Spring 2007

A Chapter of the American College of Emergency Physicians

Government Services EPIC

President's Message

CAPT James V. Ritchie, MC, USN

Best GSACEP Conference Ever
Now THAT was a phenomenal conference! I've never seen such a dense concentration of cutting edge clinical presentations, far-forward, pertinent combat innovation, technical expertise, and leadership in such a small space. The Joint Services Symposium was a masterpiece. We are most grateful to Maj James Eadie, Bernadette Carr, Maj Julio Lairet, and so many others for the most clinically and operationally influential meeting ever. We all departed fired up about the great information we were bringing home and the new contacts we made.

Who's in the room?
Have you ever spent time sitting next to someone only to discover later that they're "somebody"? I took some notes during the Chapter Lunch at JSS. Here's a partial list of titles represented in that room: Chairs, department heads, hospital directors, chiefs of staff, commanding officers, executive officers, command surgeons, operational commanders, CEOs, presidents of companies and organizations, about twenty past presidents of GSACEP, toxicologists, world experts in emergency ultrasound, researchers, writers, policy makers, fellowship-trained international medicine experts, combat traumatologists, specialty consultants, book and journal authors and editors, residency program directors, clinical professors, and the president-elect of ACEP. Such a concentration of expertise, dedication, and interest is virtually impossible to find elsewhere.

Great ideas for the future
James Eadie continues to direct JSS. I'm elated to report that Maj James Eadie, our Conference Director for this year and President-Elect of GSACEP, agreed to direct the 2008 JSS as well. He's already fleshing out ideas, and the conference will inevitably prove even more spectacular.

Developing useful policy statements. Have you ever used ACEP policy statements to help advance an improvement at your facility? Perhaps the ultrasound policy statement or consultant availability policy statement have been persuasive in your hospital. What military emergency medicine policy statements would be useful to you? We are interested in developing persuasive, germane, researched, useful statements that you can reference in your daily struggles and decisions.

Student curriculum and international medicine curriculum Maj Chetan Kharod, in the Department of Military and Emergency Medicine at USUHS, is actively seeking to develop a reliable student EM curriculum in our training centers. Obviously, EM is a crucial part of medical training, especially since so many USUHS students will have operational employment at some point. As you probably know, International Medicine has been established as a new mission for DoD, but the form of the mission hasn't been well developed. Some superb training for part of the mission already exists, such as the Tropical Medicine and Global Medicine Courses. However, a well-designed comprehensive curriculum encompassing most of the likely missions for military EM has not been assembled. Maj Kharod is actively building such a curriculum.

Research collaboration Our members are conducting exceptional, motivating research, in clinical and operational arenas. This is especially impressive in light of the additional "wickets" necessary to begin a project in the military arena. Expanding participation to multiple centers through collaboration is a "win-win." We can take advantage of each others' already-completed work in obtaining IRB approval, performing literature searches, etc, speed completion of projects, and share in the glory.

Consultants' Challenge Our Resident Board Member, Capt Torree McGowan, has introduced the Consultant's Challenge, in which EM residents from all three services compete for a paid scholarship to attend the ACEP Leadership Forum in D.C. This was our first year of this award, which was a spectacular success. See our column in this newsletter for a full description of a program we intend to enthusiastically support, and expect to bear much fruit.

Intention of the board
Your GSACEP Board met at JSS, and is excited about some additional ideas.

(continued on page 2)

In This Issue

Coppola 2007 Recipient of GSACEP Excellence Award

LTC John McManus presents plaque to COL Marco Coppola, DO, FACEP

On March 19, in San Antonio, TX., COL Marco Coppola, DO, FACEP, received the GSACEP Excellence in Military Emergency Medicine Award at the Chapter Luncheon. In his remarks introducing Dr. Coppola, GSACEP President Jim Ritchie highlighted his reasons for selection to this prestigious award beginning with his service to the chapter since 1994. Dr. Coppola served as chapter president twice and currently serves as a councillor. He has been co-chair of The Oral Board Review Course (offered at The Joint Services Symposium), for more than a decade, and a lecturer at JSS. Coppola has been an editor on all editions of the highly successful Core Lecture Series, and helped contribute to the Chapter's CME offerings.

During his Active Duty military service, Dr. Coppola served as Associate Research Director at Darnall from 1995-98 and was Program Director of the Emergency Medicine Residency from 1994-98. As a military emergency physician and leader, Marco Coppola was instrumental in improving the Darnall Emergency Medicine Residency Program and propelled them into the Top 10 in the Nation. For his efforts as an innovator as well as a proven leader, he was inducted into the Order of Military Medical Merit and received the Surgeon General's Alpha Designator as a junior Major. Because of Marco's qualifications and accomplishments he received the Alpha Designator without the required 14 years minimum time in practice and without attaining the minimum grade of Lieutenant Colonel.

When Dr. Coppola decided to leave Active Duty, he committed himself to The Army National Guard primarily to stay connected to GSACEP. In The Guard, he so devoted himself that he ended up Commander of a brigade, and served in Iraq.

Marco's academic endeavors include being a local, state and national lecturer. Not only has he lectured for GSACEP and TCEP, he has been National ACEP Faculty since 1997. He rose through the ranks in the Department of Emergency Medicine at Texas A&M University Health Science Center (TAMUHSC), starting as Research Director and Program Director. Within nine months of arriving, he was appointed Department Vice-Chair, and then as Interim Chair a few years later. His academic activities culminated in his being appointed the first Professor of Emergency Medicine at TAMUHSC at the age of 36.

Dr. Coppola is the ninth recipient of the Excellence Award.

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.

(President's Column Continued)

Speakers bureau

Our Chapter contains many world experts on operational topics, yet all too often we are hearing from inexperienced civilian lecturers at regional and national conferences. LTC John McManus, Immediate Past President, is putting together a list of experienced, knowledgeable, talented, interested speakers from our ranks to provide to National ACEP as a Speaker's Bureau. We anticipate invitations to international, national, regional, state, and local meetings.

Available lectures

Interested in having a superb lecture for your grand rounds, departmental meeting, residency, or other group, but unable to score the travel funds to support it? Many of our best lecturers have access to teleconferencing technology, which is virtually free to most commands. If you heard a great lecture at JSS and want to share, contact Bernadette Carr or the lecturer directly, and turn on some excellent learning.

Share-point

Our members are constantly producing exceptional products, in the form of after-action reports, lectures, lessons-learned briefs, research projects, operational recommendations, and others. But since the rest of the membership is usually unaware of that work, we often wind up re-inventing the wheel. Maj Rob Blankenship plans to set up a sharepoint-type site associated with our website which will allow posting and downloading of great information and products.

Combined AAEM conference

We remain open to the idea of a conference combined with the AAEM Uniformed Services Chapter. Obviously, talented, capable individuals are members in both chapters, and both would gain from collaboration. Our Board voted to keep JSS in San Antonio in 2008 for a variety of real-world reasons, and, at present, a combined conference is not in the works. But we are hopeful to be able to collaborate soon.

Ways to join in

Opportunities abound. If you're interested in joining the effort to improve military EM, let us know and we'll put you in contact with the right people. As noted above, we have opportunities in planning JSS, developing policy statements, crafting student curricula in military EM, building an international medicine curriculum for our trainees, speaking, research collaboration, and other areas. Take advantage of the expertise and mentorship available to you. Make military EM better as you build your own expertise and influence.

Winners of GSACEP Consultants Challenge

In the fall of 2006, the GSACEP Board voted to offer a scholarship to a resident from each service to attend the 2007 ACEP Leadership and Advocacy Conference in Washington, D.C. Interested residents submitted an essay for Board review. The contest was supervised by our own Resident rep, Capt Torree McGowan, USAF, MC. In January, the winners were selected and contacted. They were: Capt Andrew Muck, MD, Wilford Hall Medical Center, Lackland AFB, TX; CPT Rachel Villacorta Lyew, MD, Madigan Army Community Hospital EM Residency; LT Kristie Robson, MD, Naval Medical Center, EM Residency Program, San Diego, CA

Residents were each asked to submit an article for the EPIC reporting on a different aspect of the meeting, and to go back to their residencies and inform peers of the meeting and GSACEP. On page six, there is an article by LT Robson.

Meet Your New President-Elect
Maj James Eadie, USAF, MC

It is an honor and a pleasure to follow in the footsteps of those who have gone before. As a chapter, we have been particularly blessed with extremely dedicated and talented leaders who have blazed the trail for all GSACEP members to follow. As your President Elect, I look forward to working with the board and our members to keep the future bright for military emergency medicine.

For those of you who I have not had the pleasure of meeting, I have been instructed to give you a little background. I joined the Air Force in 1990 as an ROTC student at the University of Michigan. After being commissioned I took an educational delay and attended medical school at Harvard and then stayed in Boston to complete my residency at the Brigham and Women's Hospital / Massachusetts General Hospital program. After residency, I moved to San Antonio to join the staff at Wilford Hall and the SAUSHEC EM residency program. My experience as a military emergency physician has been fantastic. I currently serve in the roll of Vice-Chair / Director of Operations. I have had the opportunity to deploy to Balad, Iraq, as a CCATT physician in 2005, and will be deploying again this fall.

As I look ahead to the year I am struck by the tremendous potential we have. The wars in Iraq and Afghanistan have raised the national awareness of military emergency medicine. The frequent deployments may have taxed the military EM community, but the dedication and the quality of care every EM doc has provided overseas has earned the respect of our command and has given us national visibility. With this increased positive attention we have a unique opportunity to further military emergency medicine like never before.

I would like to challenge you with a few ideas.

1. **Show Up and Get Involved:** The saying that life is 80% showing up rings true. GSACEP has grown in size over the past few years. This is great news, but it is meaningless unless our members get involved. We are member-driven – so step up and offer to drive us forward. Getting involved is easy, and we need you.

2. **Identify an Issue or Idea and Run With It** : Everyone has great ideas. Our membership spreads across the globe from large level one trauma centers to flight surgery billets in Europe. What do you need from GSACEP? It is impossible for the board to completely grasp all of the needs of the membership – that is why we need you (a "GSACEP of One" campaign perhaps). Take the idea that is generated at 3:00 A.M. and rather than sharing it just with a colleague or nurse, write it down, e-mail GSACEP and then get involved. There is no better person to make positive change than you. Your ideas matter, but we need your energy and ideas to turn them into reality.

3. **Stay Involved** – There are many opportunities at GSACEP and ACEP for you. The perspective of military emergency medicine is unique and highly valued. Consider serving on a GSACEP or ACEP committee. Committees are a wonderful way to be involved and do not require a huge time commitment. Consider helping with the planning and the execution of the JSS 2008 conference. The GSACEP board meets at ACEP Scientific Assembly and at JSS. These meetings are always open and I highly encourage you to attend.

GSACEP needs you – it is time for everyone to step up to the plate and help us continue the great tradition that we have inherited.

I look forward to working with you all over the upcoming year. Please do not hesitate to contact me at any time. My email is James.Eadie@Lackland.af.mil or jseadie@gmail.com. I look forward to hearing from you!

JSS 2007 Abstract Competition

LCDR Buddy Kozen, MC, USN (left) first prize winner, and CDR James Hancock, MC, USN second prize winner

First Prize

An Alternative Field Hemostatic Agent? Comparison of a CELOX™, HemCon® and QuikClot® to Standard Dressing in a Lethal Hemorrhagic Groin Injury

LCDR Buddy Kozen, MC, USN; Sara Kircher, BS; LCDR Jose Henao MC, USN; Fermin Godinez, DO; CDR Andrew Johnson, MC, USN; NCM Portsmouth, VA

BACKGROUND: Uncontrolled hemorrhage remains a leading cause of traumatic death in both the military and civilian setting. Several topical adjunct agents have been shown to be effective in controlling hemorrhage in various pre-clinical trials and two, a chitosan wafer, HemCon, and a zeolite powder, QuikClot, are being utilized regularly on the battlefield. However, recent literature reviews have concluded that, as of yet, there is no ideal topical agent for controlling lethal hemorrhage. Newly developed products that may overcome current shortcomings require further evaluation. **OBJECTIVE**: To compare a new granular chitosan hemostatic agent, CELOX™, to HemCon and QuikClot in terms of re-bleed and survival in a lethal hemorrhagic groin injury. **METHODS**: A complex groin injury with complete transection of the femoral vessels and 3 minutes of uncontrolled hemorrhage was created in 48 swine (35.5 +/- 2.5 kg). The animals were then randomized to three treatment groups and one control group (12 animals each). Group one included standard gauze dressing; group two, CELOX; group three, HemCon; and group four, QuikClot. Each agent was applied directly to the injury according to the manufacturer's directions with 5 minutes of manual pressure followed by application of a standard field compression dressing. Hetastarch (500 mL over 30 minutes) was infused to complete resuscitation. Hemodynamic values were recorded every 5 minutes over 180 minutes. Primary endpoints included re-bleed and death. **RESULTS**: CELOX reduced re-bleeding to 0% ($p < 0.001$), HemCon to 33% ($p = 0.038$), and QuikClot to 8% ($p = 0.001$), compared to 83% for standard dressing. CELOX improved survival to 100% compared to standard dressing at 50% ($p=0.018$). Survival for HemCon (67%) and QuikClot (92%) did not statistically differ from standard dressing. There were marginally significant differences in re-bleeding ($p= 0.049$) and survival ($p = 0.049$) among hemostatic agents. **CONCLUSION**: CELOX was at least as effective as HemCon and QuikClot in controlling hemorrhage. Although all three agents were superior to standard dressing with regard to re-bleed, only CELOX improved survival in a lethal hemorrhagic groin injury compared to standard dressing. Given these encouraging results, we believe further investigation of CELOX as a potential universal hemostatic agent is warranted.

Second Prize

Fetal Loss in Symptomatic First Trimester Pregnancies with Documented Fetal Cardiac Activity

CDR James L. Hancock, MC, USN; Michael Juliano, MC, USN; NMC Portsmouth, VA, Department of Emergency Medicine, Naval Medical Center Portsmouth, Virginia

OBJECTIVE: Longitudinal fetal outcomes of women seeking emergency care for symptomatic first trimester pregnancy are not previously reported. We sought to determine fetal outcomes of women diagnosed with live intrauterine pregnancy (IUP) following emergency department (ED) presentation for abdomino-pelvic pain and/or vaginal bleeding during the first trimester. **METHODS:** Our military teaching hospital ED utilizes a unique documentation template for women who present with symptomatic first trimester pregnancy (≤ 12 weeks EGA by LMP). A retrospective analysis of consecutive charts from December 2005 to June 2006 was performed to identify patients diagnosed with live IUP defined by fetal cardiac activity via ED ultrasound. Demographic data, obstetric/gynecologic history and presenting symptoms were recorded. Outcomes were determined via computerized medical records. Fetal loss was diagnosed by falling beta-HCG or pathology specimen consistent with products of conception. Live birth was diagnosed by viable fetus at 20-week gestation ultrasound or delivery. **RESULTS:** A total of 837 patients were evaluated during the first trimester. Live IUP was diagnosed in 344 (41%); outcome data was obtained for 267 (78%) of these patients. Mean age was 25.4 years; racial distribution was 40% Caucasian and 37% Black. Fetal loss occurred in 26 (9.7%; 95% CI 6.2-13.3%) pregnancies. 24 (92%) occurred in the 162 patients with vaginal bleeding, for a fetal loss incidence of 14.8% (95% CI 9.3-20.2%) compared to 2% (95% CI -0.7-4.5%) in patients without bleeding ($p < 0.001$). Vaginal bleeding was the most important predictor of fetal loss; OR 9.0 (95% CI 2.1-38.8).**Conclusion:** Fetal loss prior to 20 weeks occurs in 9.7% of patients with live IUP diagnosed by ED ultrasound. Vaginal bleeding carries a higher fetal loss rate of 14.8%. This data will assist the emergency physician in counseling women experiencing symptomatic first trimester pregnancy.

Six years of acute unintentional epinephrine digital injections: Lack of ischemia or significant systemic effects

Muck, AE; Bebarta, VS; Borys, DJ; Morgan, DL; SAUSHEC, BAMC, Department of Emergency Medicine, San Antonio, Texas

OBJECTIVE: 1) Determine the frequency of digit ischemia after acute, unintentional autoinjector EDI. 2) Determine treatments used, systemic effects reported, and frequency of admission. **METHODS**: Epinephrine injections of the hand reported to 6 poison centers (PCs) over 6 years (2000-2005) were collected. One reviewer extracted data from the PC chart using a standardized data collection form. The reviewer was trained with a sample of charts. Definitions and outcomes were defined prior to abstraction. Ten percent of the charts were reviewed by a 2nd abstractor blinded to patient outcome. Kappa was calculated. **RESULTS**:Of 364 epinephrine injections, 212 were acute, unintentional EDIs. All 212 patients had complete resolution of symptoms (CRS), and none required hospital admission, hand surgery consultation, or surgical care. Significant systemic effects did not occur. Six patients had transient tachycardia and 1 had palpitations. 12% (25/212) received topical nitroglycerin, 4% (9/212) local phentolamine injection, and 1 local terbutaline. 139 patients did not receive medical treatment for EDI. These patients had a MINOR effect (defined by American Association of Poison Control Centers) except one. 3.7% (8/212) of patients were reported to have an "ischemic" finger (IF). Five of these cases had CRS, 3 of which occurred within 2 hours of injection. Three patients did not have followup. Two patients received phentolamine, 1 nitropaste, and 1 both. Kappa score for CRS was 0.785 (95% CI 0.72-1.2) and 1.0 for IF. **CONCLUSIONS**: Digit ischemia and significant system effects did not occur after EDI. All had CRS. Supportive care and observation only should be considered for acute, unintentional EDIs.

ABEM In-Service Exam Preparation: Comparison of CORD-EM Online Tests and Core-Content Text-Derived Written Quizzes

Samsey, K; Hilliard, M; Gerhardt, RT; SAUSHEC, BAMC, Department of Emergency Medicine, San Antonio, Texas

OBJECTIVES: To compare the correlation of CORD-based quizzes and SAUSHEC quizzes with results of the ABEM in-service exam. **METHODS:** Statistical comparisons were made using graduating-year in-service exam (PGY-3) as the dependent variable. **RESULTS:** Our analysis revealed improvement in scores on the in-service examination as training progressed, and closer correlation between in-service exam score and the SAUSHEC-based quiz scores (PGY-3 in-service versus PGY-1 Beta .15, CI95 -.45 to 1.08; versus PGY-2 Beta .403, CI95 .24 to 1.23), as opposed to the CORD-based quiz scores (PGY-3 in-service versus PGY-1 Beta -.58, CI95 -.52 to .36; versus PGY-2 Beta -.23, CI95 -.61 to .72). **CONCLUSIONS:** Directed core-content reading with periodic testing based on the reading assignments correlates better with improvement on in-service exams than does the current CORD test bank. These findings have implications for residency programs seeking to improve didactic curricula, and for individuals involved in centralized test-bank administration.

Radiation Exposure in Emergency Medicine Physicians at a Level I

Trauma Center

Solley, M; Hilliard, M; McNeil, C; SAUSHEC, BAMC, Department of Emergency Medicine, San Antonio, Texas

HYPOTHESIS: Emergency physicians are exposed to radiation in the normal course of the duties in the emergency department, via x-rays. Even though there are safety protocols in place to reduce exposure from X-ray equipment, we sought to define actual levels of exposure over a specified period to determine if radiation safety procedures were adequate to protect residents from potentially harmful amounts of radiation. **METHODS:** We issued radiation dosimeters to 28 emergency medicine physicians for a period of 3 months and asked them to wear the dosimeters on the outside of their clothing whilst on duty at level I and II trauma centers, MICUs, and SICUs. The physicians were also asked to follow the normal hospital radiation safety protocols. The dosimeters were then collected and assessed for radiation exposure. **RESULTS:** Twenty-eight dosimeters were issued, one was lost by the physician, and twenty-seven were returned. Twenty-six were found to have total cumulative doses of 0.000. One had a dose of 0.011.**CONCLUSIONS:** Over the course of this study, none of the dosimeters were exposed to harmful levels of radiation. One dosimeter had a level of 0.011, which is well below any potential harmful level and could be attributed to normal background radiation. Either the safety protocols used by physicians are adequate or the levels of occupational radiation are not high enough to be detected by the dosimeters. Regardless, the study shows that over the course of a 3 month study, physicians are not being exposed to harmful levels of radiation in the workplace.

Return of Spontaneous Circulation (ROSC) in a Public Access Defibrillation (PAD) Program Prior to Implementation of the 2005 American Heart Association (AHA) Guidelines

Sobehart, RJ; Dunford, JV; Castillo, EM; Beebe, D; O'Connor, M; Departments of Emergency Medicine, Naval Medical Center San Diego and UCSD Medical Center, San Diego, CA.

OBJECTIVES: Most automated external defibrillators (AED) currently deliver 3 sequential defibrillatory shocks in compliance with previous American Heart Association (AHA) guidelines for cardiopulmonary resuscitation (CPR). With the revised 2005 AHA recommendation that individual shocks alternate with CPR, the effectiveness of current devices is brought into question. Our objective was to assess the performance of current AEDs employed in a large public access defibrillation (PAD) program. **METHODS**: We conducted a retrospective review of all deployments of the nearly 1300 AED units managed by San Diego Project Heartbeat (SDPHB) from February 2002-July 2006. IRB approval was obtained via UCSD Human Research Protections Program. Data abstracted from the SDPHB database and emergency medical service records included: age, sex, history of heart disease, time from collapse to AED placement and EMS arrival, initial and converting rhythm, and number of shocks to achieve return of spontaneous circulation (ROSC) to hospital arrival. Only deployments in which the initial rhythm was ventricular fibrillation (VF) or ventricular tachycardia (VT) were further analyzed. Successful deployment of an AED was defined as ROSC when a shockable rhythm (VF or VT) was detected and comparisons were made for shocks delivered before and after 4 minutes from time of collapse. A single reviewer abstracted all data to a standard spreadsheet. Fisher's exact test was employed for discrete variables and linear regression for continuous variables. **RESULTS**: Of 74 total AED deployments, 47 (64%) demonstrated VF or VT. Of these, 40 (87%) were male, 22 (51%) were less than 65 years old, 11 (23%) had prior heart disease and 42 (89%) had bystander CPR prior to AED placement. 24/25 (96%) had ROSC when an AED was applied within 4 minutes of collapse versus 8/21 (38%) when placement was greater than 4 minutes ($p<0.001$). One chart had insufficient data to be included. There was no statistically significant difference in ROSC related to any other variable. **CONCLUSIONS**: Current AEDs that conform to the older AHA recommendations continue to show excellent ROSC rates when applied within 4 minutes of collapse. However, patients treated after 4 minutes continue to have dismal ROSC rates. Upgrading AEDs to utilize the new AHA guidelines may benefit the 45% of patients that have AEDs applied after 4 minutes.

Accreditation Cycle Length Trends in Military Graduate Medical Education

DeLorenzo, RA**;** SAUSHEC, BAMC, Department of Emergency Medicine, Fort Sam Houston, Texas USA

HYPOTHESIS: Accreditation cycle length of military programs is not substantially changing (improving or declining) compared to previous cycles and is equal to national values. **METHODS:** All military-sponsored core programs in specialties with at least 3 residencies are included. Programs were identified by the ACGME, Army, Air Force and Navy GME websites. Military-affiliated but civilian sponsored programs are excluded. The current and most recent cycle data was used for the study. Accreditation cycle length was calculated from effective date to the actual (if applicable) or anticipated time of next survey, rounded to the nearest whole year. For each specialty the mean current cycle length and the mean net change in cycle length (previous subtracted from current cycle lengths, averaged for the entire specialty) is calculated. National mean cycle lengths by specialty for 2005-06 are obtained from the ACGME website and used to calculate an overall national average cycle length and a net difference between mean current military and mean national cycle lengths. Comparisons are semi-quantitative and descriptive statistics only are used in this study. **RESULTS:** 99 military programs in 15 specialties were included in the analysis and the average accreditation cycle length of these programs was 4.0 years; the national average for the same specialties is 3.4 yrs. 13 (87%) of the military specialties had cycle lengths greater than the national average. 10 (67%) specialties had stable or improving cycle lengths when compared to previous cycles.**CONCLUSION:** Military GME accreditation cycle lengths are, on the whole, longer than the national average. Trends show that on average, most military programs are experiencing either stable or slightly lengthening cycles compared to previous accreditation cycles. A few specialties show a declining trend in cycle length and fewer still exhibit average cycle lengths below the national average for that specialty.

Are intern selectees who rank higher more likely to become chief of EM residents?

Hildebrand, J; Hilliard, M; Gonzalez, M; SAUSHEC, BAMC, Department of Emergency Medicine, San Antonio, Texas

OBJECTIVES: The purpose of this study is to determine if desirable qualities of EM intern selectees (those that cause them to be ranked higher) correlate with those individuals later chosen as "chief" of EM residents. **METHODS:** This study was conducted as a retrospective cohort review of existing data collected by the SAUSHEC EM Residency program from classes selected in 2003 and 2004 with a total of 31 residents included in the study. A comparison between two groups, those designated as "chief" resident and "non-chief" resident was performed. There are six chief residents selected each year from a vote by the entire first, second, and third year classes to pick those individuals out of the second-year class they feel will be the best leaders for the next academic year. The specific intern application criteria included scaled scores for the following: average USMLE/COMLEX I and II board score, class rank or GPA in medical school, letter of recommendation, interview, and overall applicant score. (The averaged overall applicant score is used to develop our rank list for the National Residency Match Program (NRMP)). A covariate analysis was conducted using information regarding prior military service and any post-graduate training. This data set was subjected to both univariate and multiple logistical regression analysis to determine any specific predictors of chief resident as a surrogate for "success" or "excellence" in residency training. **RESULTS:** Univariate analysis with a T-test showed the overall applicant score to be a significant predictor of those chosen as chief resident ($p<.004$). Chi-Square tests showed interview score of a 5 vs. 3-4 significant ($p<.003$) and board percentile (scaled score >4 to be approaching significance ($p<.056$). In regression analysis no other variables reached significance. **CONCLUSIONS:** The military consistently needs those individuals who not only do their job, but who can lead others at the same time. Our program uses a ranking system that consistently picks those individuals who score higher and are thus more likely to later become chief resident. Continuing to use this process during our application process will allow us to more effectively choose future physician leaders, ensuring accomplishment of our mission of medical excellence.

Scholarship Winner's Take on ACEP Leadership Meeting
Resident Perspective: 2007 ACEP Leadership and Advocacy Conference
LT Kristie Robson, USN, MC

Training for emergencies is our life at this point. It is hard to look beyond the edge of our standard reading texts, let alone gaze outside our military residency training programs. The 2007 American College of Emergency Medicine "Leadership and Advocacy Conference" exposed a select group of emergency medicine residents from the Air Force, Army and Navy to invaluable training and critical topics in emergency medicine.

Imagine yourself in the middle of a disaster on your base. You are chosen as the Emergency Room (ER) physician to brief the press: How will you answer the barrage of difficult questions? Do you have "bridge answers" to help you out of tough corners? Have you seen yourself on camera? Do you know where to look or what to do with your hands? These last questions may seem trivial, but if you have not received Media Training you may not realize how non-verbal gestures can destroy your message and make you appear apathetic or unprepared. Brad Phillips, from Phillips Media Relations, taught us his trade secrets as a producer on ABC's "Nightline" and CNN's "The Capital Gang." The Media Training workshop provided interactive media interview training and on camera practice, right down to the level of how to sit in a chair and use your hands for emphasis. He performed mock interviews on camera and provided rapid fire questions to workshop participants. It is unbelievably hard to get your message across and even stay on message, when you do not know how the interviewer will be posing the question. I have a new admiration for our Public Relations members and anyone who has needed to face the press. Training is essential.

Brad Phillips also provided interactive training focusing on Presentation Skills. Again, members of the audience were given the opportunity to speak before the group and learn through group critique, better ways to improve eye contact, voice, gestures, movement, passion and positioning at the podium. There are a number of components in our voice that we can improve to provide a stronger message- pitch, pace, volume and inserting pauses. His workshop challenged the presenters to change small parts of their presentation delivery; the results were immediate and impressive. He went on to share trade secrets on good and bad hand gestures during presentations. My favorite advice was not to grip the side of the podium- the audience can see your knuckles turn white.

Looking beyond our military walls, civilian EDs around the country are in crisis. On the first day of conference, ACEP President Elect and Air Force Colonel, Linda Lawrence, led a Town Hall discussion on Health Care Reform. Leaders from ED communities around the country brought their stories, opinions and ideas about Universal Health Care Coverage. ED physicians from Canada and states in the US who are working towards this system shared their viewpoints. We may not have to worry about coverage while in a military uniform, but begin worrying now if you are thinking about leaving. You may be an individual mandated by your government to purchase coverage; you may be the head of a company forced to purchase insurance for all you employees; you may be like retired Admiral Joe Sestak (PA District 7), a 1st term congressman tasked with deciding to invest your state taxes in programs to provide basic coverage. The issues are immense. ACEP provides a great link on their website: www.acep.org under the tab of "Advocacy" to understand and get involved further in these issues.

Dr. Arthur Kellerman, Professor and Chair of the Department of Emergency Medicine at Emory School of Medicine and Robert Wood Johnson Health Policy Fellow 2006-07, delivered the noon lecture titled "Influence" on day one of the conference. He shared his favorite quote from Rudolf Virchow- *"Medicine is a social science, and politics is nothing else but medicine on a large scale. Medicine, as a social science, as the science of human beings, has the obligation to point out problems and to attempt their theoretical solution: the politician, the practical anthropologist, must find the means for their actual solution."*

Dr Kellerman told a story about a diabetic ketoacidosis patient transferred from a local hospital to his ER without any care or intravenous fluid given. The man's life was in jeopardy because he did not have insurance. Inspiration for advocacy comes in many forms. As military emergency physicians, we have the luxury of living in both civilian and military medicine worlds. We are exposed to the best and the worst of ED system problems. Virchow's words ring true- we are doctors with minds that are trained to identify and fix problems. Some problems unfortunately cannot be fixed with medications and swift hands. As more hospitals and EDs close, the civilian population will continue to grow and seek care in emergency departments. It would not be outlandish to think that more members may join our forces for health care alone. Overcrowding, ambulance diversion and boarding hopefully will be words unheard in military emergency medicine practice. But just like most surge or disaster surprises, it is essential to be prepared and know your resources.

The last day of the conference was spent walking the halls of congressional and senate legislators. I joined with the ACEP chapter in Pennsylvania. We were a group of passionate ER doctors with a message on the "Access to Emergency Medical Services Act of 2007" (HR 882/S 1003). This bill is supported by over 14 national medical organizations, including the American Association of Neurological Surgeons, American Association of Orthopedic Surgeons, and American Academy of Pediatrics. The bill focuses on forming a national, bipartisan commission to examine all factors affecting the delivery of emergency medical service, including overcrowding, availability of on call specialists and medical liability. I will let you know that we were sometimes third in line behind severely handicapped people, airline pilots, librarians and a host of other passionate people with a message for their congressmen. Advocacy takes hard work and a lot more than one day of knocking on doors.

The ACEP "Leadership and Advocacy Conference" was a valuable learning experience that I hope more GCACEP members take advantage of in the future. The lectures, training, and distinguished guests alone are worth the trip to DC. Please contact me directly if you need further motivation to attend this conference next year- kristierobson@msn.com.

GSACEP Welcomes

The following people have joined the chapter since the last issue of EPIC.

Troy Akers	Candidate Member
Stanley Allen, III, MD	Active Member
David Anderson	Candidate Member
Steven M. Anderson	Candidate Member
Travis Arnold	Candidate Member
David Baker, MD	Active Member
Brock Bemis	Candidate Member
Anthony Bielawski, MD	Candidate Member
Adam Bromberg, Md	Candidate Member
David Bruner,MD	Candidate Member
Kim A Boswell	Candidate Member
Shawn Campbell, MD	Candidate Member
Adam Corman	Candidate Member
Michael Crowder, MD	Candidate Member
Amy Devlin	Candidate Member
Donald L. Dolce	Candidate Member
Karla Dunsten, MD	Active Member
Debra Feldman, MD	Active Member
Brian Felice	Candidate Member
Tom Feng	Candidate Member
Jason French	Candidate Member
Jennifer Galjour	Candidate Member
Karyn Gilbert, DO	Candidate Member
Patrick Godwin	Candidate Member
Richard Gordon Jr	Candidate Member
Jennifer Guyther	Candidate Member
Colleen Hickey	Candidate Member
Mark Hooste	Candidate Member
Sean Keenan, MD	Active Member
Robert Klever, Jr.	Candidate Member
Tristan Knutson, MD	Candidate Member
Michael J. Krentz, MD	Active Member
Ryan Lamond, MD	Candidate Member
Dara Lee	Candidate Member
Gary Legault	Candidate Member
Christiana Lietzke, MD	Active Member
Anthony Magalski, MD	Active Member
Julian Mapp	Candidate Member
Christine McFarland	Candidate Member
Sean McRoberts	Candidate Member
Christopher Mitchell	Candidate Member
Binda Nair, MD	Active Member
Todd Parker, MD	Candidate Member
Gina Quinn-Skillings, MD	Active Member
Erasmo Reyes	Candidate Member
Teresa Riech, MD	Candidate Member
Fred Romano, DO	Active Member
Stephen Sample, MD	Candidate Member
Heimi Saud, DO	Active Member
Christy Short	Candidate Member
Jessica Sotelo	Candidate Member
Ann Taylor	Candidate Member
Kevin Tench	Candidate Member
Benjamin Terry	Candidate Member
Raleigh Todman	Candidate Member
Sharon Troxel, MD	Active Member
Salvatore Verteramo, MD	Active Member
Drew Weber	Candidate Member
Anthony Woolf, MD	Active Member
Edwin Wu	Candidate Member
Wesley Yeackle,MD	Candidate Member

Teach One

Capt Torree McGowan, USAF, MC

During long nights on call in the ICU, it seems like residency will never end. The hours are punctuated by the beeping of a pager, and the hours feel like they stretch on to infinity. Somehow, through that dragging time, the end of my residency has snuck up and is now sitting there, just a little more than a year away.

This coming year will hold tremendous honor and responsibility for me. I have been chosen from among my classmates here in San Antonio as a Chief Resident for our residency program. My classmates this year comprise some of the best that military emergency medicine has to offer, so being selected from among them is a huge compliment.

As the rest of the chiefs and I prepare for the arrival of our new intern class, I have been looking back over my medical training and my time in the military, trying to think of the best things I learned. There are a few good lessons, and I thought I would share them this month.

Lesson one: For every person you see in the ED, this is the most important thing they do that day. Make them feel like they are your most important patient. This advice actually came from one of my air officers commanding back when I was in college. He was talking about airmen who bring problems to your office, but the same is true for patients in the ED. They may just be another sore throat to us, but whether it's an ingrown toenail or a myocardial infarction, this is the biggest thing they are doing that day. Give them the respect to not minimize their concerns, and to take the time to talk with them about their reasons to be in the ED. It's amazing how quickly you can get to the heart of the reason for their visit, and send them on their way happy.

Lesson two: We don't save lives, we just save them for later. We deal with sick people all the time. Sometimes we perform miracles, pull people back from the edge of death. Other times, we aren't successful. When I first started my intern year, I had a really hard time with the ones we lost. It took some time up in the ICU to realize that we may save them down in the ED, but many times they go upstairs and die anyway. There is some peace in that: it allows families to gather, to begin the grieving process. That realization helped me to remember, however, that I haven't committed a horrible sin if the person's disease process is too advanced and they don't make it out of the ED. Our mortality in this life is still 100%.

Lesson three: This job is an awesome responsibility. Study hard. Every year, our program harps on us to do well on the in-service exam. I am actually chief resident during the inservice, and I'm trying to craft the message I want my interns to take away from that experience. I think this is the message: every patient's life is important, and you better have done your homework so you have the knowledge to care for them.

Lesson four: Be nice to your co-workers. The most important ones are the nurses, unit secretaries, and housekeepers. I know all of our housekeepers by name. One of them brings me homemade tortillas; more importantly, however, when I'm on shift, the women's bathroom never runs out of toilet paper, and it's always the good soft kind. Take care of others, and they take care of you.

In closing, I wish all of our graduating third year residents the best in their new positions, and welcome the new interns into the military emergency medicine family. I look forward to working with you in the Sandbox in a few years.

GSACEP
328 Eighth Avenue, Suite 142
New York, NY 10001

WWW.GSACEP.ORG