging in pediatric head trauma patients at low risk for ciTBI, thereby reducing the risk of malignancy and other radiation-induced complications.

Methodology
- **Definition of ciTBI**: TBI either demonstrated on CT imaging, necessitating neurosurgical intervention, requiring intubation greater than 24 hours, or causing death
- **Study Type**: prospective, cohort study
- **Study Population**: patients < 18 years old, enrolled at 25 Pediatric Emergency Care Applied Research Network (PECARN) research sites in the United States (June 2004 – September 2006)
  - Derivation Phase (33,785 patients) => 8,502 pts < 2 years old; 25,283 pts ≥ 2 years old
  - Validation Phase (8,627 patients) => 2,216 pts < 2 years old; 6,411 pts ≥ 2 years old
- **Inclusion Criteria**: children with head trauma presenting within 24 hours of injury
- **Exclusion Criteria**: trivial injuries, penetrating trauma, GCS ≤ 13, coagulopathy, pre-existing neurological conditions, brain malignancies, neuroimaging studies from other facilities

Study findings
The authors enrolled 77% of eligible patients. Of these eligible patients, exclusions were: 2.2% (GCS 3-13), 0.8% (coagulopathy), 0.2% (presence of shunt), and 0.2% (missing GCS or primary outcome). The rate of ciTBI was 0.85% in the derivation group and 1.0% in the validation group.

From the derivation group, the authors identified six distinct, yet overlapping, prediction criteria for ciTBI in patients < 2yo and patients ≥ 2yo (Table 1). These criteria were entirely absent in 53.1% (< 2yo) and 59.3% (≥ 2yo) of patients in the validation group. These patients constituted the “very low risk of ciTBI” group.

Assessment of the presence of any of these criteria in the validation phase, removing them from the very low risk group, yielded 100% sensitivity and 53.7% specificity for ciTBI in patients < 2 yo (NPV=99.9%). For children ≥ 2yo, the sensitivity and specificity were 96.8% and 59.8%, respectively (NPV=99.95%).

The two patients missed in the validation phase were both ≥ 2yo with non-helmeted sports injuries (bicycling and inline skating). Both patients complained of moderate headache and had large frontal scalp hematomas. One patient had a small frontal subdural hematoma and the other required admission for two nights. Both patients survived and neither required neurosurgical intervention.

Author’s conclusions
CT scans of the head should not be performed on children meeting the defined inclusion criteria. This may help to avoid the complications of ionizing radiation in a vulnerable patient population.
**Limitations**

As CT scans were not obtained in all patients, comparison to CT findings is difficult. However, a more relevant endpoint—ciTBI—was chosen. The derived sensitivities and NPV were high, but were not 100% in all groups. The authors note that the CT utilization rates in this study were significantly lower than reported national averages, which may translate to even greater reductions in CT utilization in the community ED as a result of application of this decision tool.

While the authors did validate the decision tool (Table 1), the suggested algorithm for management of these patients (Table 2) was not validated in this study. Finally, the authors present no data and make no claims about the risk / benefit ratio of head CT to avoid delayed malignancy in children.

**How this study could change clinical practice**

This work identifies a large population of pediatric blunt head trauma patients for whom head CT should be avoided.

Application of this decision tool may increase ED flow rates and reduce the risk of delayed malignancy secondary to ionizing radiation in this population.

**Table 1. Derived and validated criteria for assessment of risk of ciTBI**

<table>
<thead>
<tr>
<th>Age &lt; 2 (preverbal)</th>
<th>Age ≥ 2 (verbal)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Altered Mental Status</td>
<td>Altered Mental Status</td>
</tr>
<tr>
<td>Loss of consciousness</td>
<td>Loss of consciousness</td>
</tr>
<tr>
<td>Severe Mechanism of Injury</td>
<td>Severe Mechanism of Injury</td>
</tr>
<tr>
<td>Palpable skull fracture</td>
<td>Signs of basilar fracture</td>
</tr>
<tr>
<td>Scalp Hematoma (other than frontal)</td>
<td>Severe headache</td>
</tr>
<tr>
<td>Acting abnormally per parent</td>
<td>History of vomiting</td>
</tr>
</tbody>
</table>

*Absence of all factors makes patient “very low risk” for ciTBI*

**Table 2. Algorithm for management of pediatric patients with ciTBI**

<table>
<thead>
<tr>
<th>Clinical Predictors</th>
<th>Age &lt; 2 years old</th>
<th>Age ≥ 2 years old</th>
<th>CT</th>
<th>Obs.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mechanism of injury</td>
<td>Severe</td>
<td>Severe</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Mental Status</td>
<td>GCS ≤ 14</td>
<td>GCS ≤ 14</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>signs of AMS</td>
<td>signs of AMS</td>
<td></td>
<td>Yes</td>
<td>maybe yes</td>
</tr>
<tr>
<td>not acting right per parents</td>
<td>LOC ≥ 5 seconds</td>
<td>History of LOC</td>
<td>maybe</td>
<td>Yes</td>
</tr>
<tr>
<td>Skull fracture</td>
<td>Palpable skull fracture</td>
<td>Signs of basilar skull fracture</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Scalp hematoma</td>
<td>Occipital or parietal or temporal scalp hematoma</td>
<td>N/A</td>
<td>maybe</td>
<td>Yes</td>
</tr>
<tr>
<td>Vomiting</td>
<td>N/A</td>
<td>History of vomiting</td>
<td>maybe</td>
<td>Yes</td>
</tr>
<tr>
<td>Headache</td>
<td>N/A</td>
<td>Severe</td>
<td>maybe</td>
<td>Yes</td>
</tr>
<tr>
<td>Risk of ciTBI (if none present)</td>
<td>&lt; 0.02%</td>
<td>&lt;0.05%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NPV (if none present)</td>
<td>100%</td>
<td>98.4%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Signs of AMS include agitation, somnolence, repetitive questioning, or slow response to verbal communication.

Severe mechanism of injury: MVC with ejection, death of another passenger, or rollover; pedestrian or bicyclist without helmet struck by motorized vehicle, falls of >5 ft (5ft for age < 2), or head struck by a high-impact object.
Phoenix Highlights

University of Alabama at Birmingham captures the Jeopardy title for the second year running!

Left to right: Edwin Lopez, MD; Charles Nunez, MD; Nick Vetrano, MD; Jim McClester, MD; and Todd Guth, MD.

Lehigh Valley Health Network
Left to right: Christine Whylings, DO; Deepak Jayant, DO; and Julie Wachtel, DO.

Synergy Medical Education Alliance
Left to right: William Bishop, MD; Dilnas Panjwani, MD; and Kristy Smith, MD

University of Chicago Medical Center
Left to right: Sabina Modelska, DO; Erin Nasrallah, MD; and Lauren Alexander, MD

Maricopa Medical Center
Left to right: Erin Kelly, MD; Rachel Leviton, MD; and Kyle McCarty, MD

Washington University in St. Louis School of Medicine
Left to right: Rebecca Bavolek, MD; Matthew Treaster, MD; and Stacy House, MD

We’ll take famous physicians for 200...
SAEM Annual Meeting...

EMRA SIM Wars

Champions

UNIVERSITY OF CALIFORNIA
SAN FRANCISCO-SFGH
Program Director: Susan B Promes, MD, FACEP
Participants: Caitlin Bilotti, MD; Marianne Juarez, MD; and Eric Silman, MD

Left to right: Sabina Modelska, DO; Erin Nasrallah, MD; and Lauren Alexander, MD

Left to right: Sabina Modelska, DO; Erin Nasrallah, MD; and Lauren Alexander, MD

University of Chicago, IL
Program Director: David S Howes, MD, FACEP
Participants: James Ahn, MD; Erin Nasrallah, MD; and Eric Beck, DO

Carolinas Medical Center, NC
Program Director: E Parker Hays, Jr, MD, FACEP
Participants: Dustin Callhoun, MD; Whitney Cabey, MD; and Patrick Burnside, MD

Mount Sinai School of Medicine, NY
Program Director: Peter Shearer, MD, FACEP
Participants: Scott Goldberg, MD; Seth Trueger, MD; and Brad Green, MD

Drexel University College of Medicine, PA
Program Director: Edward A Ramoska, MD MPH FACEP
Participants: Heidi Baer, MD; Matthew Jones, MD; and J. Hopkins, DO

Detroit Receiving Hospital – Wayne State University, MI
Program Director: Robert P Wahl, MD, FACEP
Participants: Devon Moore, MD; Robert Klever, MD; and Marjan Siadat, MD

HealthPartners – Regions Hospital, MN
Program Director: Felix K Ankel, MD, FACEP
Participants: Kate Graham, MD; Bjorn Peterson, MD; and Nate Curr, MD
EM reflections

EMRA Spring Award Winners

Assistant Residency Director of the Year recipient: Albert B. Fiorello, MD, FACEP, University of Arizona.

Research Grant recipient Ben Cloyd, University of Nebraska School of Medicine (left) and Edwin Lopez, MD, EMRA President (right).

Residency Director of the Year recipient: Douglas Mark Char, MD, FACEP, Washington University in St. Louis School of Medicine.

Residency Coordinator of the Year recipient (left): Sherrill Mullenix, Christiana Care. Dedication Award recipient (right): Julie M. Sullivan, MD, Christiana Care.

Dr. Alexandra Greene Medical Student Award recipient: Claire E. Broton, SUNY Upstate Medical University.

Research Grant recipient: Thomas Gilmore, Drexel University College of Medicine (right) and Edwin Lopez, MD, EMRA President (left).
Call for 2010 EMRA Fall Award Nominations

It’s time to nominate yourself or a colleague for an EMRA Award. Visit the website for application instructions. Deadline for submission is **August 15**. Awards will be presented at the **EMRA Award Reception** during **Scientific Assembly** in Las Vegas, NV, September 29, 2010.

- **Augustine D’Orta Award**: Bestowed upon a resident physician who demonstrates outstanding community-minded, grass-roots oriented political involvement in health policy or community issues.

- **Excellence in Teaching Award**: Given to an outstanding faculty member who has served as a unique role model for residents.

- **Joseph F. Waeckerle Founder’s Award**: Honoring a physician who has made an extra-ordinary, lasting contribution to the success of EMRA.

- **Clinical Excellence Award**: Recognizes a resident who has done outstanding work in the clinical aspect of emergency medicine.

- **Local Action Grant**: Promoting the involvement of emergency medicine residents in community service and other activities that supports the specialty of emergency medicine.

- **EMRA Mentorship Award**: This award recognizes an EMRA alumnus who has demonstrated exceptional service as a mentor for medical students and/or residents in Emergency Medicine. The dedicated recipient is an outstanding role model for future emergency physicians.

- **Leadership Excellence Award**: Presented to a resident who has demonstrated outstanding leadership ability.

- **EMRA Travel Scholarship to Scientific Assembly**: These $500 scholarships assist a resident or student member of EMRA in the costs associated with attendance of Scientific Assembly. Up to three applicants may be chosen based on financial need and academic pursuit.

**EMRA Fall Elections**

EMRA Elections will be held during ACEP Scientific Assembly in Las Vegas, Nevada, September 29, 2010 for the following positions:

- **President-Elect**: Candidates for President-Elect must make a three-year commitment to EMRA. The first year serving as President-Elect. The second year in the term is as the President. The third and final year is spent as Immediate Past President/Treasurer.

- **Vice Speaker of the Representative Council**: This two-year term with the first year serving as Vice Speaker and the second as Speaker, assists Speaker as Parliamentarian for the Representative Council, acts as director of all Representative Council taskforces, and is the EMRA Delegate to the AMA Resident and Fellows Section at the annual and interim AMA meetings.

- **Legislative Advisor**: Candidates for Legislative Advisor must make a two-year commitment to EMRA. Position is responsible for coordinating and running the Residents and First-Timers Track at ACEP Leadership and Advocacy Conference, generating and updating the *EMRA Emergency Medicine Advocacy Handbook*, as well as helping foster resident advocacy.

- **ACEP Representative**: This two-year position requires significant travel and interaction with a number of leaders in emergency medicine. In addition to the regular duties of an EMRA Board member, you will attend all ACEP Board of Directors meetings, serve on the ACEP Steering Committee, and be primary liaison with EMRA Representatives serving on ACEP Committees.

- **Member-at-Large**: This Board of Directors position serves as a two-year term and is the EMRA liaison to the American Board of Emergency Medicine (ABEM), works with the Academic Affairs Rep to organize the EMRA National EM Jeopardy Contest, and serves as board liaison to the Critical Care Committee.

*For full position descriptions, please visit [www.emra.org](http://www.emra.org).*

If you are interested in running for a position, please email your CV, a statement of interest (200 words or less), letter of support from your residency director, and a photo (jpg format) to mbyers@emra.org by August 30, 2010 EMRA will post statements and photos received from candidates on the EMRA website. Nominations from the Council floor will also be accepted.
Don’t roll the dice on your emergency medicine career.

Plan Now to Attend the EMRA Activities at ACEP’s Scientific Assembly
September 24-October 1

Register today at www.ACEP.org/SA or call 800-798-1822 for more information.
**Medical Student Events**

**Saturday, Sept 25**
1:00 pm – 5:00 pm  EMRA Medical Student Governing Council Meeting
5:30 pm – 7:30 pm  EMRA MSCG/EMIG Representative Mixer

**Sunday, Sept 26**
8:00 am–8:50 am  EMRA Medical Student Forum  *Which Type of Residency is Right for Me?*  Stephen Wolf, MD, FACEP*, Denver Health Medical Center
9:00 am–9:50 am  *Common Mistakes Made When Applying to EM & How to Avoid Them*  Robert Rogers, MD, FACEP, University of Maryland
10:00 am–10:50 am  *Getting into the Residency of Your Choice,* Micelle Haydel, MD, FACEP, University Hospital, LSUHSC
11:00 am–11:50 am  *Interview Day Tips,* John Rose, MD, FACEP, University of California/Davis
12:00 pm–1:00 pm  Panel Discussion/Roundtable  *Networking Luncheon with Program Directors*
3:00 pm–5:00 pm  EMRA Residency Fair  *Attend the EMRA Residency Fair to help you scout out the more than 100 residency programs from around the country. Medical students cannot afford to miss this terrific opportunity to network with program directors, coordinators, and chief residents.*

**Representative Council Meetings**

**Tuesday, Sept 28**
7:30 am–8:30 am  EMRA Resident Forum
8:30 am–10:00 am  *Financial Planning for Young Physicians,* M. Shayne Ruffing, CLU, ChFC, AEP, The Benefit Planning Group
10:00 am–11:30 am  *Taking Care of Business: What You Should Know About Fair Business Practices & Contracts*  Todd Taylor, MD, FACEP and Joseph Wood, MD, JD, FACEP
11:30 am–12:30 pm  *Your Job Search: Identifying and Evaluating Real Opportunity*  Barb Katz - The Katz Company EMC, Inc.
12:30 pm–1:30 pm  *Resident Networking Lunch*  *Been There Done That: Tips from EMRA Alumni on Life After Residency Market Breakouts:* Eastern, Western, Southern & Northern
1:30 pm–2:15 pm  *EMRA Job Fair*  *Looking for that perfect job? EMRA is here to help! All EM job seekers need to attend the largest and best Job Fair in the specialty of Emergency Medicine. With more than 150 companies expected to participate in this year’s event. You are bound to find the job that’s just right for you!*
5:00 pm–7:00 pm  EMRA Job Fair

**Other FUN Stuff**

**Wednesday, September 29**
1:30pm–5:30 pm  EMRA Resident SIM Wars Competition
6:00 pm – 7:00 pm  EMRA Fall Award Reception
9:00 pm – 2:00am  EMRA Party

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*invited
An ambulance rolls into the emergency department bay with a 3-year-old girl who was found down in a neighborhood pool unconscious and pulseless. The crew performs CPR as they transfer the patient to the cot. Once the airway is secured, a nurse puts her head in the room to relay that the family has arrived.

Already an emotionally charged room, the tension increases. What to do with the family? Place them in the quiet room? Bring them back? What if they have a meltdown? Is there someone to deal with the family? Is there time for this right now? What about patient care?

Many questions and controversies surround patient- and family-centered care (PFCC) in the emergency department, especially regarding family presence during invasive procedures and resuscitations. PFCC is an approach to health care that emphasizes the importance of family in the care of patients, promoting respectful partnerships between patients, family, and emergency medicine providers to improve health care, patient safety, and patient satisfaction.

This model promotes a change in the current culture of emergency medicine, shifting from a practice where the physician has strict control to one that is more centered on the patient and family needs. As with every culture change, there are questions, resistance, and unease. Therefore, a review of the literature may attempt to answer these questions and concerns.

**Why should I care about PFCC?**

PFCC will likely become the focus model of emergency care in the near future, especially in an era of ensuring patient safety and satisfaction. The Institute of Medicine (IOM) has identified PFCC as one of the six attributes of high-quality healthcare in its 2001 report *Crossing the Quality Chasm: A New Health System for the 21st Century.*

In its 2006 report, *Emergency Care for Children: Growing Pains,* the IOM concluded that failure to incorporate PFCC and culturally effective care into emergency care practice “can result in multiple adverse consequences, including difficulties with informed consent, miscommunication, inadequate understanding of diagnoses by families, dissatisfaction with care, preventable morbidity and mortality, unnecessary child abuse evaluations, lower quality care, clinician bias, and ethnic disparities in prescriptions, analgesia, test ordering, and diagnostic evaluation.”

Given these reports, as well as support from many organizations including the American College of Emergency Physicians (ACEP), American Academy of Pediatrics (AAP), and the Emergency Medical Services for Children (EMS-C), more attention and research will be focused on this model for providing better patient care.

**What is the benefit of PFCC?**

PFCC offers many benefits well documented throughout the emergency medicine, pediatric, and surgical literature for patients, families, and health care providers. For family members, the benefits of family presence during resuscitations have been found to include increased knowledge that “everything was done” for the patient, greater understanding of the patient’s condition and care received, greater ability to provide emotional support and comfort for the sick family member, fewer feelings of helplessness and anxiety, and assistance with closure and bereavement by bringing a sense of reality to the treatment efforts.

Physicians involved in PFCC have noted greater job satisfaction, less “burnout”, decreased barriers to communication with young patients, improved knowledge of patient’s medical history, fewer medical errors, a better sense of the patient as a human being, and reduced need for sedatives or restraints.
as family members aid in calming the patient. These established benefits, it is clear that patient care is overall improved with PFCC.

What are the barriers to PFCC?

There are several characteristics unique to the emergency department that serve as barriers necessary to overcome to successfully implement PFCC. The increasing problem of overcrowding in the emergency department can delay and disrupt care, making establishing relationships with patients and families more difficult, and provides challenges of relaying sensitive information as hallway patients increase.

Other barriers include children arriving without family members, children seeking care without the knowledge of their family, visits related to child abuse or domestic violence, and time-sensitive procedures. Health care providers also have other concerns including family interference with patient care, increased stress, fear of litigation, and lack of available staff to support family. Although these concerns have yet to be supported in the literature, they provide some of the largest barriers, requiring anticipation and planning to provide effective PFCC.

How do I begin to implement PFCC?

Certainly, as physicians who care most about providing the best care possible for our patients, we can begin to implement PFCC in our practices, even if it is not the standard practice of our department. Use of PFCC in the emergency department requires that families have access to a family guide to provide explanation of medical care and support for families during their presence for procedures and resuscitations.

The family guide’s responsibility should be solely to the family without any direct patient care. There are many resources available in the literature and through the Institute for Family-Centered Care providing guidelines for institution of PFCC as well as recommendations for overcoming some of the barriers mentioned above.

The nurse escorted the family back to the trauma bay where the resuscitation of their child continued. CPR was continued as the staff physician explained the child’s condition, medical treatment, and prognosis. The mother placed her hand on her child’s hand and sobbed.

Despite resuscitative efforts, the child died. Afterwards, the family expressed gratitude for being able to be with their child during their death and thankful that their child was not experiencing any pain. This patient encounter with PFCC has given me a special connection with this family; a reason I entered the medical profession. Subsequent experiences with PFCC have enforced this practice. The question that remains is: Can we get more health care providers to understand and implement PFCC?

Resources

Case presentation
A 25-year-old man with no past medical history was brought into the emergency department with agitation by emergency medical services (EMS). According to EMS, the patient got into a verbal argument with his mother the prior night. On the following morning, the patient was agitated and throwing objects all over the house. The police, as well as paramedics, were called to the scene. The patient admitted he took a “bunch” of pills in an attempt to kill himself. After the police were able to calm the patient, the patient was brought into the emergency department by EMS. On arrival, his vitals were normal, and his blood glucose was 110 mg/dL. During the patient’s evaluation, he had a generalized tonic-clonic seizure which lasted three minutes. He was then given an intravenous dose of lorazepam. Despite several repeated doses, he continued to seize.

Discussion
The toxicologic causes of seizures are many and can include anything from high-dose penicillin to cocaine; however, the differential diagnosis of status epilepticus from ingestions is far shorter. While medical causes of status epilepticus may be more common, the following xenobiotics in Table 1, though not an exhaustive list, should always be considered. Two of these drugs will be discussed further.

<table>
<thead>
<tr>
<th>Table 1. Drugs that may cause status epilepticus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hydrazine-containing compounds</td>
</tr>
<tr>
<td>Isoniazid (INH)</td>
</tr>
<tr>
<td>Rocket fuel</td>
</tr>
<tr>
<td>Gyromitrin mushrooms</td>
</tr>
<tr>
<td>(“false morel”)</td>
</tr>
<tr>
<td>Methylxanthines</td>
</tr>
<tr>
<td>Tetramine</td>
</tr>
<tr>
<td>Methyl bromide</td>
</tr>
<tr>
<td>Extended-release bupropion</td>
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<tr>
<td>Carbon monoxide</td>
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</tbody>
</table>

Isoniazid (INH)
INH should be an important consideration in any tox-related status. The mechanism of seizure related to INH is two-fold. Hydrazone INH metabolites inhibit pyridoxine phosphokinase, the enzyme responsible for the production of pyridoxal-5’-phosphate, which is needed for eventual production of GABA. INH will also bind with pyridoxal phosphate to produce an inactive hydrazine complex that is renally excreted.

An INH overdose will often produce the triad of refractory seizures, severe acidosis, and coma. Other monomethylhydrazines such as those found in Gyromitrin mushrooms and rocket fuel have a similar mechanism of action.

Critical actions
While the use of benzodiazepines remains the mainstay for the treatment of seizures, pyridoxine (Vitamin B6) is the antidote of choice for hydrazine-related seizures/status.
The dose in adults is 1 gram of pyridoxine for each gram of INH ingested, to a maximum of 5 g or 70 mg/kg in the pediatric population, which can be repeated if needed. Benzodiazepines should also be used at the same time, as they are synergistic.

**Methylxanthines**
Methylxanthines include caffeine, theophylline, and theobromine. An overdose of this class of medications often has multi-organ involvement that includes severe nausea and vomiting, electrolyte imbalances such as hypokalemia, and seizures/status. While all methylxanthines are capable of causing seizures, caffeine has better central nervous system penetration due to an extra methyl group. Caffeine is often utilized as a dietary supplement but is also used medically in situations such as post-lumbar-puncture headaches and neonatal apnea. While the use of theophylline has decreased over the years, it is still used in the management of severe COPD and asthma. Theobromine, found in chocolate, is reported to cause animal poisonings, but is not typically associated with human poisonings.

**Critical action**
The management of methylxanthines poisonings often includes supportive care with the use of benzodiazepines. A unique mechanism of methylxanthine-induced seizures involves the antagonism of adenosine in the central nervous system. Serious manifestation of poisoning such as refractory hypotension and seizures should be referred to nephrology for hemodialysis. The low volume of distribution and protein binding make this drug particularly amendable to extracorporeal removal.

**Case Conclusion**
The patient was recognized to be in status epilepticus. As the patient was being prepared to undergo endotracheal intubation, it was discovered that one of the medications that was ingested was isoniazid. Given the history of ingestion and refractory seizure, the patient was given five grams of isoniazid along with another dose of lorazepam. The patient’s seizure soon terminated. The patient was admitted to the intensive care unit and successfully extubated the following morning with no sequelae.
On March 23rd, President Obama signed the Patient Protection and Affordable Care Act into law. This complex legislation includes many changes to the health care system that will influence patients and providers over the next ten years.

So, will all the patients in my emergency department now have insurance coverage?

Most components of the law which expand insurance coverage take effect in 2014. The Congressional Budget Office estimates that an additional 32 million people will be covered by 2019, which is a 59 percent reduction in the number of uninsured.

Despite these reforms, it is anticipated that eight percent of the nonelderly population (23 million people) will remain uninsured. This group will include undocumented immigrants, individuals for whom insurance is unaffordable despite subsidies, and individuals choosing to pay fines rather than obtain health insurance. Currently, 50 million people are uninsured (19 percent of the nonelderly population), and this number would be anticipated to continue to rise over the next ten years if health care reform were not enacted.

What kind of insurance coverage will the newly insured receive?

Increased coverage will be accomplished by expanding Medicaid eligibility to all individuals under age 65 with incomes of less than 133 percent of the poverty line ($23,800 for a family of three, in 2009) and providing subsidies to allow individuals and families with incomes from 133-400 percent of the poverty line to purchase private insurance in newly established state exchanges. Insurers will be required to provide coverage to all individuals, regardless of age or pre-existing conditions. Premiums will no longer be allowed to be based on gender or health status.

What provisions in the bill will specifically impact emergency medicine?

The bill will establish an “essential health benefits package,” which describes mandatory benefits for all insured individuals. This package includes coverage for emergency services, without requiring prior authorization. The “prudent layperson” standard states that an individual has an emergency condition if that person, possessing an average knowledge of medicine and health, believes that urgent or unscheduled care is required.

This standard currently covers Medicare and Medicaid patients, as well as other federal health care programs, and is now applied to privately insured individuals as well. In addition to these insurance

Fast facts about health care reform for the emergency physician

Alison Haddock, MD
University of Michigan/St Joseph
Ann Arbor, MI
provisions, the law requires the Secretary of Health and Human Services to support adult and pediatric emergency care research, pilot projects for the regionalization of emergency care and programs to improve trauma centers.

**Will physician incomes drop as a result of this bill?**
The expanded insurance coverage provided in this bill should reduce the burden of uncompensated care significantly by decreasing the number of uninsured and “self-pay” patients. While no permanent changes to emergency physician payment were established in this bill (specifically, scheduled pay cuts for physicians under the Medicare program were not eliminated), many provisions of the bill may change how physicians are paid in the future. Pay for primary care physicians practicing in health professional shortage areas is increased.

The “pay-for-performance” (PQRI) Medicare program is extended, expanded, and becomes mandatory in 2015 (or face a 1.5 percent cut in Medicare payments). Demonstration projects will be established to examine how medical homes, accountable care organizations, and payment bundling may be used to allow providers to be paid for the value of the care they provide, rather than the volume. In addition, an Independent Payment Advisory Board, comprised of 15 appointed members, will submit legislative proposals to the President and Congress for immediate consideration if the growth rate of Medicare costs exceed a predetermined target growth rate.

**Does the law include malpractice reform?**
There are no overall changes to the current medical liability system in this legislation. However, the law does provide minimal funding for states to develop, implement and evaluate “alternative” means of resolving disputes, with an emphasis on reducing medical errors and improving patient safety while increasing efficiency.

**Does anything in the bill take effect before 2014?**
Multiple insurance reforms will take effect over the next two years. Insurers will be required to allow young people to stay on their parents’ policies until age 26, and they will not be able to deny coverage to children with pre-existing conditions or impose lifetime limits on coverage. In addition, high-risk pools will be established on a state-by-state basis to provide coverage currently uninsured individuals with preexisting conditions.

In 2011, insurers will be required to provide 100 percent coverage for preventive services. Efforts to increase the number of primary care GME slots will be initiated. Medicare cuts to nursing homes, long-term hospitals, and ambulance services will begin.

**How will all the provisions of this bill be implemented?**
As with any law, regulations will be proposed by the federal departments and agencies with jurisdiction over these measures. Most of the provisions in the new health care law will be implemented by the Department of Health and Human Services (HHS), and the Secretary of HHS will have a tremendous amount of authority to interpret the law and create policy. In addition, each state will be responsible for operating a health benefits exchange and determining whether any additional benefits beyond the federally established “essential benefits package” must be covered.

**What can I do to get involved?**
As implementation progresses, there will be many opportunities for physician input on the federal, state and local levels. Stay informed by becoming a member of ACEP’s 9-1-1 Legislative Network. Don’t hesitate to contact your representatives as issues which will affect your practice and your patients arise.

**For more information**
ACEP’s Federal Issues:  
http://acep.org/advocacy
Kaiser Family Foundation:  
http://healthreform.kff.org/
Official US Government Website:  
http://www.healthreform.gov/

**References**
2. Health Policy Alternatives Inc; Summary of Patient Protection and Affordable Care Act
3. Hart Health Strategies Health Reform Law Timeline
In 1975, my parents left a war-torn country with only a suitcase in hand to move to America. This past November, I had the distinct honor of accompanying them back to Vietnam for the first time in over 30 years. During our three weeks there, I also participated in an emergency medicine elective at Cho Ray Hospital, one of the largest teaching hospitals in Vietnam.

The Socialist Republic of Vietnam is a communist country located in Southeast Asia with a population of over 80 million people, making it the 13th most populous country in the world. Vietnam is an agricultural civilization that depends largely on exports of rice, coffee, and tea to sustain its economy. Although the country has made significant progress since the war, Vietnam is still a predominantly poor country. The GDP per capita is only US $2,300 as compared to the United States’ GDP of US $46,300.

Cho Ray Hospital is located in Ho Chi Minh City, formerly known as Saigon. It serves as the main referral center for nearly 40 million people among the Southern provinces. Cho Ray Hospital employs approximately 500 medical staff and delivers treatment for over 457,000 outpatients and 80,000 inpatients per year. It has many departments including trauma, interventional cardiology, neurosurgery, critical care, and tropical medicine.

The emergency department comprises approximately 35 beds spread out between a triage space, a critical care room, and the main emergency department. The department receives 250 to 350 patients per day and has an annual patient census of almost 90,000. Emergency care in Vietnam is a fee-for-service system, and the average cost of a visit is approximately US $20. Patients are not allowed to get their prescriptions, procedures, or discharge instructions until they have paid in full.

Most patients arrive to the emergency department via private transportation. Upon arrival, patients are evaluated at the triage area and then taken back to main emergency department where they are formally examined by an attending physician. There is also a separate air-conditioned VIP room for foreigners that can accommodate three to four patients at a time. Foreigners who come to Cho Ray are seen immediately but are charged more expensive rates for procedures and imaging than the native Vietnamese patients. For example, a Vietnamese patient would pay US $40 for a non-contrast CT while a foreigner would pay US $55.

During my time at Cho Ray Hospital, I was able to experience and treat a wide variety of cases ranging from routine chest pain to exotic tropical diseases. Traumas prevail and I often found myself spending a shift suturing nearly 20 laceration repairs as a result of numerous motorbike accidents, often referred to as the infamous “Honda Disease.” Motorbikes are the primary mode of transportation, and traffic can be pretty chaotic during rush hour given the large population of people within the city. The Vietnamese government finally mandated helmets in 2007, which has reduced the incidence of traumatic brain injuries.

Currently, emergency medicine is not recognized as a board certified specialty in Vietnam. There are no professional organizations or unified training requirements. An emergency department physician makes an average of only US $350 per month and works approximately six shifts per week. Most of the doctors that work in the emergency department are often sent to work there by the government or their department chairs. The preceptor that I worked with was actually a former critical care attending who was forced to work in the emergency department after he had a quarrel with his boss.

For these reasons, this is a very exciting time to be involved with emergency medicine in Vietnam. This fall, Hue Medical College will be starting the first emergency medicine residency program in Vietnam. To help support this endeavor, the Good Samaritans Medical and Dental Ministry organized the Emergency Medicine Symposium which was held in March of this year.

This conference was significant, as it marked the first time that emergency medicine was recognized as a unified and independent specialty in Vietnam. It also brought together over 300 physicians, nurses, and medical students from all over the country. I was able to return to Vietnam along with 60 other US emergency physicians and served as a faculty member for this conference. It was such a meaningful experience for me to be a part of history in the making. The field of emergency medicine in Vietnam is now entering into a whole new era, and the future is looking very bright.
PEER VII is ACEP’s Gold Standard in self-assessment and educational review for emergency physicians. EMRA members can purchase PEER VII at a significant discount at www.acep.org/bookstore.

For a complete reference and answer explanation for the questions below, visit www.emra.org.

1. An important consideration regarding pneumonia in elderly patients, compared to younger patients, is that:
   A. Elderly patients are less likely to have pneumococcal bacteremia
   B. Elderly patients are less likely to present in an advanced stage of illness
   C. Elderly patients are less likely to present with productive cough and fever
   D. Mycoplasma is the most common atypical causative agent in elderly patients
   E. Temperature higher than 38.3°C (100.9°F) is more worrisome in younger patients

2. A 75-year-old nursing home patient with a past medical history significant only for mild dementia choked on water while sitting at a table eating his lunch. He recovered uneventfully but was sent to the emergency department for evaluation of aspiration pneumonia. He is in no respiratory distress and has normal vital signs, including pulse oximetry, an unremarkable physical examination, and a normal chest x-ray. Which of the following considerations regarding his treatment is correct?
   A. Anaerobes have a major role in aspiration pneumonia
   B. Antibiotics should be initiated early regardless of whether he is symptomatic
   C. Early initiation of corticosteroids will not help prevent lung injury
   D. Expectorated sputum cultures will have high yield in identifying the causative organism
   E. He is likely to have lung involvement in the superior segments of the lower lobes

3. Which of the following statements regarding pleural effusions is correct?
   A. A common cause of atraumatic hemothorax is systemic lupus erythematosus
   B. A pH of less than 7.3 strongly suggests pleural empyema or esophageal rupture
   C. Effusions associated with pulmonary embolism are transudative
   D. Management of complicated parapneumonic effusions includes tube thoracostomy
   E. The most common cause in developing countries is congestive heart failure

4. Which of the following conditions is most likely to be a precipitating factor for pneumothorax?
   A. Chronic obstructive pulmonary disease
   B. Cigarette smoking
   C. Marfan syndrome
   D. Physical exertion
   E. Pneumocystis carinii pneumonia

5. A 22-year-old college basketball player presents with sudden-onset shortness of breath. Chest radiography reveals a 10% pneumothorax. The patient has not had a prior episode of pneumothorax. He is not in acute distress, and vital signs and oxygen saturation are within normal limits. Without any intervention, approximately how long will it take for the pneumothorax to resolve on its own?
   A. 12 hours
   B. 24 hours
   C. 36 hours
   D. 1 week
   E. 3 weeks

Answers: 1 C 2 A 3 D 4 B 5 D

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Risk management pearls for management of hypertension in the emergency department

1. **Patient factors may lead to an erroneously high BP reading.**
   Recheck the patient’s BP.

   Serial BP measurements are more accurate than a single reading. Be sure the cuff fits the patient properly. If the reading obtained does not fit the clinical scenario, check the patient’s BP manually in both arms. Confirm that the true pressure is being measured.

2. **The asymptomatic patient does not need a rapid correction of the BP level.**

   Patients with chronically high BP may have reset the autoregulation parameters that control their cerebral circulation. A rapid decline in pressure might put the patient into intracranial hypotension, resulting in an ischemic stroke. There is no proven benefit from quickly lowering BP in an asymptomatic patient.

3. **Overly aggressive use of antihypertensive agents should be avoided in patients with an acute ischemic stroke.**

   The evidence suggests that having hypertension after a cerebrovascular accident actually protects patients. For extremely high pressures, some control of BP is warranted. (See section on Acute Ischemic Stroke and the Clinical Pathway For Symptomatic Hypertension) Modest reductions in extreme hypertension (DBP > 120 mm Hg) and permissive hypertension for those with more reasonable values is the rule.

4. **“Everyone with an elevated BP requires a recheck.”**

   People who present to the ED with incidental findings of hypertension are likely to have true hypertension or prehypertension. Although these findings probably would not lead to immediate problems, the ED can be an effective screening tool for patients who use the healthcare system infrequently. This is a ideal opportunity to encourage patients to see their primary care provider or initiate a primary care relationship.

5. **“Sublingual nifedipine should be avoided.”**

   Nifedipine sublingual (SL) provides unpredictable and relatively long-acting antihypertensive effects. The patient may not respond at all—or more dangerously, may become hypotensive. Long-acting, long-onset medications should be avoided in hypertensive emergencies, as they cannot be well-titrated or controlled.

6. **“If emergency clinicians assume the role of primary care providers, the patient requires a primary care workup.”**

   Too often, ED clinicians are faced with a situation where they must expand the scope of their practice. Chronically elevated BP needs to be treated. If the ED is becoming the de facto primary care contact, clinicians must do the same workup that a primary care provider would do, including ECG, BMP, and CBC. Furthermore, medications that require monitoring for electrolyte levels or that may cause rebound hypertension should be avoided.

7. **“Medications with rapid onset do not necessarily have a short half-life.”**

   Drugs such as nicardipine that have rapid onset may have a long half-life after prolonged administration. Any patient receiving an IV medication for a hypertensive emergency should be monitored extremely closely. The rate of BP change should be noted so that extreme high or low values can be avoided. Additionally, medications that are cleared primarily by redistribution or that depend on a damaged end organ for metabolism may have a longer-than-expected effect.

8. **“Induction of reflex tachycardia in patients with an aortic dissection should be avoided.”**

   Patients with an aortic dissection do benefit from vasodilator therapy, but watch for tachycardia in these patients. Often, a b-blocker is needed to control the patient’s heart rate.

9. **“Prescribed medications should be affordable.”**

   If the patient cannot afford the prescribed medication, he or she cannot take it. A switch to the generic drug will likely improve adherence to therapy.

10. **“Complicated dosing regimens should be avoided in patients who have difficulty adhering to them.”**

    A once-daily drug might be warranted, despite the increased cost.
Risk management pitfalls to avoid in pediatric gastroenteritis

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1. “That kid you sent home last night with acute gastroenteritis is back. The surgeon who just saw him thinks that he has acute appendicitis.”
   Early appendicitis and gastroenteritis can be difficult to distinguish on clinical grounds alone. In fact, 10% to 33% of young children with appendicitis will present with a symptom complex that includes diarrhea. The history of pain that migrated to the right lower quadrant or the presence of right lower quadrant tenderness on examination should heighten your suspicion for appendicitis, whereas frequent bouts of copious diarrhea should lower your suspicion for appendicitis. Regardless, observation and good discharge instructions are key.

2. “How would I know their child would end up in the pediatric intensive care unit, I thought his symptoms would get better in a day or two”
   For any child who is dehydrated, your discharge conversation and instructions should specifically highlight the symptoms and signs of worsening dehydration (See Sample Discharge Instructions on page 14). In general, discharge instructions need to be written in simple language and should be location-, time-, and action-specific. For example, “Return to the ED immediately if your child continues to vomit and is unable to keep any fluids down” is preferred to “Return if worsening.”

3. “I examined that child when he first came to the ED. After some oral fluids, the nurse said he looked OK, so I sent him home.”
   Yeah, but that same nurse forgot to tell you that she saw him vomit everything up and that his repeat vital signs were unchanged before he left. Three steps will reduce the risk of missing an alternative diagnosis leading to an unexpected return visit to the ED. First, document serial abdominal examinations and response to hydration strategy. Second, read the nursing notes and talk to the nurse caring for the patient to make sure you have not missed any important information or events that took place while the patient was in the ED. Third, talk to the family and document location-, time-, and action-specific return precautions.

4. “The nurses had a hard time getting an IV on that kid so I just told them to forget it and let the parents feed him small sips.”
   Failure to place an IV in a pediatric patient can be due to nursing inexperience but can also be due to severe dehydration in children. Your best IV starter has just 3 attempts before you should go to an intraosseous line or nasogastric tube for rehydration in the severely dehydrated child.

5. “I had no idea that the family of the infant that I sent home lived 40 minutes away and did not have a car to return for a repeat evaluation today.”
   Consider extended ED observation or hospital admission for any infant < 1 year of age with gastroenteritis, especially if the family has limited access to healthcare.

6. “Our QA committee just asked me to justify why I sent home a child with compensated shock. I don’t even know what compensated shock is.”
   Compensated shock is a condition where a child displays all the signs of poor peripheral perfusion but is maintaining an adequate central blood pressure. For example, a severely dehydrated child with cool extremities and no urine output who is tachycardic and tachypneic but is able to maintain a minimal blood pressure is likely to be in a state of compensated shock. Children presenting with signs and symptoms consistent with severe dehydration should be admitted to the hospital or a short-stay unit for further observation.

7. “I ended up admitting that kid you signed out to me who developed abdominal pain and diarrhea after starting his antibiotics for a skin infection. Did you consider that he may have C difficile colitis?”
   Any child with diarrhea following recent antibiotic use should be evaluated for C difficile infection. Although mild infection may be self-limited, the presence of fever, leukocytosis, or abdominal tenderness can indicate significant colitis requiring antibiotic treatment with metronidazole or vancomycin.

8. “That kid we just sent home with gastroenteritis is back. His parents now say that he just had a bloody bowel movement.”
   Bloody diarrhea is unusual for viral gastroenteritis and is more commonly associated with bacterial enteritis. In the absence of fever, consider intussusception, hemolytic uremic syndrome, inflammatory bowel disease, and pseudomembranous colitis. Once these diagnoses have been eliminated, the diagnosis of intestinal enteritis can be entertained.

9. “Doc, I just roomed a little 2-month-old with bilious vomiting in the next room. Do you want me to get anything started on him?”
   Yes. Bilious emesis is always worrisome in an infant and should be considered a surgical emergency until proven otherwise. The top consideration in this child is intestinal malrotation.

10. “The family you asked to come back today is doing fine. They say their daughter is doing much better today.”
    Recommend 24-hour follow-up, either in the ED or in a pediatrician’s office, for any child that you are worried about. This is especially true for patients who present with abdominal pain and vomiting only. Although the ultimate diagnosis may be gastroenteritis, the lack of diarrhea should be considered an atypical finding and should be further explored while in the ED.
Sepsis Bundle Goals for Severe Sepsis/Septic Shock:

- Achieve SBP ≤ 90 mm Hg or increase from baseline ≥ 40 mm Hg
- Achieve CVP of 8-12 mm Hg (12-15 mm Hg if mechanically ventilated)
- Achieve mean arterial pressure (MAP) > 65 mm Hg
- Draw blood cultures x 2 (one percutaneous, all prior to antibiotics)
- Obtain serum lactate
- Achieve ScvO2 ≥ 70%

**Hyperdynamic State**

- Diazoxide 0.5-1 mg/kg bolus
- Dopamine
  - 5 mcg/kg/min IV for hypotension
  - 20 mcg/kg/min IV (entire dose of 5 mg/kg) if inadequate response

**Hypodynamic State**

- Vasopressin: 0.01-0.04 units/min
- Norepinephrine: 2-20 mcg/min IV (preferred)
- Vasopressin: 0.01-0.04 units/min

**Clotting Abnormalities**

- Platelet transfusions: 5-10 U
- Fresh frozen plasma: 6-10 U
- Prothrombin complex concentrate: 20-40 U
- Recombinant factor VIIa: 15-30 mcg/kg

**Hypothermia**

- Core temperature < 35°C
- Antipyretics
- Manually warm patient
- Blankets
- Forced-air warming

**Hyperglycemia**

- Glucose > 140 mg/dL or 7.7 mmol/L in the absence of diabetes
- Insulin infusion: 0.05-0.2 U/kg/hr

**Nutrition**

- Early goal-directed nutrition
- Caloric intake: 20 kcal/kg/day
- Protein intake: 2-2.5 g/kg/day
- Feeding: Early and goal-directed

**Organ System Dysfunction**

- Pulmonary: Respiratory rate > 20 breaths/min, need for supplemental oxygen
- Cardiovascular: SBP < 90 mm Hg, 20% decrease from baseline
- Renal: Serum creatinine > 2 mg/dL
- Hepatic/Gastrointestinal: Total bilirubin > 3 mg/dL
- Hematologic: Platelet count < 100,000/mm³
- Metabolic: Base deficit > 6 mmol/L
- Neurologic: Disorientation, altered mental status
- Coagulopathy: INR > 1.5
- Cardiovascular: Echocardiographic evidence of hypoperfusion
- Central nervous system: Glasgow Coma Scale

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PROGRAM PURPOSE
To provide clinical training, process improvement, hands-on bedside teaching, and supervision of clinical service delivery, using United States trained emergency physicians at district level hospitals in Ghana.

PROGRAM OBJECTIVES
With the support of GE Foundation and in collaboration with the Ghana Health Service, we have developed a pilot project to provide technical knowledge transfer at Kintampo and Mampong District Hospitals for 3 years, using United States trained emergency physicians.

ELIGIBILITY
Emergency Medicine Resident Physicians must be in their third or fourth year of training at an accredited US program in Emergency Medicine by July 2010.

Emergency Medicine Attending Physicians who are board prepared or board certified in EM are also welcome to apply.

Please send all information to our Senior Program Officer, Beth Rubenstein, MPH, MBA via email at: sidharte@columbia.edu.

PROGRAM INFORMATION
The sidHARTe Program consists of the following components:

1. **Supervising clinical service delivery** at either Kintampo District Hospital or Mampong District Hospital
2. **Training of health staff** which includes: physicians, medical officers, midlevel providers, nurses and midwives
3. **Health systems process improvement** with the Ghana Health Service and other programs
4. **Monitoring & Evaluation** (external evaluation)

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The Department of Emergency Medicine at the George Washington University is inviting applications for Fellowship positions beginning in the Summer of 2011. The Department offers Fellows a common interdisciplinary curriculum, focusing on research methodologies and grant writing. Tuition support for an MPH or equivalent degree is also provided.

**Clinical Research:** This specialized two year clinical research fellowship provides a unique opportunity for advanced professional training, including the opportunity to pursue an MS or an MPH degree. This fellowship focuses on developing robust research skills, with special emphasis on clinical research design, critical appraisal of the literature, statistical analysis, presentation of results, manuscript preparation, and grant writing. Direct mentorship is key to the success of this fellowship, and fellows will have the opportunity to work with clinical researchers in various fields with funding from NIH, CDC, foundation, and industry.

*Director: Kabir Yadav, MD, MSc | kyadav@mfa.gwu.edu*

**Disaster/EMS:** Fellows develop skills to become effective emergency managers and emergency medical services leaders through mentorship, experiences, and opportunities. This two year program also includes a Master's Degree in the appropriate area of concentration.

*Director: Bruno Petinaux, MD | bpetinaux@mfa.gwu.edu*

**ED Operations and Leadership Fellowship:** The program trains future ED Medical Directors and physician group leaders. The curriculum is oriented toward ED operational metric analysis, the development of quality improvement and patient satisfaction programs, hospital and physician group staff issues, billing and coding, medical entrepreneurship, and ED informatics. The fellow will pursue a Master's degree and will attend the ACEP Director's Academy.

*Director: Griffin Davis, MD, MPH | gdavis@mfa.gwu.edu*

**Health Policy:** Fellows pursue a didactic fellowship curriculum and have the opportunity to rotate through congressional or federal agency offices. Fellows will work on a variety of policy-related contracts and research projects. Pursuit of an MPH or Certificate in Health Policy in the School of Public Health is highly encouraged.

*Director: Jennifer Lee, MD | jelee@mfa.gwu.edu*

**International Emergency Medicine:** Fellows actively participate in the implementation of new and ongoing educational, clinical and prehospital EM projects and programs throughout the world. Pursuit of an MPH degree and collaboration with the Department of Global Health in GW's School of Public Health is emphasized.

*Director: Katherine Douglass, MD, MPH | kdouglass@mfa.gwu.edu*

**Operations Research:** Fellows learn research methods and practical techniques to implement and study operational interventions in the emergency department. The scope of the fellowship content and project (i.e. more research or more implementation) is decided upon by the fellow and the fellowship director. Pursuit of an MPH degree and collaboration with the Department of Health Policy in GW's School of Public Health is emphasized.

*Director: Jesse M. Pines, MD, MBA, MSCE | jesse.pines@gwumc.edu*

**Toxicology:** In this ACGME accredited program, fellows provide telephone and bedside consultations through the National Capital Poison Center and several area hospitals. Course work in research and policy aspects of toxicology is offered through the NIH and GW's Schools of Public Health and Law.

*Director: Kathleen Clancy, MD | cat@poison.org*

**Travel and Transport:** This program focuses on the special health needs of travelers in our increasingly globalized society. Fellows have practical experience in the cruise and travel assistance industries, while pursuing coursework in GW's School of Business.

*Director: Sol Edelstein, MD | sedelstein@mfa.gwu.edu*

**Ultrasound:** Fellows gain expertise in clinical applications of bedside ultrasound, learn aspects of US program administration, participate in an active training curriculum and perform research. Fellows work toward RDMS certification during fellowship.

*Director: Keith Boniface, MD | kboniface@mfa.gwu.edu*

Fellows receive an academic appointment at George Washington University School of Medicine and work clinically at a site staffed by the Department. Before entering the Fellowship, an applicant must have completed an accredited residency training program in Emergency Medicine and be eligible for state licensure. A CV is considered a completed application.

Additional information can be found at [www.gwmed.edu](http://www.gwmed.edu). Interested candidates are invited to directly contact the fellowship director of their program of interest with any questions.
The Emory/Centers for Disease Control and Prevention (CDC) Medical Toxicology Fellowship Program

Panama, Kenya, Bangladesh, Ethiopia, Mexico, Nicaragua and the Ukraine....

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- Aflatoxicosis from contaminated maize
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This two-year program offers you affiliations with the Emory University School of Medicine, CDC, the Agency for Toxic Substances and Disease Registry (ATSDR), and the Georgia Poison Center. The Georgia Poison Center is among the 5 busiest poison centers in the United States and receives more than 90,000 calls per year. As an Emory/CDC Medical Toxicology Fellow you will:

- Participate in the toxicological evaluation, management and bedside care of patients at five Atlanta-area metropolitan hospitals
- Provide expert toxicological guidance and consultation for the Georgia Poison Center
- See a wide variety of environmental and occupational cases of illness through the Grady Toxicology Clinic
- Learn from a diverse faculty that includes more than 10 board-certified medical toxicologists
- Work and train with international Medical Toxicology Fellows and Pharmacy Clinical Toxicology Fellows as well as mentor/teach medical students and rotating residents
- Have protected time to moonlight and maintain your primary clinical skills within and/or outside of the Emory system
- Participate in international and domestic chemical-associated out break and public health investigations
- Receive formal training in epidemiology, statistics, scientific writing, medical management of both biological and chemical casualties, public health risk assessment, laboratory science, and more

For more information please contact:
Brent Morgan, M.D.
Director, Emory/CDC Medical Toxicology Fellowship
Georgia Poison Center
50 Hurt Plaza SE, Suite 600
Atlanta, GA 30303
(404) 616-6651
bmorg02@emory.edu
www.emory.edu/em/fellowships_toxicology.html

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For more info, contact:
Dr. Sassan Naderi
Director, International EM Fellowship
North Shore-LIJ Health System
Assistant Professor, Albert Einstein College of Medicine
snaderi@nshs.edu
917-699-4797

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Maryland, Eastern Shore: Maryland Emergency Medicine Network (MEMN) is a well-established group that currently has opportunities for talented BC/BP emergency physicians seeking staff positions within Maryland. Opportunities are available in our two Eastern Shore communities that enjoy excellent public and private schools, family-centered activities, shopping, and gourmet restaurants. Choose this beautiful setting for its close proximity to the Chesapeake Bay and the Maryland/Delaware beach resorts. Enjoy boating and water sports not far from the excitement of metropolitan life in Baltimore and Washington, DC. Employee status with excellent compensation package including shift differential and incentive plan. Malpractice insurance provided. Please forward CV and letter of interest to Susan Kamen at skamen@memn.org or via fax 410-328-8028. Phone 410-328-1859 for additional information.

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Michigan, Tawas: EPMG is seeking BC/ BP EM physicians for a 15,000 annual visit ED located in Tawas City, Michigan. 12-hour shifts. Tawas City is located on the beautiful shores of Lake Huron. EPMG offers paid family health, prescription, vision, dental, life, LTD, flexible scheduling, 401(k) employer contribution, paid malpractice, and much more. Please contact Carrie Dib at 800-466-3764, x336 or cdib@epmgpc.com.

New Jersey, Toms River: Great opportunity. Jersey Emergency Medicine Specialists staff the Emergency Center at Community Medical Center in Toms River, New Jersey. We are looking for an exceptional physician to join our group. We are one of the busiest emergency departments in the east, and have excellent coverage for the volume. We cover about 120 hours per day to staff our department that sees 105,000 patients a year. Our facility has recently been renovated and expanded and is now one of the largest on the east coast. We are a democratic group that has been at our location since 1993. For more information; see our website www.jemsdocs.com or contact Mark Meredith, MD, FACEP, MMM at 732.557.8060 or mmeredith@sbhcs.com.

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Wisconsin, Wisconsin Rapids: Partnership Opportunity - Infinity HealthCare a well-established Emergency Medicine group with over 30 years of experience in staffing and managing emergency physician practices invites you to join us in a new exciting practice at Riverview Hospital. Located on the banks of the Wisconsin River; this area provides an outdoor recreational playground for camping, hiking, skiing and fishing. Centrally located it is within a few hours from Milwaukee, Madison and the Twin Cities. Comprehensive package includes competitive salary and incentive compensation, in addition outstanding benefits, retirement plan and equity participation. Please direct inquiries to: Johanna Bartlett or Mary Schwein, Infinity HealthCare, 111 E. Wisconsin Ave, Suite 2100, Milwaukee, WI 53202, Toll Free 888-442-3883, email:ihc-careerops@infinityhealthcare.com.

Wyoming, Cheyenne: Join a dynamic emergency physician team in beautiful, historic Cheyenne, Wyoming. Frontier Emergency Physicians (FEP) is seeking an energetic and enthusiastic team member, a physician who is board certified/board prepared in emergency medicine. He or she would fill a position at Cheyenne Regional Medical Center, which hosts a level II trauma center, operated by FEP, that sees about 35,500 patients a year. FEP offers a competitive salary, benefits, and partnership opportunities. Interested physicians should send a cover letter and a copy of their curriculum vitae by email to tlong@seriollc.com or by mail to SERIO Physician Management, Attention: Teresa Long, 1241 W. Mineral Ave., Suite 100, Littleton, CO 80120. Or, call Dr. Mike Means at (307) 633-7550.

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**Tips to help you get ready for Scientific Assembly in September**

**Wrinkle-free packing**

**Rolling, rolling, rolling.** You have two options for items that you’re not hanging: folding or rolling. Rolling is a great space-saving and wrinkle-reducing choice for jeans and T-shirts. Here’s how you do it: take a pair of jeans and fold them lengthwise so that the legs are stacked on top of each other. Now, starting from the cuff, roll your way up. For T-shirts, place face down, fold arms back (you should now have a long rectangle), fold lengthwise, and roll up.

**Lighten your load.** Jamming your suitcases as full as a subway at rush hour will leave your clothes as exhausted as a crushed commuter. Clothes become wrinkled almost as soon as you shove that last leaden item into your bag. The easiest things to jettison? Hairdryers and clothes irons as almost every hotel room in the world have these items.

**One word: Plastic.** If you remember only one word in your packing efforts, this is the one. And here’s why: friction causes wrinkling, plastic reduces friction. It’s that easy. The best way to utilize this basic plastic physics is with dry-cleaner bags. All hanger items should be packed in individual bags (one outfit per dry-cleaner bag). Clothes arrive in a perfectly preserved state. _Really!_ Another great plastic tip: zip-top baggies. Use these for dirty shoes, shampoo bottles, or anything else you want to isolate from your good clothes.

**Fold it.** For sweaters and other non-T tops, the square fold is the way to go. Here’s a quick primer: button all buttons and lay shirts face down on a bed or flat surface. Smooth away wrinkles. Fold material in at the shoulders and lay arms flat along the body so that you create a roughly two-inch overlap of material on both sides. Now fold up a third of the material from the bottom and overlap a third from the top. You should now have a tidy package worthy of any chain retailer.

**Delicate situation.** What to do with your undies and lingerie? Buy inexpensive mesh laundry bags; they’re made of nylon and are lightweight. Stow your delicates in here. An added bonus: if your bag is inspected, no one need touch your underwear since an inspector will be able to see into the bag. Socks, by the way, should be rolled up and placed inside shoes or used to fill gaps in your bag.

**“It’s your aptitude, not just your attitude that determines your ultimate altitude.”**

—Zig Ziglar

**Instant de-stressors**

- Take three slow, deep breaths through your nose, and out through pursed lips.
- Daydream on purpose. Think happy thoughts for a few minutes about time spent with a loved one, a fantasy vacation, or a favorite pastime.
- Make yourself laugh. Go watch your all-time favorite You Tube video, Saturday Night Live skit, or clip from your favorite comedian.
- Play with your pets or walk them around the block. Animals and exercise are a double-whammy against stress.
- Get comfortable – change into less restrictive clothing and find a comfy chair to reduce tension in your body.


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