Fall 2006

A Chapter of the American College of Emergency Physicians

Government Services EPIC

GSACEP ENDORSES COL LINDA LAWRENCE, MD, FACEP, FOR ACEP PRESIDENT ELECT *(see page 3)*

President's Message

LTC John McManus, MC, USA

WELCOME NEW RESIDENTS!

The "new" academic year is well under way, and "we," the Board of Directors of GSACEP, welcome new residents to the U.S. military! To become a teacher and healer while serving your country is a true honor and privilege. GSACEP wants to help you make this a successful endeavor. Many challenges lie ahead in your future military, and, eventually, your civilian, medical career. Issues such as overcrowding and reimbursement seem to not matter now, but actually loom near in your future. There is a nice article in this Epic that reiterates some of societies and practitioners' concerns about current medical care written by our Resident Rep, Torre.

Upon graduation, many of you will actually be immediately placed into leadership positions in the military healthcare systems. Furthermore, upon graduation, most of you will have the chance to serve in austere and potentially tactical environments which possess many challenges. As you progress through your early career, it may well seem overwhelming at times without much guidance or the apparent ability to control your career. However, there are several available resources out there! You just have to be a little proactive in seeking out guidance and mentorship! GSACEP is here to serve as one of those invaluable sources not only for mentorship, but also for overcoming administrative and academic challenges which may confront you.

Some of the resources that GSACEP offers include:

- An annual Emergency Medical Director's Course at the Joint Services Symposium
- A Web-based resource for mentors and leadership contacts
- An opportunity to network with previous members, current leaders and members in sister services and organizations
- An opportunity for early leadership in a national organization
- A platform to unite all military emergency medicine on current and sometimes controversial topics
- Successful mentors outside your chain-of-command and your service
- An advocate for military emergency medicine and "best practice" for our patients

What's Going On?

This year has some exciting endeavors by our organization and many of its members! First and foremost, Col Linda Lawrence is a candidate for national ACEP President Elect. We congratulate her on an outstanding career thus far and truly expect her to win! Those of you who may also be active in state chapters, as well as those who have connections with other councillors and leaders, please remind them that we would appreciate their support in electing Linda!

Furthermore, we are very proud of many of our members who have been named to ACEP national committees and task forces. (see page 9). Military emergency physicians have surely been more appreciated for their service in the current War on Global Terrorism and are also being recognized for their expertise! Congrats to those members. We have also established the first military Emergency Medicine fellowship at Brooke Army Medical Center, an EMS fellowship. Although, currently open to only US Army active duty emergency medicine physicians, the hope is to expand to a tri-service fellowship opportunity in the next two years. Finally, the GSACEP Board is considering possibly instituting a "new" academic journal which would focus on disaster and operational medicine. This journal would appeal to both military and civilian healthcare providers involved in this type of training, education, research and practice. (If interested in being a part of this endeavor contact me at john.mcmanus@amedd.army.mil)

Final Thoughts

As your leader, I urge you to support Scientific Assembly in New Orleans. The military services certainly have supported this conference in the past. ACEP leadership is urging us to continue this support, especially for New Orleans this year. The city is well on its way to becoming a premier tourist attraction again and the Garden District and French Quarter are up and running. Besides, don't you want to support Linda in her bid for ACEP President Elect? We also have many colleagues presenting and attending! Furthermore, when Col Lawrence ***is*** elected, we will insist that she buy the beverages!

In This Issue

GSACEP Welcomes

Seth L. Baruffi, MD	Ft. Lewis, WA
Jon Christopher Carter, MD, FACEP	Charleston, SC
Bradley C. Cowley	Holladay, UT
Christopher Cox, MD	Freeport, ME
Sean Cullen, MD	Peoria, IL
Bobby K. Desai, MD	San Antonio, TX
Michael E. Dowler, MD	Kettering, OH
Chad H. Felsenstein, Md	Philadelphia, PA
Katharine E Hughes	Bolingbrook, Il
Antonio Garcia	Erie, PA
Nicholas Gentry	Columbia, MO
Darius Greenbacher, MD	Northampton, MA
Rodrigo Guzman, DO	Kansas City, MO
R David Herring, Js	Spring, TX
John P. Hill, MD	P C Beach, FL
Robert William Jensen, MD	Seatlle WA
Alisa Marie Koval, MD	New York, NY
Joshua Kubit	Cleveland, OH
Celina C. Martinez	Baltimore, MD
Thomas OH, MD	Woodbridge, IL
S John Pappas, MD	Maumee, OH
Eleni Pentheroudakis, MD	Philadelphia, PA
Andrew D. Powell, MD	Sanford, ME
Jason Smith, DO	San Antonio, TX
Trent W. Smith, DO	Pittsburgh, PA
Angela Scharnhorst	Pewaukee, WI
Eric Vaughn, MD	APO, AP

Memorial Day in Baghdad

There were no barbeques.
There was no baseball.
But there was heat and American flags everywhere.
It was Memorial Day 2006 in Baghdad.
It will be one I will never forget.
I was working the day shift in the ER.
At noon we got a call of multiple US casualties secondary to a VBIED (vehicle borne improvised explosive devise...basically a car bomb).
Within five minutes we had reports of multiple dead at the scene. VBIED always translates into death or horrific injuries.
The first three casualties were sent directly into the main trauma bay.
Two went directly to the OR after they were intubated and stabilized.
The "lucky one" with face and hand burns was admitted to the surgical ward
Five more were taken to the back rooms
All five required surgical interventions to stop hemorrhage.
Everyone lived.

On this day when we celebrate memories of those who died serving our country, I celebrate those who lived...serving our country.
Memorial Day will never be the same for me. It will forever be embedded with the memories of those who lived.
Maybe next year I will celebrate with some barbeque and baseball.
God bless our troops.
God bless America.

MAJ Sumeru Mehta, MD, MPH MC, USA
10th Combat Support Hospital
Baghdad, Iraq

Congrats

LTC(P) Adams and MAJ(P) Barry, both of BAMC, were recognized by Annals of Emergency Medicine as “top reviewers” this July

Board of Directors and Committees

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For more nformation about GSACEP, pleaes call our office at 877-531-3044. Our office hours are 0900 to 1700 EDT, or visit our website at www.gsacep.org

GSACEP ENDORSES COL LINDA LAWRENCE, MD, FACEP, FOR ACEP PRESIDENT ELECT

Dear Fellow Councillors:

Skillful, innovative, consensus builder and visionary! These are all adjectives that have been used to describe my esteemed colleague, Linda Lawrence.

Beginning in 1997, when Linda was elected President of GSACEP, she has excelled in all facets of our chapter, particularly through educational development and leadership. Some of her accomplishments include development of innovative educational programs to include: 1) online CME programs, 2) development of a successful Core Lecture Series, and 3) development of an Emergency Department Director's Course. Furthermore, she has served on our board for over 10 years and has been instrumental in fostering junior leadership and increased membership significantly. These efforts culminated with our chapter awarding Linda "The Excellence in Military Emergency Medicine" award in 2005.

Linda has proven herself as a tireless servant and mentor for our society!

Linda's previous service to our college is vast and includes the positions of Vice-President, Secretary-Treasurer, Editor of ACEP News and EM Today, multiple Board liaison positions, residency and chapter visits. She has served as Chair of the Reference committee and as a member of the Steering, the Educational, and the Academic Affairs Committees. Linda has been deeply involved in policy making and instrumental in the recent success the college has seen through the current issues confronting our members including homeland security, liability reform, emergency overcrowding and disaster response.

Linda's emergency medical career is extensive and well-versed!

Linda's background is vast— from rural EDs, to suburban and academic settings, to experience abroad and she is still an active clinician. As an outstanding military physician, she now serves as the Air Force (AF) Emergency Medicine Consultant to the Air Force Surgeon General, a position that helps guide the practice of emergency medicine across the AF and develop the careers of all AF Emergency Physicians. Linda's background has allowed her to understand all issues facing emergency physicians in the varying levels and areas of practice throughout the country. She also currently serves as the Chief of Medical Staff for the second largest hospital in the AF. Her experience in senior administrative leadership, daily interactions with all specialties and responsibility for quality and patient safety of the hospital will serve her well in leading ACEP to work with the necessary constituencies to find solutions for ACEPs priority objectives.

Linda knows how to respond to the needs of members, and, more importantly, she anticipates their needs!

But beyond all of her experience and success in her local and national chapters is the character of Linda Lawrence. She is simply one of the finest human beings it has been my privilege to know. Her character and deeply routed work ethic has contributed to the level of excellence we "all" strive for at GSACEP and in the US military. Her desire to foster future leaders and clinicians in the field of emergency medicine is exemplary. These virtues will most assuredly carry her to become a successful president if afforded the opportunity.

Linda knows ACEP, cares deeply about it, and has clear-cut goals to improve it during her Presidency and beyond!

The AF has selected her for the senior most position of EM leadership, her colleagues on the ACEP Board of Directors have elected her to executive offices of leadership, now it is our turn to vote. I respectfully ask you to join our Chapter in support of the election of Col Linda Lawrence, MD, FACEP, to the position of President-Elect for the American College of Emergency Physicians. Please contact me with any questions: 210-916-8218 or john.mcmanus@amedd.army.mil

Sincerely,

LTC John McManus MD, MCR, FACEP

President GSACEP

Important GSACEP Dates 2006-2007

GSACEP Board of Directors Meeting
Monday, October 16, 1100-1200, Mardi Gras C, New Orleans Marriott

GSACEP Reception
Monday, October 16, 1800-1900, La Galerie 6, New Orleans Marriott

ED Director's Course - Sunday, March 18, 2007
The Crowne Plaza Hotel, San Antonio, TX

Joint Services Symposium 2007 - Monday, March 19 - Wednesday, March 21
The Crowne Plaza Hotel, San Antonio, TX

Contact GSACEP office for more information at 877-531-3044

Joint Services Symposium 2007
EMERGENCY MEDICINE ON THE RIVERWALK
CALL FOR ABSTRACTS

THE GSACEP RESEARCH COMMITTEE IS SEEKING SUBMISSIONS OF ORIGINAL RESEARCH FOR PRESENTATION AT THE JSS 2007 RESEARCH FORUM. THIS PROGRAM, WHICH HISTORICALLY HAS SHOWCASED BOTH CUTTING-EDGE INVESTIGATION AND UPCOMING MILITARY HEALTHCARE RESEARCHERS, WILL BE CONDUCTED ON 20 March 2007 AT THE Crowne Plaza HOTEL, SAN ANTONIO, TEXAS.

Abstract Submission Requirements:

Original research: Abstracts should represent original basic science or clinical research. Residents and students may submit on-going projects or projects that have previously been presented within the last calendar year (April 2006 – March 2007). Attending faculty may submit only previously unpublished or unpresented material. Abstracts must include the following subsections, consistent in style with those appearing in *Annals of Emergency Medicine*: title, study objectives, methods (design, setting, type of participants), results and conclusions. The abstract should fit on a single page of 8 _ x 11inch paper, typed double-space with margins, with a minimum font size of 12 point, Times New Roman or Tahoma preferred. Tables and figures should not be submitted during the initial review. Submission in electronic format is required. The file should contain names of all authors, appropriate institutions, main point of contact, title of abstract, text of abstract, and statement of IRB oversight if applicable. Primary investigators should also identify themselves as in-training (medical students and house staff) or attending staff. Entries should be submitted to LTC John McManus (john.mcmanus@amedd.army.mil) with a firm deadline of 1700 hours (5:00 pm) EST on 29 January 2007. Abstracts will undergo screening by peer review. Those that are accepted will have been judged scientifically valid and as yielding important information which will ultimately affect patient care. Abstracts will be reviewed for oral presentation or poster exhibition. If accepted for oral presentation, one of the authors will have 15 minutes (10 minutes for presentation and 5 minutes for discussion) to present their work on 20 March 2007. A copy of your PowerPoint presentation must be sent to LTC McManus at the above email address no later than 10 March 2007.

Previously presented research: We encourage **ALL** research previously presented or published within the last calendar year (April 2006 – March 2007) be displayed in poster format.

GSACEP will present an award for best scientific presentation and best scientific poster. For further information see the GSACEP Web site GSACEP.org or contact GSACEP: GSACEP@AOL.com / 877-531-3044 or LTC McManus: mcmanujo@ohsu.edu / 210-916-8218

WHERE WILL YOU BE OCTOBER 15-18? WHY, NEW ORLEANS, OF COURSE!

GSACEP members: Are you willing to match the commitment hundreds of your colleagues made during Hurricanes Katrina and Rita? Many put their lives on the line. They cared for patients for days without water, power, or food. After the storms passed, they dedicated weeks and months helping those in the affected areas. We need your support to match the commitment of those brave physicians by returning to the Crescent City for *Scientific Assembly*, October 15-18, 2006.

This year's meeting provides a unique venue in which to learn about trends and concerns in your practice, exchange ideas, solve problems, and network with other professionals from around the world. *Scientific Assembly* offers a world-class educational experience with more than 300 intellectually stimulating educational courses, a variety of exciting hands-on skills labs, an exceptional showcase of 300 exhibitors, and many social opportunities.

Many sections of New Orleans suffered tremendous damage. However, the city's downtown area, the French Quarter, and the Garden District were only minimally affected. All are ready to provide the type of food, atmosphere, and hospitality for which New Orleans is famous.

GSACEP Activities

Col Linda Lawrence, MD, FACEP is running for President Elect, ACEP. If elected, this would be the first time an Active Duty military emergency physician, and a member of GSACEP, was elected to this office.

GSACEP Board of Directors Meeting (open to all GSACEP members)

Monday, October 16, 1100-1200, Mardi Gras C , New Orleans Marriott

GSACEP Reception (open to all GSACEP members)

Monday, October 16, 1800-1900, La Galerie 6, New Orleans Marriott.

GSACEP members speaking at SA:

MAJ Robert Blankenship, MD, FACEP,

Handholding for Handhelds: Palmtop Principles for the Practitioner (SU-18), Sunday, October 15, 12:30 PM - 1:20 PM

Advanced Uses of Palm-Based Handhelds (SU-58), Sunday, October 15, 5:00 PM - 5:50 PM

Electronic Emergency Department Record: Do the "Write" Thing (MO-147), Monday, October 16, 5:00 PM - 5:50 PM

LTC David A. Della-Giustina, MD, FACEP

Rational Evaluation and Management of Low Back Pain (MO-87), Monday, October 16, 9:00 AM - 9:50 AM

"My Hand Feels Funny and My Foot's Asleep": Peripheral Nerve Problems (MO-140), Monday, October 16, 4:00 PM - 4:50 PM

LTC John G. McManus, Jr., MD, MCR, FACEP

Maintaining Your ABEM Certification: Review of 2006 LLSA, Monday, October 16, 9:00 AM - 9:50 AM

Innovations in Combat Casualty Care: Civilian Application (MO-138), Monday, October 16, 4:00 PM - 4:50 PM

Advocacy in the Fast Lane

by CAPT Torree McGowan, USAF, MC, GSACEP Resident Rep

Take a look at your emergency department waiting room. Check out the national news. Emergency medicine across the United States has some major challenges on the horizon. It is very tempting to try to ignore these problems and hope that someone else will work them out. After all, we're just residents, and we don't have the voice, or the time, to change things. Plus, we're in the military, and it won't affect us, right? Wrong, wrong, wrong. The changes taking place in emergency medicine will most certainly affect us, not only in our professional and personal lives once we leave the military, but right now.

I used to be a strong supporter of the "ignore it and hope it will go away" school regarding health care policy. After all, I have signed most of my natural life away to the military. I will almost be ready to draw social security before I have to worry about the problems facing emergency medicine. However, after a generously funded trip to the ACEP Leadership and Advocacy Conference, courtesy of GSACEP, I have become a reluctant convert. The LAC is an absolutely fantastic experience, and I highly recommend it to all who have a chance to participate.

In this article, I will share highlights from the LAC of hot advocacy topics. In the next EPIC, I'll share a few ideas on how those of us who just don't have time to change the world by ourselves can help this effort.

Access to Emergency Medical Services Act

Congress is currently debating ACEP supported legislation entitled the Access to Emergency Medical Services Act. These bills, one in the House and one in the Senate, will not fix all the problems involved with emergency medical care. However, the proposed legislation is an important first step in addressing some of the issues hamstringing emergency rooms today. Full information on the House and Senate bills can be found at http://www.acep.org/webportal/Advocacy/fed/.

The first section of the bill seeks to address the liability crisis that is crippling our ability to find consultants to care for our patients. Under the provisions of the bill, physicians providing EMTALA mandated or post-stabilization care to uninsured patients will be covered under the same liability umbrella as physicians in the military are. Malpractice claims against physician in these cases will be defended by the government, as if the physician were a government employee.

The next section of the bill provides a 10% payment increase for Medicare patients treated in the emergency department, attempting to address the huge volume of uncompensated care provided in EDs. A recent study indicated that the average emergency physician in the US provides $140,000 per year of uncompensated care. The financial projection to pay for this increase is on the order of $180 million per year.

The final provision provides financial incentives to hospitals to end boarding of patients in the emergency department and admit them to the hospital in a timely manner. Emergency department visits have increased from 90 million in 1993 to 114 million per year in 2003. However, in that same time period, we have lost over 100,000 inpatient hospital beds. With an average of one ambulance per second across the United States being diverted everyday and patients dying because of longer transit times, the issues of ED overcrowding are making front page news.

Medicare and the Sustainable Growth Rate

Medicare reform has been the politicians' favorite dead horse to beat for years, and every four years in late October the words create a distinct feeling of nausea in me. After the LAC, and becoming more informed on the issue, I fear I may progress to active emesis next fall.

The problems with Medicare reform right now are tied to the Sustainable Growth Rate, or SGR. The concept, in a very simplified nutshell, is this: in year 1, Congress allocates $1 billion per year to pay for Medicare costs in the US. If you use more that your allocated amount, you have to "borrow" from the next year. So in year 1, if you use $1.1 billion, to start year 2, you now only have $900 million. In year 2, it's now more expensive to provide the care, and you end up using $1.3 billion. Now, for year 3, you only have $600 million to use. It's easy to see how this can snowball quickly, and one of the ways that the government compensates is to cut physician payments. If the SGR is not repealed, in the year 2013, taking into account the projected cuts to physician reimbursement and the increasing cost of providing health care, physicians will be reimbursed at a level of 50% of what we were paid in 2002. That is less than half of what we are paid now (or would be if we were staff).

ER One

The Washington DC area has set about to design and build the ultimate emergency department. They have fantastic diagrams, patient flow ideas, and really neat ways to make the ED of the future more patient and physician friendly, while allowing for a huge surge capacity for mass casualty events. Check out their website at www.ERone.org.

Institute of Medicine Report

This report addresses many of the issues that I mentioned above, just in much greater detail. It is a landmark look at in-hospital emergency care, EMS systems, and pediatric emergency care in the US and the challenges we face. Our practices and emergency departments will be different in the future based on this report, which tells us what most of us already know: As a nation, our EDs are in trouble. If you don't have the attention span for 800 plus pages, check out http://www.acep.org/webportal/Newsroom/NewsMediaResources/PK/iom/ for the Cliff's Notes version.

This article is a just a brief overview of the current issues in emergency medicine, and hopefully will motivate you to speak up and be heard on these issues. The final, and most important, lesson I learned in Washington DC is that legislators want to hear from us, want to listen to our stories and our ideas. Our voices as residents are very strong, as we are so close to the problems at their worst levels in urban EDs, and because we can help create our own future in emergency medicine. Next issue, I'll tell you how to do it and still have time to eat and sleep.

GSACEP – A New Journal for a New Direction?

by LTC John McManus MD, MCR, FACEP

One of my endeavors as your current President has been to improve not only communication in our society, but also to improve communication among emergency medical specialists in our military services as well as our colleagues who also practice operational medicine. Most of you who have tried to publish or promote disaster or operational medicine in any current civilian forum or publication have probably learned that many of the current publications and societies have a very narrow-minded view on how medicine is "truly" practiced in these environments. Furthermore, there really is no single venue that we can rely on to deliver high-quality research or reviews in pertinent operational topics. So, recently I approached the Board with dissolving the *Epic* publication and incorporating the content into a new emergency medical journal, the *Journal of Disaster and Operational Medicine.* I would envision the following:

The *Journal of Disaster and Operational Medicine* would be a quarterly peer-reviewed journal which would serve as the official Journal of the Government Services Chapter of the American College of Emergency Physicians (GSACEP). Its purpose would be to serve as an international forum for debate and exploration of the key strategic, scientific, and operational issues posed by tactical and disaster situations. Health leadership, comprehensive health systems as well as individual healthcare providers must be equipped with knowledge, experience, flexibility and advanced technology to effectively respond to any threat. Responding and practicing emergency medical care in these "austere" and challenging settings is a complex, multi-faceted, and multi-disciplinary task. The goal of the emergency medical healthcare provider is not only to treat the exposed and injured, but also to manage their social, familial, economic and community needs. The *Journal of Disaster and Operational Medicine* would be devoted to the field of disaster and operational medicine. Practitioners and researchers in health-care, academia, industry and government and the US Military around the world would find analyses, ideas, new applications of knowledge, and discussions of pertinent issues that will help them enhance the efficiency and effectiveness of their policies in the practice of emergency medical care in the operational and disaster settings. Editors and reviewers would be "true" experts and visionaries who have all not only practiced in these challenging environments, but who have also published extensively in this sub-specialty of healthcare. The *Journal of Disaster and Operational Medicine* would strive to provide readers with the latest experience, research, reviews and debates included (but not limited) to the following areas:

- Research within all fields of tactical and disaster and battlefield (combat) medicine
- Planning and preparedness
- Injury patterns
- Triage and related physiologic variables
- Practical management, organization, mitigation, response, treatment and recovery for natural and man-made incidents
- Traumatology and Tactical Combat Casualty Care
- Prehospital and Public health planning, mitigation, preparedness and response
- Hazardous materials
- Chemical, Nuclear, Biological and Explosive Events (CBRNE)
- Psychological reactions and healthcare
- Terror and armed conflicts
- Humanitarian response and healthcare
- Telemedicine and remote healthcare
- Homeland security

The *Journal of Disaster and Operational Medicine* would publish peer-reviewed information relevant to the practice, educational advancement, and investigation of operational and disaster medical emergency care, including (but not limited to) the following types of articles: Original Articles, Collective Reviews, Preliminary Reports, Case Discussions, Clinical Practice Guidelines, Deployment Discussion Topics, Editorials, Letters to the Editor, Media Reviews, Advanced Technologies and Special Contributions.

I'm interested to hear what the members think of this possible endeavor (pros and cons). Currently, the Board is debating the issue and is soliciting feedback. If any member has pertinent comments or wishes to participate in any capacity, please write LTC McManus at: John.mcmanus@amedd.army.mil).

Emergency Medical Services Fellowship

Emergency Medical Service- BAMC-Brooke Army Medical Center announces the creation of a one- year Emergency Medical Services (EMS) Fellowship to begin July 2007. This EMS fellowship was created to provide emergency physicians with the necessary experience in operations, training, research and administration to contribute to EMS systems in a variety of settings, particularly in the pre-hospital combat environment. Applicants will rotate through Army and civilian EMS systems as well as be required to maintain active clinical practice at Brooke Army Medical Center including shifts in the Department of Emergency Medicine. The fellow will also be expected to serve as the assistant medical director of Fort Sam Houston and Camp Bullis Fire Department(s).This fellowship is currently open to all US Army Emergency Medicine Residency trained Medical Corps officers (0-3 to 0-6). All interested applicants will be required to submit a pre-proposal detailing the area of clinical research to be completed during the fellowship. The pre-proposal will be scored in addition to the standard documents utilized by the Joint Service GME Selection Board when considering applicants for this program. Point of Contact for this program is LTC John McManus, Emergency Department, Brooke Army Medical Center, DSN 429-8218 COM (210) 916-8218.

GSACEP Member Takes Command

LTC Frank Christopher, MD, FACEP, took command of the 261st Multifunctional Medical Battalion from LTC William Terry on July 7 at Fort Bragg, NC, at a ceremony presided over by BG Philip Volpe, Commanding General, 44th Medical Command.

LTC Christopher is the first Medical Corps officer since WWII to command the 261st.

The 261st MMB was first activated in 1942 as an Amphibious Medical Battalion and immediately saw action during the invasion of Sicily, later supporting campaigns in Naples and Rome. It earned distinction as the only medical battalion to complete the amphibious assault on Normandy during D-Day, earning both the Presidential Unit Citation and the French Croix de Guerre. Inactivated in 1945, the battalion was reconstituted as an Area Support Medical Battalion in 1991, and its headquarters and units have deployed to Hurricane Andrew, the Balkans, Kosovo, Afghanistan, and Iraq. Today, it is the largest and only airborne medical battalion in the Army, consisting of a headquarters detachment, four area support companies, two forward surgical teams, a preventive medicine detachment, and a combat stress control detachment. Several of its units are currently deployed or scheduled to deploy in support of the war on terror.

LTC Christopher recently completed a tour as Chief, Department of Deployment Health, Womack Army Medical Center, concurrently serving as Medical Director of the Fort Bragg Reserve/National Guard Mobilization Platform. Previously, he served as Division Surgeon, 82D Airborne Division, and in staff EM roles at both Brooke and Womack AMCs. He deployed to both Afghanistan and Iraq with special operations forces; and to Iraq with the 82D. He is an Associate Professor of Military and Emergency Medicine at USUHS. His awards and decorations include the Bronze Star Medal, the Meritorious Service Medal (3 OLC), the Air Medal, the Combat Action Badge, the Combat and Expert Field Medical Badges, the Senior Flight Surgeon Badge, the Senior Parachutist Badge, and the Order of Military Medical Merit.

New Army Consultant-Elect to the Surgeon General

by LTC (P) Ian Wedmore, MC, USA

To those of you I haven't met at some point in my army career, I would like to introduce myself. I have recently been appointed Army Consultant-Elect to the Army Surgeon General. I have a VERY tough act to follow. LTC Dave Della-Giustina, MC, USA, has been an outstanding consultant, and one of the best emergency physicians and soldiers I have had the pleasure to know. I don't think there is an emergency physician out there, military or civilian, who hasn't heard of Dave, talked to him or attended one of his lectures at national ACEP. He has kept Army Emergency Medicine strong and pointed in the right direction for which we should all be thankful. I am glad that we will be able to work closely together until I can get a handle on this job and that he will be available to help guide me through the problems a consultant must handle.

So what's my background? I came into the army from NY Medical College on an HPSP scholarship. I got a three-and-a half year scholarship and somehow ended up owing four years, but it didn't matter because I had a great time from the start. I did officer basic at Ft Campbell (in 1987 there were a number of places you could go) where I made some long-term friends and was able to go through the air assault course. I did my internship in Internal medicine at BAMC in 1990 and then went to MAMC in 1991 for the emergency medicine residency. After the residency I stayed at MAMC as teaching staff and simultaneously became involved with the SOF community. I have remained at MAMC and been with SOF for 12 years now. I have been deployed for Operation Uphold Democracy, been overseas on numerous occasions for training, and have deployed six times to either OEF or OIF and will soon depart on my seventh deployment. I have been in austere environments and believe they are where emergency physicians really stand apart from other specialties, and why we are quickly becoming the most sought after specialty by operational unit commanders.

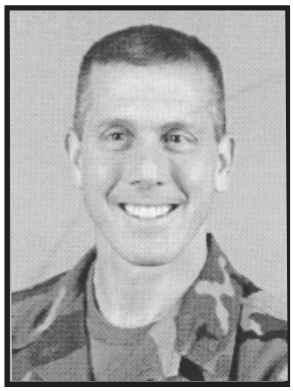
Army Emergency Medicine has and will continue to have many challenges over the next several years. Op-tempo will remain high. Emergency physicians can expect to be deployed, and graduating emergency physicians can expect to go to operational assignments. We continue to evaluate what type of electronic medical record will work in the ED, particularly in the face of the implementation of AHLTA. We always face the challenge of how to get our patients cared for, admitted, and followed-up as resources become slimmer and slimmer and medical costs higher and higher. These are but a sampling..

I don't want to go on too long but hesitantly look forward to taking over from Dave in January, 2007, when I return from deployment. He remains the consultant until then, and we will work closely together during and after the transition process to provide the best consultant support possible to Army Emergency Medicine. Dave will be doing the ODP process/presentation as well as the GME selection board and I will concur with his decisions and recommendations that come from that meeting. Though Dave is still Consultant, please feel free to contact me with any questions or issues. Do it soon because my e-mail access will soon be pretty spotty at best.

LTC(P) Ian Wedmore, MC, USA

Should Residents Deploy?

by LTC Robert A. De Lorenzo, MC, USA
GSACEP Immediate Past President



A senior resident in my program recently asked to arrange an elective in the combat zone of Iraq. He knew several of our faculty members were assigned to a level III field hospital in theater and he planned to capitalize on this unique educational opportunity. In self-motivated fashion, he had already thought through many of the details of travel, learning objectives, and such. As program director, of course I wanted to support my resident's professional and educational development. But having been engaged in this discussion in previous years, I knew of the challenges and complexities involved.

The discussion begins with a look back to Gulf War I when residents (in emergency medicine, mostly) were involuntarily deployed. The resultant disruption in training and displeasure from the Accreditation Council for Graduate Medical Education (ACGME) caused all three service surgeons general to rewrite the regulations governing resident deployments. The net result was a general prohibition on resident deployments short of all-out war. While these policies technically don't prohibit educationally focused deployments, a lingering reluctance to repeat the experience Gulf War I remains. More recently, rules have been relaxed slightly and residents have deployed on humanitarian missions. Pediatrics, for example, has maintained a regular mission to South America. However, combat deployments have not been approved at the service level despite active discussion among program directors and military graduate medical education (GME) staff.

The arguments in support of combat deployments are readily apparent. Military emergency medicine residents are essentially training for the wartime mission, so it makes sense to provide a relevant educational opportunity. Few could argue the clinical value of resuscitating combat casualties. A combat medicine rotation also goes to the heart of the military GME relevancy. So why is it that four years into war have essentially no residents deployed on such a combat zone experience? The answer lies in understanding the challenges created by the complex interplay of resident, education program, military, and the public.

The ACGME, through its individual specialty Residency Review Committees (RRC) governs the structure and learning environment of all residency programs. While specific rules for each specialty differ in the details, a consistent theme is the requirement for a safe, sound, and educationally appropriate experience with qualified faculty supervision at all times. In the combat zone, assuring quality of teaching and continuity of supervision will be challenging, although not impossible. Carefully linking deployed residents to faculty could mitigate supervision concerns. More difficult will be accrediting the field hospital or deployed unit as a teaching institution. Simply put, GME is not on the mission-critical list of most units, and in wartime, secondary missions are rarely given priority. It will also be difficult to convince the ACGME that a safe learning environment can be assured. No matter how it is explained to civilian authorities, safety in a designated combat zone is not likely to sound convincing. Nevertheless, a comprehensive curriculum combined with strong program, institutional, and service commitment could conceivably overcome any ACGME skepticism.

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There are also practical program and military issues to consider. Funding for elective temporary duty (TDY or TAD) is very scarce, and permissive TDY is not allowed since regulations prohibit the conduct of official business while in PTDY status. Even if TDY orders are funded, authority rests with the theater combatant commander and not the service or program. Thus, control of timing, duration, and assignment is not assured. This can be problematic since poor timing can result in missed regular rotations for the deploying resident or schedule disruptions for other residents in the program. Worse, if the deployment, to include any pre-deployment train-up, gets extended much beyond one month (even by a few weeks), rigid RRC rules regarding time away from the program kick in. An extension of training will likely be required and the late-graduating resident will exacerbate existing service staff shortages. Lastly, there is the issue of providing a deployment experience for all residents in a program. While setting up a rotation for a single resident is challenging enough, establishing one across a class of 8 – 16 residents is a huge task. If all the military emergency medicine residencies participated, approximately 50 rotations in the combat zone would be needed for each class each year. A systematic, service wide (or better still, DoD-wide) approach would be needed to meet this high demand.

The last hurdle to surmount, and potentially the most difficult to control, is public perception. It is unclear how the public would respond to the news that "trainees" were caring for their wounded sons and daughters. Never mind that senior residents are far more skilled in resuscitation than the many general medical officers, physician assistants, and other generalists assigned to resuscitative positions in the field. Even carefully orchestrated public relations efforts may not overcome public skepticism, or worse, vocal opposition. One strategy might be to shift the focus from training doctors to improved care of the troops.

As the war grinds on, will obstacles come down and policies change? It is difficult to predict, but at the moment there seems little groundswell for change. Many military residency programs are experiencing painful faculty turnover, budget cuts, and Tricare decrements, and interest in combat rotations will necessarily take a back seat. Service leaders, too, are fully engaged in more pressing matters and are unlikely to be able to lend strong support. Nevertheless, under the right circumstances, a combat medicine rotation offers unique clinical potential, and the idea deserves continued attention. Attempts by residents and faculty alike to create unique educational opportunities should be both encouraged and supported.

ACEP Board of Directors Update

by Col Linda Lawrence, Vice President ACEP

The ACEP Board of Directors met June 21-22, 2006, for the final meeting for FY 06. At that time we approved a budget for FY 07 that included a $373,251 contribution to equity without raising member dues. This is the ninth consecutive year member dues in ACEP will remain constant as the budget reflects our ongoing commitment to streamline activities and direct funds toward the College's priorities. The BOD also received an update on FY 06 and one highlight was the significant growth in membership. In FY 06 ACEP membership added 789 new Active members. This growth is significantly more than we have seen in the past four years.

Significant amount of time was spent discussing the development of a quality measure mandating the collection of hospital data quantifying the time a patient spends in the ED. The BOD agreed this measure should establish a goal that total time in the ED for patients should not exceed six hours. Further work has already occurred and ACEP is now working with leadership of AHA and other hospital groups in hope of building some consensus before submission to the National Quality Forum and meeting with CMS and JCAHO. Expect to hear a lot more about this effort in the near future. This is an example of one more bold effort by the College to galvanize the support needed to address the issue of crowding. We hope to work collaboratively with hospitals to relieve the wait times and boarding.

The BOD discussed the recent release of the IOM report and prioritized efforts identifying where ACEP needs to take a lead. In the near future the IOM will be conducting town hall meetings. In addition ACEP has offered support through grants for states to establish governor task forces and other efforts to start working on fixes for problems identified by the National Report Card on Emergency Care and the recent IOM report.

The DC office continues to expand with the recent addition of Ms. Angela Franklin as ACEP's new Quality/HIT director. Ms Franklin will be the lead staff person working with members and staff of leading organizations in the development and approval of quality reporting and performance measures, and health information technology standards.

These are just a few of the highlights of what has been happening at the national level. The past year has been the most productive and successful year I can recall in ACEP history. We began the year with the Rally on Capitol Hill and introduction of HR3875 where we now have 34 co-sponsors (18-Republicans/16-Democrats) in the House and three co-sponsors in the Senate. In January, ACEP released the National Report Card on Emergency Care and had unprecedented media attention at national and local levels. In the DoD the report card garnered attention by senior leadership and resulted in several articles in military papers. Finally, in June, the Institute of Medicine released the study they spent almost three years developing on the state of emergency care in the U.S. This report gives credence to the messages ACEP has been delivering for several years and hopefully will be the catalyst to gain the attention needed by Congress and the public.

In my opinion, I think we are poised for another exciting year and have never felt more optimistic that reform is possible. But to do this it is going to require all of us to get involved. I encourage you to first be sure your colleagues are members of ACEP – numbers matter and never before has it been more important for our voice to be heard. Second – support NEMPAC. ACEP has set a goal to establish a $2 million PAC and we are on our way to meet that goal. The stage has been primed and emergency medicine is center stage – let's be leaders in the world of advocacy. Third – become a spokesperson in your community. Talk to patients, write articles for the local paper. ACEP has several resources that can help and make this really easy. Finally, seriously consider joining your colleagues in New Orleans for Scientific Assembly October 15-18, 2006 as we have a lot to celebrate and colleagues to recognize who supported relief efforts post Katrina. Hope to see you there!

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