A Chapter of the American College of Emergency Physicians

GSEPIC

Government Services

Fall 2007

It's Our 30th Year!

see page 2

President's Message

CAPT James V. Ritchie, MC, USN

Welcome to New Members!
"Welcome aboard" to our new members! We're excited to have you with us. You joined 832 (as of July) other current and former military Emergency Physicians who are motivated by the mission, the camaraderie, and common interests. Please let us know how we can help you with all aspects of your practice. You will find a wide variety of resources, including free subscriptions, educational aids, lessons-learned, and more, available at our website (www.gsacep.org). And you'll find a spectacular treasure of experience in your fellow members. We can put you in touch with people who can provide advice with virtually any problem in military emergency medicine.

Membership drive results:
A hearty thanks to Marco Coppola and everyone who helped us win the ACEP Membership Drive, taking the Medium-Sized Chapter category with 24 new members. ACEP presented us with a $5,000.00 prize, which we will put to use for you.

ACEP Council Meeting in October- We want your input!
The ACEP Council is the "legislature" of our organization. Each chapter sends representatives to the Council, held just before the Scientific Assembly. This Council debates resolutions that guide the direction and policies of the College. Prior action at this level led to many advances in our specialty and our College. Tell us of your practice difficulties that can be addressed and aided by College Resolutions. We will be happy to bring them to the floor and advocate for you.

ACEP Policy Statements – Put to use for your benefit.
Is someone in your hospital giving you difficulty with your options of procedural sedation agents? Are you being told to staff your ED in a means you consider unsafe? You should be aware that ACEP has crafted almost 200 policy statements intended to assist you in your practice. Check out http://www.acep.org/webportal/PracticeResources/PolicyStatements/ and you'll find help on diverse subjects such as Procedural Sedation, Use of Ultrasound in the EMD, Internet Access, Shift Work, and even a policy on Military Emergency Medicine.

Joint Services Symposium
Make plans now to join us March 16-19 in San Antonio for the finest Military Emergency Medicine conference on the planet! Jim Eadie and Julio Lairet have laid out another spectacular conference, where we will be treated to the cutting edge of both civilian and military EM. Rear Admiral William Roberts, the Chief of the Navy Medical Corps and the Medical Officer of the Marine Corps (two big hats, one excellent emergency physician) will give our military keynote address. Rob Blankenship and his Madigan consortium of experts will show us the most innovative uses of battlefield ultrasound.

Smell a rose or two
I was reminded recently of a couple of reasons to revel in what we do. The first was mentioned by a reservist, who always loves her active duty time because she doesn't have to deal with the spitting, threatening, drug-and-staff-abusing population that plagues her in her usual practice. We have a noble patient population, by and large. They have their challenges (don't we all!), but most of them know what it means to serve something bigger than themselves through sacrifice and discipline. It's motivating to take care of people like that. The second was from a resident who was dismayed at how patient flow had ground to a halt during a prolonged resuscitation. A man had run into the treatment area with his apneic two-year-old son, who lost consciousness during an asthma attack about half a mile from the hospital. Forty-five minutes of intensive resuscitation later, the department was a mess, with impatient patients fussing, interns and students queued up to present new patients, and no movement. But after the resident's comment, we saw the asthmatic kiddo sitting up by himself, hugging his dad. That kid had been all but dead. The small stuff is small stuff. When you're disillusioned by some absurd obstruction, it's rejuvenating to remember that we get to save lives for a living.

Thanks for doing what you do.

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The opinions and asserttions in this issue are solely those of the authors, or GSACEP, and are not necessarily those of the Department of Defense or any other US government agency.

GSACEP Reception --Get Onboard

Dear Member,
You should have received a formal invitation to GSACEP's party at Scientific Assembly. If not, here is a copy of the invitation. Please confirm if you're coming!

The Government Services Chapter ACEP
in honor of
ACEP President Col Linda Lawrence, MD, FACEP
and in celebration of GSACEP's 30th anniversary
cordially invites you and a guest aboard
The Royal Argosy
for a buffet supper, bar, and musical entertainment
boarding at Seattle Harbor Pier 55
at 7:15 P.M. Tuesday, October 9
and cruising the harbor from 8:00 P.M. to 11:00 P.M.
Casual dress
PLEASE RSVP by September 21 to GSACEP
gsacep@aol.com or 877-531-3044
Sponsored by
Hemcon, Microsoft, Northwest Emergency Physicians of Teamhealth,Sonosite, Ultrasonix, Verathon

GSACEP Board of Directors Meeting

The GSACEP BOD meeting is Tuesday, October 9, 1100 to 1230. Madrona Room, Sheraton Seattle. All members are invited.

Congratulations . . .

To Dave Barry and Bruce Adams for being named as Senior Reviewers for the specialty's top journal, Annals of Emergency Medicine. Top Reviewers are chosen based on a formula that ranks them on their total performance in timeliness, review quality, and volume of reviews performed. Reviewers who have appeared on the annual Top Reviewers list twice or more in the last 4 years are truly the best of the very best, and to recognize their contribution they are listed on the masthead each month as Senior Reviewers. This is incredibly prestigious and a superlative achievement that recognizes their national prominence.

To LTC (P) Robert De Lorenzo for promotion to the full editorial board of Annals.

To RADM (select) Bill Roberts for his recent promotion to Chief of the Navy Medical Corps and Medical Officer of the Marine Corps.

High Score for Reisdency Program

LACKLAND AIR FORCE BASE, Texas (AFPN) -- The Emergency Medicine Residency Program at Wilford Hall Medical Center scored in the top three percentile in the nation in June. Out of 152 emergency residencies across the country, the emergency residency at Wilford Hall scored above 97 percent of the other residencies on in-service training exams for emergency medicine.

The program began in 1977 and started as an Army-only residency program until the Air Force joined 10 years later. It is now the oldest joint-program combining Air Force and Army residents. "The purpose of the residency is to treat emergency residents," said Maj. (Dr.) Robert Thaxton, assistant program director. "We spend alot of time and focus on patient care and medical knowledge."

A faculty of 21 Air Force and 15 Army personnel are responsible for training 47 residents overall, which include 24 Air Force and 23 Army residents. Dr. Thaxton says the faculty can devote a lot of time to residents because of a relatively smaller patient volume than other emergency rooms in San Antonio.

The three-year residency includes in-house and country-wide rotations that residents must follow to satisfy graduation requirements. Some of the rotations are in cities such as Austin, Texas; Fort Hood, Texas; and New York. Other rotations are in departments such as the surgical intensive care unit, neonatal intensive care unit, orthopedics, anesthesia, cardiac care unit, toxicology and the emergency department. Residents also are sent out in military environments to learn how to be an emergency physician in austere conditions. There also are 19 rotations outside of the emergency department from different universities giving residents a better understanding and knowledge of emergency patient care.

"We are blessed to have excellent residents and a complimentary faculty that bring a breath of experience to teach different aspects," said Maj. (Dr.) Robert Kacprowicz, incoming program director. "We are able to draw from their strengths."

What makes the program military-unique is that it aims to send residents across the country for their rotations and has a robust program curriculum where residents are expected to study hard and learn as much as they can while in it, said Dr. Thaxton. The curriculum is centered on what faculty can teach the residents using what Dr. Thaxton calls weekly 'ground-round' teaching. Emergency residents must complete one publishable research project and participate in monthly procedural and simulation labs where both animals and simulators are used as learning tools. To graduate, residents must be able to identify all life threatening diseases, and must identify, resuscitate and treat any patient. "When we treat patients, we have a chief complaint and don't have the advantage of knowing the patient's history," said Dr. Thaxton. "We have to analyze on the go." Quality patient care and ranking in the top 10 percent are things both Dr. Thaxton and Dr. Kacprowicz hope to continue accomplishing.

"We want to keep and promote a joint environment where residents work toward a common goal regardless of affiliation," said Dr. Kacprowicz. He also said full credit should be given to Army Lt. Col. (Dr.) Robert De Lorenzo, outgoing program director, because of the work he did to help the residency program score very well.

The emergency residency program has expanded and now offers a fellowship. That is a first for a military emergency residency. Many of the graduates have gone on to high positions, such as program directors, elsewhere.

Across the Department of Defense, the emergency residency program at Wilford Hall is the most highly sought after and had the most competitive applicants for the year 2007, said Dr. Thaxton. There were 99 applicants and only 16 slots available. (http://www.journals.elsevierhealth.com/periodicals/ymem/current)

Get Involved!

Col Linda Lawrence, USAF, MC

AF SG EM Consultant, President-Elect ACEP

As I pondered what to write I couldn't decide which hat to wear: Should I write to you from the perspective of Air Force Surgeon General EM Consultant, or as soon-to-be ACEP President? I finally decided my message was really the same from either perspective…GET INVOLVED!

So, first let me start by welcoming all our new docs fresh from residency to the military EM family. Notice I didn't say AF EM family. That's because we really are a joint specialty. We have a joint residency program, hold an annual Joint Services Symposium (JSS) every March in San Antonio, deploy together and, lastly, network and work together through GSACEP. Over the course of my military career, I can count as many close colleagues and mentors in the Army and Navy as I can in the Air Force. It is not uncommon to contact one of the other service EM Consultants or a colleague to see how they are handling an issue. These relationships all formed through GSACEP. So, I encourage you to get involved with the chapter and join us in Seattle for our activities, come to JSS this upcoming spring, and make the most of your time in the military, however short or long. I began many years ago thinking I was in for four years and here I am, several assignments later, still enjoying military EM. I attribute a large part of my remaining in the military to my experiences and the relationships I built through GSACEP and ACEP.

To all – AF, Army and Navy – get involved in your hospital and beyond! Step up to leadership roles. I always encourage young docs to volunteer for something they enjoy and have a passion for before they find themselves "volunteered" for some other task. Become leaders within your hospitals and be active on committees, try to improve your ED operations, and step up to leadership positions. As I tell my medical staff, earn your bitching rights. Don't just complain; offer some ideas on how you think the system can improve. If you don't attend committee meetings, medical staff meetings or other functions, the voice of EM will not be represented and our unique practice will fail to be understood. Sure, this might involve coming in to the hospital on a "day off" but this is critical. Contracts in the civilian sector are often lost because EM docs fail to get involved and establish relationships with other medical colleagues. Decisions unfavorable to EM are made in our hospitals because our voice is not present. Plus, it is a lot harder for the surgeon to yell at you in the middle of the night when you want to admit someone if you've established a relationship with him or her. For the new docs, don't be afraid to speak up. Trust me: You know a lot more about the practice of emergency medicine than most on the hospital staff.

Get involved and step up to leadership. We are overdue in the AF for taking control of our EDs. As I challenged everyone last spring, I want to see all our EDs with EM physician Flight Commanders. Now is the time as our staffing has never been better. So for those of you who have a few years under your belt, start stepping up to other positions of leadership.The more EM docs we have in senior positions the better for the specialty, and, I believe, the better for military medicine. I could go on for pages on this topic but instead defer to the wonderful article on leadership written by Col Payne, my hospital Commander. I enjoy working for an EM physician because we think the same and tackle problems with the EM mindset…make a decision and get the job done!

It is exciting to see EM physicians finally serving in senior positions within our services. I want to personally congratulate a longtime friend and mentor RADM (sel) Bill Roberts on his recent selection to flag officer. Bill rose in the ranks of EM but took his talents beyond and has been a role model and inspiration to many of us. On a personal level, he helped me through a tough time in my military career when I thought of leaving…this is what I was referring to above. Thanks, Bill, and best of luck in your new role.

Get involved in ACEP/GSACEP and speak up for your specialty. Finally, Americans have become frustrated with our crumbling healthcare system, a system controlled by insurance companies and a legal community who have driven up costs and cut benefits. It is a system that's destroying the practice of EM, leaving patients boarding for days in our hallways, ambulances driving around our cities looking for an ED not on divert, oncall panels void of many specialists and EDs operating at full capacity daily lacking any surge capacity if a disaster occurred. With the upcoming elections, healthcare reform will be broadly discussed and we have a great opportunity to get involved and help frame this debate. As President of ACEP, I hope to put a face on this issue. Let Americans know that they have a group that understands the issues and are true patient advocates every day.

At ACEP we are trying to expand our Spokesperson network so everyone can get involved even if it is just to send off a pre-drafted editorial to your local paper. It will function much like our 911 network (which, incidentally, I encourage you all to join). It will make it easy to send a scripted e-mail to your legislators. I am often asked: Can I do that as a military member, and the answer is, "Yes, in a personal capacity." That means leave off your rank and duty title but you can write as Dr X, an American tax paying voting citizen. So please take 15 minutes to let your voice be heard. If collectively we all gave an hour a year to advocacy, we would be a lot further in our agenda.

The ACEP Board also started a new foundation this spring – the ACEP Foundation. This will be targeted to the public and allow us to get the message out and form relationships with non-medical organizations very influential in the political arena. Please encourage your family and friends to check it out once we get it up and running…more info to follow. And speaking of family and friends set up a group email and forward them the messages you get from ACEP PR or 911 programs and get them to write their legislators. Think of how far around the joke e-mails you get from friends make it through cyberspace and then imagine what we could do collectively working our networks to educate the public.

Lastly, get your colleagues involved. When you are finished reading this EPIC, share it with a colleague who might not be a member and encourage him to join. Be sure those who just joined your staff from the civilian sector and are ACEP members have transferred their membership to GSACEP as this doesn't occur automatically but can with one quick e-mail or call to ACEP member services at 800-798-1822. It is exciting to see GSACEP as one of the larger chapters within ACEP. Even more exciting was our recent victory in the ACEP Membership Challenge. A huge thanks to Dr Marco Coppola, an Army National Guard Colonel, and longtime leader within GSACEP, and other chapter members who brought home this win.

In closing, I look forward to Seattle and hope to see many of you at the meeting. This is going to be a big year for GSACEP as we celebrate our 30th anniversary. Thanks to Bernie Carr and others we are having the party of a lifetime for GSACEP. So, don't miss the boat!

When I think of the state of EM when I first entered, I can't even imagine what it had to be like 10+ years earlier. Then, I reflect on what has happened in the past couple of decades and I know our future will be even brighter. We have defined our critical role in operational medicine and made ourselves an invaluable asset within military medicine. I encourage all of you to GET INVOLVED. The future is yours to define both within the military and beyond.

Leadership Imperative

By Col Lee E. Payne, Colonel, USAF, MC
Commander, David Grant USAF Medical Center

Have you ever considered leaving full-time clinical practice to take on some other role in your hospital or military service? For most of you, I imagine that question conjures up images of crossing over into the "dark side" and other nightmarish thoughts! In fact, during the early years of my career I felt the same way. There was no way, I thought, that I would ever leave the clinical practice of emergency medicine. Although I still practice clinically occasionally today, the majority of my job as a medical center commander does not allow me to be in frontline clinical care. My goal today is to convince you that, not only is it desirable, it is imperative that at least some of us take on leadership opportunities outside of the clinical practice of emergency medicine.

Emergency physicians are well-suited for crossing over into leadership roles within the hospital and other arenas. Our specialty requires that we be well-organized. We process information quickly, and often have to make decisions before 100% of the required information is available. By virtue of our specialty, we interact with most physicians on the medical staff, and, while those relationships are not always the warmest in some quarters, a well-run ED with highly-trained emergency physicians makes the lives of our colleagues better. When the medical staff figures out that you know what you're doing, are consistently accurate in your assessments and treatment, care for their patients and appropriately package them for admission or schedule them for a needed follow-up appointment, they grudgingly appreciate the amount of work you save them by being good at what you do. You also have a better understanding, than many other specialists, of most disciplines of medicine. You know the old saying, "Emergency medicine is a mile wide and an inch deep"! We know a lot about our colleague's work, particularly those that interface with the ED. These types of relationships, decision-making skills, and problem-solving abilities serve emergency physicians well when they cross over into other realms.

In today's world of large-scale natural disasters, and terrorist attacks with the potential for biological, chemical, and nuclear weapons, emergency physicians are perhaps the best specialists to help make sure our communities are prepared to respond and survive. You all know that should one of these tragedies occur in your community you will be on the frontlines caring for the ill, the injured, and the anxious. Many of you are already in a leadership role in your hospital and/or local community helping to plan for a response to these events. Your expertise is essential, but you probably have learned that others will not always seek you out. You must be proactive, make yourself available, and be a willing participant in the process. And this is one of the major reasons emergency physicians must step up to other leadership roles. If we are not at the table, or even in the room, when leaders are making key decisions, locally, regionally, or nationally, the special viewpoint and interests of emergency physicians, the specialty, and our patients will not be properly represented.

Another means of spreading your leadership wings and gaining experience is to get involved in ACEP, at the chapter and national level. It is a great way to understand the challenges faced by organized emergency medicine in today's highly competitive and increasingly disheartening national medical system. We know what those problems are: a fragmented care system, the rise of specialty hospitals, declining reimbursement, ED overcrowding, and specialists who are unwilling to take calls for patients after-hours. ACEP is the collective voice of our specialty. If you want your voice, your ideas, and solutions to be heard you have to be part of that process. You also can't expect to start at the top! Begin at the chapter level working on key projects or on a committee, and work your way onto the chapter board. In October, Col Linda Lawrence will assume her year as president of national ACEP. This is an important milestone for Linda personally, and for military emergency medicine as a whole. This didn't happen overnight. Linda worked hard over many years in the GSACEP chapter and at national ACEP to gain the experience, leadership, and reputation required to enable her to be elected ACEP president. We know she will do a great job. As military emergency physicians, we need to stand ready to help her in any way we can to support her presidency in the next year!

It takes a long time to develop leaders. Emergency medicine is still a relatively young specialty but we have been in existence long enough and have achieved a level of notoriety and respect as a specialty so that we are beginning to see career emergency physicians branching out and leading on the national level. An example is Dr. Art Kellerman who is an academic emergency physician and a leader in injury prevention and gun control that has used his talents and research to impact emergency medicine and our nation. There are many others. These emergency physicians have chosen to use their training and skill to lead and to make a difference on the national stage.

One of the great things about military medicine is that you often get leadership opportunities at a young age. We are often thrust into roles for which we may not feel completely prepared. This is actually a good thing! Given the opportunity to lead, you can grow. Each job the military gives you stretches you a bit and gives you new skills that will help you when you reach the next job. Over time, your experience is broadened and you are prepared for the toughest leadership challenges. One of the concerns I have in Air Force medicine is that not many young physicians, even those who are intent on making the Air Force a career, are stepping up to leadership roles early enough in their careers. When you do not compete for

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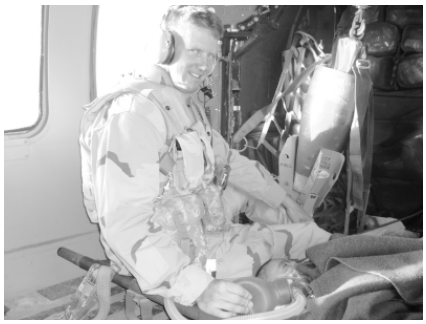
Provincial Reconstruction Mission in Afghanistan

By LtCol Chris Scharenbrock, USAF, MC



It has been several months now since I returned from my assignment as a Chief Medical Officer for a Provincial Reconstruction Team (PRT) in Southern Afghanistan. A few days ago, one of our radiologists from the 60th MDG at Travis AFB approached me with questions about upcoming 365 day tours for physicians to Afghanistan that will focus on building up the Afghan National Army healthcare system. From our talk, I realized that there is a tremendous thirst for knowledge out in the AFMS community about these assignments, and that, sharing my experience, might help.

In January, 2006, I found out that I was at the top of the non-volunteer list for a one year emergency medicine physician tasking to be a part of the new PRT mission that the Air Force was acquiring from the Army. AFPC was offering base of preference or two-year extensions on station to volunteer for this assignment. I was up for PCS the following year with a family that has grown very fond of the Northern California lifestyle. So, after some deliberation, I agreed to the assignment and took the extension option. What started as a very difficult choice turned out to be the experience of a lifetime.

Pre-deployment training began at Fort Bragg, NC, on February 26. It consisted of six weeks of combat skills training, including a course intended to hone field medical treatment abilities. There were plenty of opportunities to jump in and out of vehicles, learn land navigation, and weapons training. We received some Afghan cultural awareness training, but felt we certainly could have used more. During this time, I met the other members of our PRT medical team including Lt Col Jon B. (Ben) Woods, a pediatric infectious disease specialist, Capt Jacqueline King, a family practice physician assistant, and four medics, TSgt David Quarnstromm, TSgt Michael Ball, SSgt Daniel Izon, and SrA Jennifer Wollersheim. We found out that our team would be assigned to the Qalat PRT (one of six AF PRT's) and would work in Zabul Province about 90 miles north of Kandahar.

The mission of a PRT is to promote good governance and justice, enable an effective Afghan security apparatus through training and mentorship, and facilitate reconstruction, development, and economic growth. As our PRT commander, Lt Col Kevin "Beav" McGlaughlin would say, "to work ourselves out of a job". To do this, we had a 100+ person team that included an infantry platoon, engineers, medical, civil affairs officers and support personnel. In addition, we had representatives from the US State Department, US Agency for International Development (USAID), and US Department of Agriculture. We worked hand in hand with other coalition forces including Special Forces, 10th Mountain, 82nd Airborne, and Romanian Army as well as the Afghan provincial government and security forces, and other non-governmental organizations like UNAMA, UNICEF, and WHO.

Zabul province is a strategically important Afghan province that borders Pakistan and is on the "ring road" between Kandahar and Kabul. It is an extremely poor, rural province of less than 300,000 people with an under age five mortality of 260/1000. The literacy rate is 15% overall and less than 5% for women. Qalat's claim to fame is that it is overlooked by a fortress built by Alexander the Great more than 22 centuries ago. The ruins are still there and provide one of the few "tourist sites" in the area.

When we arrived in Zabul in late April, we were greeted very briefly by the outgoing Army team and found out that one of the reasons we had been sent to Zabul with a larger than average medical team was that a new 150 bed hospital (Zabul Provincial Hospital) had been built in Qalat as a donation from the United Arab Emirates. It had not been fully staffed and the Afghan physicians did not know how to use the equipment that had been donated. We worked closely with Afghan Ministry of Health officials to help make the hospital functional. PRT initiatives included re-work of electrical and plumbing systems, building a dining and laundry facility, adding a morgue and medical incinerator, and repairing equipment. Even more important than physical facilities, we initiated programs to train and mentor Afghan healthcare professionals. This included a six-week EMT training course, a one year LPN course, and physician training programs. We would go to the hospital at least weekly, go on rounds with the doctors and nursing students, and speak with the Hospital Director about projects we were working on and how to improve their services. Over the course of the year, improvements at the hospital resulted in 500% increases in number of surgeries performed, inpatient stays, and infant deliveries. Women were actually coming to the hospital for childbirth rather than home deliveries, which had been the cultural norm. Although there were certainly dangers in our area of Afghanistan, I found that most Afghan people were very happy with the US presence. The Afghan doctors were very friendly and jumped at the training opportunities we provided.

While over there, I would often be asked what a typical day was like. My answer was always, "There are no typical days". One day we would be out on a mission to assist Afghan doctors, providing medical care to impoverished men, women, and children in one of the nearly inaccessible distant districts. The next day, we would be in attendance at a meeting with the governor of the province and personnel from the UN Security Council.

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Mission in Afghanistan

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Again, when the engineers or civil affairs teams went out on missions, we provided a medic (doc, PA, or tech) who had to pack a full bag ready for any contingency. There was a Forward Surgical Team co-located at the Forward Operating Base (FOB) where I was; we provided assistance to them whenever the casualties started rolling in. This also provided a great venue for my AF medics (some who had never worked outside a clinic) to learn some valuable trauma care skills.

We also had to take care of our own team. I found that it was best to simply have an open door policy rather than set hours as missions seemed to occur at all hours of the day. It was easier to see patients when they needed to be seen rather than work around both our schedules. A lot of time was spent coordinating projects and planning missions including embedding a 150 member Jordanian medical team at the Zabul Provincial Hospital to train and mentor the Afghan medical staff.

On an average of every five days, our PRT hosted a visit from important people such as former Senator Bill Frist, Senator Martinez, former Secretary of Defense Rumsfeld, the Romanian president, and high ranking Jordanian, UN Security Council, EUCOM, and USAID officials. Both Dr. Woods and I made trips to Kabul for direct contact with Ministry of Health officials and had numerous luncheons and dinners at Governor Arman's residence.

Afghan surgeons learn central sterile techniques

A highlight of the tour for me was escorting two of the Afghan surgeons from the Zabul Provincial Hospital to Bagram for an intensive two week course at Craig Joint Theater Hospital, where they learned a tremendous amount from working with Air Force medical staff deployed there. We happened to be there when an IED exploded outside the gate at Bagram on February 26, 2007. The Afghan surgeons were there to assist US surgeons with mass casualty care of the many seriously injured Afghan bystanders.

In April, 2007, we passed the torch on to a new PRT team. Lt Col Michael Gauron and Maj Deborah Roberts are both family practice physicians and are continuing our efforts. They are providing additional focus on women's healthcare and plan to provide an introduction to nurse midwifery which is desperately needed in outlying clinics throughout Zabul province. The key to success in our reconstruction efforts will be a long-term approach focusing on building the capacity of the Afghan people.

Leadership Imperative

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command and other leadership opportunities, you take yourself out of the running—before you even start—for our most senior leadership positions. To choose the best to lead our hospitals, medical centers, and to serve as our general officers, we need a good pool of qualified candidates from which to select. By turning down these opportunities early you make it impossible to compete for the critical positions later in your career when you may see things a bit differently than you do now and want the chance to make a difference at the next level.

In no way do I think that those who choose the leadership path are in any way better than those who choose to care for patients day in and day out. There is nothing nobler. You can clearly make significant and important contributions to our specialty and our healthcare system as a clinician. The majority will choose that path. However, some of you out there will feel the need to answer the call of the leadership imperative. Whether it is in your local community, in the academic arena, through ACEP, or by rising in the leadership chain of your respective services, some of you will and must rise up to take on those challenges. The future depends upon you. The next time a leadership opportunity knocks—answer!

Scholarship Winners reflect on Leadership Conference

Part I By CPT Rachel Villarta Lyew, USA, MC

Why did you want to become a physician? Do you remember how you answered before you started medical school/residency? Residency seems to demand all of our time and energy because of all of our academic, professional, and clinical obligations. Sometimes, after a long, tiring shift, it is increasingly difficult to quiet the whispering voices of cynicism. I think each of us holds on to the idea of making the world a better place through medicine, but I think we forget that we can- and often do- make a difference in our society.

I had the amazing opportunity to reconnect with the passion within medicine this past spring by attending the ACEP Leadership and Advocacy Conference in Washington DC as part of the First Consultants Challenge on behalf of GSACEP. As a resident who had become caught up in the daily grind, I was inspired with the collective power and motivation of the leaders and our peers, from fellow residents to veteran attendings. I had the opportunity to exchange stories and ideas with the leadership of GSACEP informally over dinner with MAJ James Eadie and COL Linda Lawrence, learn more about the leadership and development of EMRA and their advocacy fellowship, and meet with the Washington state chapter president and its most active members as part of our congressional visits. There were inspirational talks by Dr. Arthur Kellerman, chairman of Emory University's Emergency Department currently completing the Robert Wood Johnson Health-Policy Fellowship, on making a difference through emergency medicine and by Admiral John Agwunobi, the current Assistant Secretary of the Department of Health and Human Services.

The first day of the conference included a town hall meeting - an open forum for ACEP members with the ACEP leadership and the lobbyists responsible for representing our organization's interests on Capitol Hill. Every member spoke and passionately shared stories about the need for change in the spectrum of universal healthcare, the impact of ED boarding, and consultant compensation.

I attended a session entitled "Best Practices to Reduce Boarding of Patients in the ED" where a panel of physician shared creative solutions to reduce episodes of boarding in the ED. There was a description of a New York state hospital that frequently found itself boarding 50-70 patients in its ED. Their solution including an "extended ED observation unit" that allowed them to provide a 6:1 patient to nurse ratio to meet their patients needs. Dr. P. Viccellio also spoke about his experiences in emergency medicine and the need to identify a framework and associated goals with the needs of the patients in mind rather than the current system designed to cater to the desires of the staff.

The final day of the conference culminated in meeting with congressional members and their staff. We were lobbying on behalf of the Access to Emergency Medical Services Act and, more importantly, educating the policy makers on what happens within an emergency department and hospital with overcrowding and limited resources. We were able to connect the personal stories with the statistics they read about. It was exciting to have a dialogue with congressional members and their staff, commanding their attention as they asked questions about the work we do, and then gained their support. Making a change in health care policy happens one step, one voice at a time. I also learned the roles of NEMPAC and the 911 Legislative Network in continuing to provide a voice and influence on policy decisions on a daily basis for ACEP on Capitol Hill.

While we are somewhat "protected" or insulated from issues of universal health care, consultant compensation, and ED boarding, while we are training in our respective government institutions, we will face these issues of the healthcare system at some point in our career. Besides, the military health care system is not completely impervious to the finance and policy guidelines created for the civilian sector, as more patients are being diverted out of the military system to civilian providers, sometimes against their wishes, because of the limited resources and ever-changing priorities of the military health care system. Going to the emergency department may be the most important thing a person does that day. What if we can not actually provide appropriate care in the department because of prolonged wait times? What if there are no hospital beds for admitted patients? We can do better. We must do better.

The ACEP Leadership and Advocacy Conference truly was a phenomenal experience, meeting and exchanging experience with the people of ACEP and GSACEP, to re-ignite the passion and motivation about making a difference in our society. I was reminded the while every individual contributes something each day as a scientist, physician, and social advocate, the organization and unity of a dedicated group of these individuals can do much more to effect changes in the big picture of health care for our patients. We, as physicians in emergency medicine, as members of GSACEP, and as members of society, are all connected. I hope that each of us remains connected to the original reasons for becoming a physician, connected to the desire to make things better, and connected to using our organization and its resources to influence change. If you have a story to share, want to know more about the conference, or have an interest in taking part of policy development, please email me at Rachel.Villacorta@us.army.mil.

Part II continued on Page 8

Scholarship Winners reflect - (con't)

Part II By Capt Andrew Muck, MC, USAF

The GSACEP Consultant's Challenge provided me with the opportunity to attend the ACEP Leadership and Advocacy Conference in Washington, D.C. The experience dramatically changed the way I think about the future of emergency medicine as well as about the role I can play in its future.

Prior to attending the conference, I was dispirited by some of the obstacles we face in emergency medicine, such as an overburdened system, decreasing resources, ambulance diversions, and specialist shortages. Some of these issues seem rather complicated and quite intimidating to a lone resident, so I had resorted to just passively, if anxiously, standing on the sidelines waiting for someone else to decide the future our profession. Not only did I feel as though I had no voice; I felt that no one wanted to listen, even if I chose to speak.

Through the ACEP Conference I found that I have a voice. ACEP and GSACEP offer us an opportunity to stand up for the bettering of our profession by encouraging our individual voices as well as serving as a collective voice for all of us. It all begins with things as simple as physicians having a chance to address the leadership of GSACEP/ACEP on a personal level. For example, the leaders of GSACEP/ACEP were available to speak with us at multiple social gatherings and public forums at the conference. At one forum, ACEP president-elect Col Linda Lawrence addressed anyone and everyone with an open-microphone for questions and concerns.

Involvement in GSACEP and ACEP gives emergency medicine physicians a collective voice that can be heard by those who hold the highest positions in the country, as well as the everyday citizen. As part of this conference, I was educated on how to approach lawmakers directly to inform them on the needs in emergency medicine. After having received the training, I sat face-to-face speaking with a Texas Congressman in a meeting arranged by ACEP, to promote the "Access to Emergency Medical Services Act of 2007." Seemingly as important as our lawmakers at times is the press. I was able to attend a forum on how to speak with the press. ACEP is skilled in presenting the issues to the press and training its members to do the same, which gives us a voice to the everyday citizen. Of note, ACEP offers resources for press releases and notification of upcoming legislative actions through the 911 Legislative Network (see www.acep.org for more information).

I am very thankful to GSACEP for the opportunity to attend the Leadership and Advocacy Conference through the Consultant's Challenge Scholarship. It was humbling to see that there are so many people working very hard for all of us and to recognize how much has already been accomplished without full participation. So, I want to conclude by emphasizing that you are part of a team, whether you know it or not. GSACEP/ACEP provides us with a way to participate in making positive changes, and it is imperative that as many as possible work to advance the field of emergency medicine. The conclusion in the end is to get involved, somewhere, somehow. Please feel free to contact me with any questions about the conference or any other thoughts you may have. (Andrew.Muck@Lackland.AF.MIL).

A History of GSACEP Presidents

07-08	CAPT James V. Ritchie, MD, FACEP
06-07	LTC John G. McManus, Jr., MD, FACEP
05-06	LTC Robert DeLorenzo, MD,FACEP
04-05	MAJ Robert Blankenship, MD,FACEP
03-04	CDR David S. McClellan, MD, FACEP
02-03	COL Marco Coppola, DO, FACEP
01-02	CAPT Michael J. Krentz, MD, FACEP
00-01	MAJ Brian D. Baxter, MD, FACEP
99-00	LTC David Della-Giustina, MD, FACEP
98-99	LTC Marco Coppola, DO, FACEP
97-98	Maj Linda Lawrence, MD, FACEP
96-97	CAPT David W. Munter, MD, FACEP
95-96	Maj Tracy G. Sanson, MD, FACEP
94-95	CAPT David W. Munter, MD, FACEP
93-94	Maj James G. Adams, MD
92-93	COL Matthew M. Rice, MD, FACEP
91-92	Monte T. Mellon, MD, FACEP
89-91	COL Cloyd B. Gatrell, MD, FACEP
88-89	William C. Dalsey, MD, FACEP
87-88	John E. Prescott, MD
86-87	Samuel T. Coleridge, DO, FACEP
85-86	COL Glenn W. Mitchell, MD
84-85	Patricia H. Sanner, MD
82-84	Robert P. Banka, MD
81-82	P. Byon Vaughn, MD
80-81	Robert P. Banka, MD
79-80	Steven J. Hazen, MD
78-79	Gerald P. Whelan, MD

GSACEP's Resident Rep: Lies and URIs

Capt Torree McGowan, USAF, MC

This week, we had a "first" in the McGowan household. For the first time in our relationship, my husband brought home a cold and gave it to me. I'm sure many of you can relate: the reverse situation of me infecting my husband is commonplace. This time, however, the world turned upside down and he was the one who brought the sickness home.

During the early years of our relationship, while I was still in medical school, it was a monthly occurrence that I would change rotations, and pathogens, that I was exposed to. I would get a little sniffle, and poor Tim would end up with a horrible week long viral syndrome that wiped him out. Since we all spend so much time around sick people, our immune systems get the equivalent of marathon training every day. Our loved ones, however, are not always as lucky.

I am happy to report, however, that continued exposure to me and my germs has toughened my husband's immune system to the point that he rarely gets sick anymore. However, this recent change in affairs of him getting me sick left me outraged and cranky. I'm not the best of patients, you see.

In the middle of plotting my revenge for him spewing his viral droplets in my home environment, I started to think about the things we bring home to our families. After a little guilty reflection, I realized that the upper respiratory infections are probably the most benign thing I bring home in my baggage.

We bring home the patient who yelled at us because they sat too long in the waiting room, and our patience for our family becomes less. I routinely have people wait eight hours to see me in the ED, so why should my family get mad when they have to wait 45 minutes for me to get off the internet?

We wave merrily to the patient who was sent home as they walk out, but now we're just a little concerned that he may not do well. Should we call the hospital and make sure he didn't bounce back onto the next shift? I didn't get his home number – I could call the unit secretary and they could get it for me…We bring that worry home, and it steals our attention from our family.

One day, while resuscitating a crashing trauma patient, the central line needle slips and we see the tiniest pinprick of blood under our glove. We bring the specter of HIV and hepatitis into our homes, the unmentioned visitor that makes us glove up each time we put a bandage on our child's knee. Months of agony ensue as two hearts wait on each HIV Western blot and hepatitis panel result to come back negative.

Our children don't understand why each time they ride their skateboard, they are protected by military grade body armor and a helmet that would meet NASCAR standards. However, if they get sick, our answer, rather than compassion and a kiss to make it better, is often, "It's a long way from your heart." We see sicker patients than that every day, right? They'll survive.

We desperately want to lie to our patients' families when we walk out of the resuscitation room. We'd like to lie and say they'll be coming home tonight. We bring those untold lies home with us, and tell them to our families instead. We say nothing is wrong, despite our silence and our long, sad hugs.

I remember those things that we bring home; my mom, an ED nurse, brought them home all through my childhood. Now I'm trying to learn from her, to bring home fewer lies and worries. I am exceptionally lucky to have a husband who is very supportive, and willing to listen to all of my tales of woe. I'm trying to learn to use that willing ear better, with more appreciation for the true gift that understanding and a chance to decompress really represents.

When you leave the ED each evening, drive home safe and hug your family tight. Wash your hands before you leave, and try to bring home only the good things to the ones you love.

Combat Emergency Medicine Symposium JSS 2008 – Be There!

By Maj James Eadie, USAF, MC

Greetings from Iraq!

It is easy to forget how hot it can get here. Despite having been here before, I was struck by the wave of heat that greeted our flight last night as we arrived. I am sure it will take a few days for the jet lag to wear-off and the body to adjust to the warmer environment. I just hope my clinical skills adjust as fast.

I deployed as CCATT two years ago, but this time I am in the ED at Balad. I have not worried about what I needed to pack or what in the world a DFAC was. No, this time I have worried about being up-to-speed with the current practice of combat emergency medicine. The EM docs who are out here continue to push the art of emergency medicine forward. I have been amazed at how much the clinical management of burns or traumas has evolved over just the last two years. I find myself asking a lot of questions.

What is the current thought on whole blood resuscitation?

Who are we giving Factor VII to and what about the reported risks of DVT / PE?

What is the best way to staff the ED during a mass casualty event?

What issues as a medical director do I need to stay on top of in the deployed setting?

How do I do research while deployed?

In an effort to address these issues and many more, GSACEP will be hosting the first full-day symposium dedicated to combat emergency medicine on Monday March 17, 2008 as part of JSS 2008. In the past there have been isolated lectures dedicated to operational EM, but this year we are expanding both the breadth and scope of the material covered. There will be cutting edge clinical presentations like Factor VII and the current transfusion guidelines; there will be expert panel discussions, presentations of current clinical research coming out of the EDs in the AOR, and breakout sessions on operational / "outside the wire" emergency medicine.

The goal of the combat emergency medicine symposium is to bring together our members to share their wealth-of-knowledge and experience, and to discuss and debate the cutting issues facing the deployed EM physician. Whether you are a seasoned deployer, someone heading back to AOR looking to get up-to-speed on the most recent developments, or a graduating resident who has never deployed, this symposium is for you.

On Sunday March 16th there will be the pre-conference tactical ultrasound course designed specifically for the deployed environment. This was a tremendous success last year and will fill up quickly so sign up early.

Of course, we are also continuing the excellent ED Directors Course on Sunday, and offering a full range of clinical topics on Tuesday and Wednesday.

I look forward to seeing you all in San Antonio in March 2008!

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WWW.GSACEP.ORG

Join us in Seattle for Scientific Assembly October 8-11
and come to the GSACEP reception