Newsletter of The
Government Services Chapter of ACEP

August 2000

The EPIC

The President's Letter

MAJ Brian C. Baxter, MD, FACEP

Having just returned from the ACEP Committee Chair's Workshop, I am rejuvenated and energized with regards to the national organization and our participation in it. Now is your opportunity to become active and re-energized. You might ask: Can I really make a difference? The answer is: Yes. Several of our members will be on national committees for the upcoming year. Everyone I have spoken to truly enjoys his/her experience. One effort I personally participated in was on the Membership Committee this year . We recommended to the Board of Directors, and they approved, the Installment Plan for dues. Now, members can pay dues in quarterly installments. We have also recommended a retirement category of membership, which will go to the Council in October for a vote. These are two examples of how you can make a difference. Congratulations to Tamara Hoover, GSACEP Membership Committee Chair, on working to achieve a record high member number for the Chapter. We have 506 members as of June 30. We need to maintain 500 to keep the additional councillor seat for next year.

Now is your opportunity to become active and re-energized. You might ask: Can I really make a difference? The answer is: Yes!

Make plans now to attend the many activities of Scientific Assembly! If you have never been to the Council meeting, it is well worth your time to see how the College functions. GSACEP will have a chapter meeting/board meeting on Sunday, 22 October at 1930-2130. This is an excellent opportunity to help guide the Chapter. Additionally, please review the Chapter's Strategic Plan in this issue and provide us with any input you may have. GSACEP will also host a reception at Scientific Assembly on Tuesday, October 24, from 1830-2000. Come and see all of your colleagues from the past and present!

Lastly, in an effort to meet your needs and keep the vitality of our Educational Meetings, Joint Services will be held in San Antonio, TX in March 2001 (dates are March 26-March 29). Then, in 2002, we plan to hold a national meeting in Orlando, FL in March. We hope this will encourage support from some military members and non-members who have never attended our meetings. We also hope it will encourage families to attend. We have made special arrangements with the hotel to keep rates low before and after the meeting dates. Please provide your feedback.

Hope to see you in October. If there are any concerns you'd like to see supported or discussed, let your Board know.

Earn This

CPT Stephen R. Ellison, M.D.

Your note about the movie Saving Private Ryan touched me deeply. As you know I am a doctor specializing in Emergency Medicine in the Emergency Departments of the only two military Level One trauma centers. They are both in San Antonio, TX and they care for civilian emergencies as well as military personnel. San Antonio has the largest military retiree population in the world living here because of the location of these two large military medical centers.

As a military doctor in training for my specialty I work long hours and the pay is less than glamorous. One tends to become jaded by the long hours, lack of sleep, food, family contact and the endless parade of human suffering passing before you. The arrival of another ambulance does not mean more pay, only more work. Most often it is a victim from a motor vehicle crash. Often it is a person of dubious character who has been shot or stabbed. With our large military retiree population it is often a nursing home patient. Even with my enlisted service and minimal combat experience in Panama prior to medical school, I have caught myself groaning when the ambulance brought in yet another sick, elderly person from one of the local retirement centers that cater to military retirees. I had not stopped to think of what citizens of this age group represented.

I realized that I had seen these same men and women coming through my Emergency Dept and had not realized what magnificent sacrifices they had made.

I saw Saving Private Ryan. I was touched deeply. Not so much by the carnage in the first 30 minutes but by the sacrifices of so many. I was touched most by the scene of the elderly survivor at the graveside asking his wife if he'd been a good man. I realized that I had seen these same men and women coming through my Emergency Dept and had not realized what magnificent sacrifices they had made. The things they did for me and everyone else that has lived on this planet since the end of that conflict are priceless.

Situation permitting I now try to ask my patients about their experiences. They would never bring up the subject without the

continued on page 3

Congratulations

Several of GSACEP members have recently been appointed to key leadership positions in ACEP. We do not have everyone's name yet, but will publish them as we learn of them.

MAJ. Brian Baxter, MD, FACEP, named Chair of the ACEP Membership Committee.

Marco Coppola, DO, FACEP re-appointed to the Academic Affairs Committee of ACEP.

LtCol.Linda Lawrence, MD, FACEP, re-appointed to the ACEP Educational Meetings Committee.

Bernadette Carr, Executive Director, re-appointed to the Public Relations Committee of ACEP.

Scientific Assembly Announcements

The Government Services Chapter and Board of Directors meeting at Scientific Assembly is being held on Sunday evening, October 22, from 1930 to 2130 at The Philadelphia Marriott. We don't have the room number yet, but will publish it on the website. All GSACEP members are welcome.

GSACEP will have booth number 756 at Scientific Assembly. Come visit us from 0930 to 1530 Monday, October 23 through Wednesday, October 26.

The GSACEP reception is being held on Tuesday eve ning, October 24, from 1830 to 2000 at the Philadelphia Marriott. GSACEP members and their guests only. Reception room to be announced on our website.

Advertise in the EPIC

For more information, or to place an ad, contact the GSACEP office at 718-759-0699.

Full Page B/W (7 1/4" by 10") $300
Two-Thirds B/W (4 3/4" by 10") $200
Half Page BW (7 1/4" by 4 3/4") $150

New Members

Aaisya N. Ansari-Lawai, MD	Blanchfield Army Comm. Hospital, Ft. Campbell, KY
Todd Eric Arkava, MD	Darnall Army Comm. Hospital, Ft. Hood, TX
John Joseph Coakly, DO	Fayetteville, NC
Chad Scott Crystal	Darnall Army Comm. Hospital, Ft. Hood, TX
Diane Devita, MD	San Antonio, TX
Christopher Drew, MD	Arlington, VA
Allen Daxter Holder, MD	East Amherst, NY
Michael D. Jones, MD	Ft. Sam Houston, TX
Paul W. Krantz, MD	Darnall Army Comm. Hospital, Ft. Hood, TX
Evan W. Lee, Jr.,DO	Tulsa, OK
Susan J. Letterlee, MD	Naval Medical Center, Portsmouth,VA
Richard Charles Lotsch, DO	Travis AFB, CA
Kelly Manning, MD	Wright Patterson Med Ctr, Fairborn, OH
Brit McLeod Lovvorn, MD	Birmingham, AL
Tina J. Nelders, MD	Madigan Army Medical Ctr., Tacoma, WA
Jamie M. Patel,MD	Darnall Army Comm. Hospital, Ft. Hood, TX
Donald Sallee, MD	Naval Medical Center, San Diego, CA
Christopher Sullivan	Ardmore, PA
Kimberlee Ann Yeargin	Seattle, WA

Earn This

continued from page 1

inquiry. I have been privileged to an amazing array of experiences recounted in the brief minutes allowed in an Emergency Dept encounter. These experiences have revealed the incredible individuals I have had the honor of serving in a medical capacity, many on their last admission to the hospital.

There was a frail, elderly woman who reassured my young enlisted medic trying to start an IV line in her arm. She remained calm and poised despite her illness and the multiple needle-sticks into her fragile veins. She was what we call a "hard stick." As the medic made another attempt I noticed a number tattooed across her forearm. I touched it with one finger and looked into her eyes. She simply said "Auschwitz." Many of later generations would have loudly and openly berated the young medic in his many attempts. How different was the response from this person who'd seen unspeakable suffering.

A long retired Colonel who as a young USN officer had parachuted from his burning plane over a pacific island held by the Japanese. Now an octogenarian, his head cut in a fall at home where he lived alone. His CT scan and suturing had been delayed until after midnight by the usual parade of high priority ambulance patients. Still spry for his age, he asked to use the phone to call a taxi to take him home then realized his ambulance had brought him without his wallet. He asked if he could use the phone to make a long distance call to his daughter who lived 70 miles away. With great pride we told him that he could not as he'd done enough for his country and the least we could do was get him a taxi home, even if we had to pay for it ourselves. My only regret was that my shift wouldn't end for several hours and I couldn't drive him myself.

I was there the night MSG Roy Benavidez came through the Emergency Dept for the last time. He was very sick. I was not the doctor taking care of him but I walked to his bedside and took his hand. I said nothing. He was so sick he didn't know I was there. I'd read his Congressional Medal of Honor citation and wanted to shake his hand. He died a few days later.

The gentleman who served with Merrill's Marauders, the survivor of the Baatan Death March, the survivor Omaha Beach, the 101 year old World War I veteran, the former POW held in frozen North Korea, the former Special Forces medic now with non-operable liver cancer, the former Viet Nam Corps Commander. I remember these citizens. I may still groan when yet another ambulance comes in but now I am much more aware of what an honor it is to serve these particular men and women. I am angered at the cut backs, implemented and proposed, that will continue to decay their meager retirement benefits. I see the President and Congress who would turn their back on these individuals who've sacrificed so much to protect our liberty. I see later generations that seems to be totally engrossed in abusing these same liberties won with such sacrifice. It has become my personal endeavor to make the nurses and young enlisted medics aware of these amazing individuals when I encounter them in our Emergency Dept. Their response to these particular citizens has made me think that perhaps all is not lost in the next generation. My experiences have solidified my belief that we are losing an incredible generation and this nation knows not what it is losing. Our un-caring government and ungrateful civilian populace should all take note. We should all remember that we must " Earn this."

Rangers Lead the Way!

CPT Stephen R. Ellison, M.D.

Editors Note: This letter from an Army Captain resident physician in our emergency department was first sent earlier this month to a retired special forces friend in Dallas in response to an email about "Saving Private Ryan," his response has been forwarded around the globe, civilian and military alike, including some of the top leadership of the Army and Air Force.

Biography: Captain Stephen R. Ellison, M.D. is a resident physician specializing in Emergency Medicine in the joint Brooke Army Medical Center - Wilford Hall Medical Center Emergency Medicine Residency in San Antonio, TX. He is a native of San Marcos, TX and a graduate of Jack C. Hays High School in Kyle, TX. He received his B.S. in Biology from Southwest Texas State University in San Marcos, TX. He then enlisted in the U.S. Army, serving in the 1st Battalion, 75th Ranger Regiment, Hunter Army Airfield, GA. He was the Enlisted Honor Graduate of his Ranger School class and participated in the parachute assault of Torrorrijos/Tocumen Airport, Panama during Operation: Just Cause. He attended medical school at the University of Texas Health Science Center at San Antonio on a U.S. Army scholarship and received his Doctor of Medicine degree in 1995. His transitional internship was performed at Brooke Army Medical Center. He then served as the initial company commander and program director for the new Joint Special Operations Medical Training Center, Ft. Bragg, NC. He currently resides in San Antonio, Texas, with his wife Marta and his two children.

Strategic Goals 2000 - 2001

On March 12th GSACEP held its annual Strategic Planning Meeting in San Antonio, Texas. During this meeting the following goals and objectives were made:

Education Committee
1.Increase market share/penetration of CME
2. Develop an identified network of experts.

Communications Committee
1. State of the art technology
2. Archival databases

Membership Committee
1.Chapter membership will be greater than 500*
2. Membership on committees will increase
3.A large number of members will run for elected leadership positions
* Goal was reached in June.

Policy Committee (position open)
1.Needs of Chapter members are identified
2 No gaps exist between chapter policies and identified needs
3. Solutions to shared challenges are communicated through all levels of the organization, 100% of the time.
4. Chapter members are consulted by ACEP leaders and other chapters on all policy positions in members' areas of expertise.

Board Consultants
1. EM faculty positions are coveted, and academic productivity increases.
2. EM residencies receive the highest applicant/position ratio
3. Members will renew their commitment to military service

Wellness Committee (position open)
1. Wellness information is disseminated.
2. Mentoring

Resident's Corner

CPT Steve Currier, MD

Welcome to all the new interns and congratulations to everyone else on another year survived. This column is supposed to cover resident issues. I often cover issues which affect us at a national level or other issues more specific to the military but today I want to talk about education. No, not another boring lecture but a list of web based resources that make my life easier and hope will help you in your search for answers to everyday questions in Emergency Medicine.

1. ACEP.ORG. This is the official ACEP website it contains information on meetings and issues that impact Emergency Medicine at a national level.

2. GSACEP.ORG Similar to the ACEP site but limited in focus to the Government Services Chapter of ACEP.

3. EMRA.ORG This site contains information more specific to residents as a group. It does have some educational content such as the pearls section, which focuses on day to day issues in the workplace rather than actual clinical questions.

4. eMedicine.com This site is great! It is strictly academic and has folders for various specialties. Emergency Medicine is one of the only folders finished. This is similar to a textbook with up to date information and references.

5. East.ORG I will warn you now: DON'T type east.com or you will find yourself on a web page that may land you in trouble if you are on a government system.

This site is a trauma site with limited information but the few topics they cover are outstanding. Their opinion is backed up by literature and they will break the subject down stating where there is level I, II, III data for each point. If you find yourself with a lecture topic on trauma, I recommend this be the first site you visit.

6. MDConsult.com You have to pay for this one or use your library's subscription. It gives you instant access to full text articles from 50 journals. This makes the literature search on a subject much less library intensive.

I know there are many more sites out there but these are the ones I find most helpful on a day-to-day basis.

As I sat down to write this column I checked my e-mail and Dr. Baxter the President of GSACEP dropped me a line. He wanted me to drum up business for ACEP. Simply translated this means: Make sure all the military residents join ACEP. As I checked my lists of residents, I found there are many military residents who are not members of GSACEP. Please, let your fellow residents know ACEP is our one national voice and we need to be a part of it. ACEP fights for many causes such as the patient bill of rights or, closer to home, our reimbursement from HCFA. There has been a lot of negative talk about ACEP from other groups. However, if you just ask them what they are doing about the issues they say ACEP is not addressing, you will see they are talkers not doers. The easiest way to join GSACEP is on the GSACEP webs site. Just log on and follow the directions.

MEMBERSHIP COMMITTEE GOALS AND STRATEGIES

LCDR. Tamara Hoover developed these membership committee goals in response to GSACEP's Strategic Plan. We will publish the goals of other Committe Chairs as we receive them. If you are interested, please contact us and we will put in touch with Dr. Hoover.

I. Chapter membership will remain greater than 500
  A. Vigorously promote membership among PGY-1's
  B. Vigorously promote membership among GMOs
    1. Obtain the lower $50.00 membership fee for post-internship GMOs (This is being addressed by Brian Baxter with national ACEP.)
  C. Keep GSACEP members who have moved. [Note: This actually was addressed by Patty Stowe at ACEP last spring and is working quite well].

II. Membership on committees will increase
  A. Committee chairmen and members (with e-mail addresses) will be published in EPIC annually
  B. Committee Goals and strategies will be published annually in EPIC
    1. Specific committee needs must be identified and publicized
  C. Committee members will be rewarded for their service
    1. Establish annual awards for outstanding contributions

III. A large number of members will run for elected leadership positions
  A. Leaders will be rewarded for their service
    1. Consider free attendance at all GSACEP conferences
    2. Consider reimbursement for airfare to all GSACEP conferences
    3. Establish annual awards for outstanding contributions
  B. Leadership position descriptions must be published with approximate time commitments required to fulfill that obligation
  C. A questionnaire will be disseminated among chapter members to define their expectations of what GSACEP membership and its leaders should provide

CME Articles Online

A decision has been taken by GSACEP to publish the CME articles online only. GSACEP understands that the CME article is very popular with our membership and we wish to continue to offer CME to our members. However, by publishing the EPIC's CME article online instead of in the EPIC, we will save thousands of dollars which will help us to keep our membership costs down.

The CME articles can always be found on our website at http://www.gsacep.org/Members/Epic.cfm . The articles are published with Adobe Acrobat to perserve the qaulity of the article. If you have any difficulty logging in to the web site, please contact our webmaster at webmaster@gsacep.org.

CME #15 - NEUROLEPTIC MALIGNANT SYNDROME

CPT THOMAS N. BOTTONI, LCDR, MC, USNR

Government Services EPIC CME Course has been approved by the American College of Emergency Physicians for up to 10 hours of ACEP Category I credit.

This article is an educational activity sponsored by the Uniformed Services University of the Health Sciences (USUHS). USUHS is accredited by the Accreditation Council for continuing Medical Education (ACCME) to sponsor continuing medical education (CME) for physicians. USUHS designates the enduring material for 1 hour Category 1 towards the Physicians Recognition Award of the American Medical Association. The CME was planned and produced in accordance with the ACCME essentials.

17th Annual Emergency Medicine Symposium

GSACEP and Naval Medical Center San Diego jointly sponsored with ACEP the 17th Annual EMS at the Concourse in San Diego.

The conference featured several nationally known speakers and a full curriculum for its three-day-sessions from Monday, July 24 to Wednesday, July 26. Course Coordinator LCDR Peter Mishky took over in March from Dr. Gerry Van Houdt who left military service for a civilian appointment in Washington State. Dr. Mishky and his team did an outstanding job.

Our sponsors included Audio Digest Foundation, a nonprofit arm of the California Medical Association, who recorded parts of the conference. If you attended and are interested in obtaining a particular speaker's lecture, contact Marilyn Lowry at Audio Digest (818)240-7500. Not all speakers will be available, but she will let you know who is.

We want to thank sponsors Ortho-McNeil and Wyeth-Ayerst as well as our exhibitors: Abbott, Bayer, Boehringer Ingelheim, Dura Phamaceuticals, Medtronic Physio-Control, Merck, Pfizer, Smithkline Beecham, SonoSite, and Zoll Medical.

IMPORTANT DATES

October 21-22: Council Meeting ACEP, Philadelphia, PA
October 23-26: Scientific Assembly, Philadelphia, Pa
October 22: Chapter and Board Meeting, GSACEP, 1930 to 2130, Philadelphia Marriott
October 24: GSACEP Reception, 1830 to 2000 Philadelphia Marriott
March 25, 2001: GSACEP Strategic Planning Meeting and Board meeting, Sheraton Four Points, San Antonio, TX
March 26-29: Joint Services Symposium 2001, Sheraton Four Points, San Antonio, TX

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Government Services Chapter ACEP

Spring 2003

The EPIC

DEPLOYMENT: A Special Edition

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February 2003

Dear GSACEP Member,

As military emergency physicians we are experiencing one of the most challenging times our specialty has ever encountered. For the past two decades we have struggled to define our specialty within the military. Our success can be clearly measured by the high op tempo emergency physicians are experiencing since Sept 11, 2001. It is no longer a question IF you will be deployed but WHEN.

Our specialty training has prepared us well to succeed in the austere operational environment and the military line and medical leadership know this fact. However, while we all may have the medical skills to perform our job, the ability to treat both battle injuries and non-battle disease injuries, and the ingenuity to adapt to remote environments, deployments can still be very stressful to each of us and our families. While the GSACEP Board of Directors was distressed to have to cancel the 2003 Joint Service Symposium due to the heightened op tempo they wanted to do something to help members. The following has been prepared in an effort to help members who may be deploying.

The articles you will find are practical tools to help you get ready. Websites for more information on medical care aspects will be available in the future on the GSACEP website. There is a wealth of resources easily accessible on medical management of combat casualties. Thus the focus here is to help one get out the door and spend those final moments with your families and friends. Also a couple of articles have been included on new training opportunities and detainee medicine.

The enclosed information will also be placed on the GSACEP website. The goal is to see this website grow. Please share with us articles, case reports, pictures or anything else from your deployment experiences you think may be of benefit to your military emergency medicine colleagues. Please contact Ms Bernadette Carr, GSACEP Executive Director at gsacep@aol.com if you have something to share.

On behalf of the GSACEP Board of Directors we hope you find this resource helpful. We applaud each and every one of you for the courage and sacrifice you have made and will make in the future as military emergency physicians. We pray that God watches over you and your families during these challenging times and keeps us all safe and healthy.

Sincerely,

LtCol Linda Lawrence, USAF, MC

Inside

Contributors

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Packing Tips for Exercises and Deployments

by CPT Ilse Alumbaugh, RN

Editor's Note: The following was prepared by CPT Ilse Alumbaugh, a student in the Graduate School of Nursing at Unformed Services University. These lessons learned were shared with the medical students as they prepared for their senior one-week field exercise. Whether you are a novice field goer or seasoned veteran I am sure you will find a pearl or two among these that will make a huge difference in your future field experiences. Even if you won't be residing in a tent there are several helpful hints that can apply to all of us. I have added a few commentaries in italics from my field experiences. Yes even us Air Force type sometimes find ourselves away from the club.

This list of tips is written for general field survival and deployments. It's based on 20 years of field experience, deployments and humanitarian missions. Must do items for this exercise have been underlined. Store the rest away for later reference.

Packing Tips:

Tip #1: Line your duffle bag with a 33 gallon garbage bag. Invest in a strong lawn/leaf bag that resists punctures. If you don't normally buy large garbage bags, get together with friends and share a box. Take at least 1-2 extra bags for whatever.

Tip #2: Line your sleeping bag cover with another bag. The waterproof bags (aka, the Willie P) can sometimes come with holes – even the new ones.

Tip #3: Line your ruck sack with a 3rd bag. Take at least 1-2 extra bags for whatever. *Bring extra of all kinds of bags – garbage, gallon ziplock, quart ziplock. Don't take much room and great to keep dry things dry, wet things away from dry and storing those coveted snacks from predators. At the end of the exercise when heading home there is the temptation to toss everything together but if you bag the mud it makes it easier at the cleanup.*

Tip #4: Pack an A bag and B bag. In most units, the hospital command determines which bag will be which for shipping and storing purposes. The A bag is usually your ruck sack and should contain stuff you need quickly. A change of clothes, three days of socks, underwear, and t-shirts (may increase based on your unit's mission and travel time), a toiletry bag, 2-3 days of MRE's, and gas mask and LBE if you're not carrying it. Also pack your woobie (poncho liner) and a pillow on the top. These will be handy in intemperate hangers waiting for transportation for chilly weather and a quick nap.

The B bag is usually your duffle bag and contains the majority of your supplies and clothes. This includes an off weather gear for long deployments.
a. Pack pt clothes, military and civilian for off duty time. Take at least three t-shirts on deployments.
b. For deployments, pack 2-3 sets of civilian clothes NO MATTER WHAT THEY TELL YOU regarding actual need. You will be told you don't need them. You won't, everyday. But you will need them for R&R. Take them. At some point you will need them. *Even if you don't get to go anywhere it feels great to wear something different for a change. Nothing like wearing those favorite comfy jeans and shirt to pick up your spirits.*

The C bag is often authorized for long deployments and may be shipped. This is where your survival stuff will go. Pack your lawn chair, plastic shelves, etc. in here. Do not pack anything in this bag you can't live without. That includes cold or hot weather gear even if you THINK you're going to a hot or cold weather climate. If your gear is shipped it can take up to three months to get to you and things change quickly during deployments.

The Double Duffle Bag Theorem:
A. Whatever you need the most will sift to the bottom of your duffle bag.
B. Whatever you needed the last time you looked and no longer need will always be on the top of the duffle bag until you need it again, in which case it will mysteriously sink to the bottom again.

Tip #4: Pack three days of under items in a bag. Pack as many bags as you need for the deployment or field exercise. For long deployments, laundry may be scarce for the first couple weeks. Bring at least 14 days of under things. Pack one bra, three t-shirts, three socks, and three pairs of undies into a 1 gallon bag, or a long plastic newspaper bag. I highly recommend the latter. When you're reaching around blindly in your duffle bag, they will be the easiest to find. This tip is helpful for anything you think may be hard to find. Put 1-2 bags of under items in your A bag as needed.

Tip #5: How to Organize Your Duffle:
a. Make 3-5 day layers in your duffle bag. Fold or roll your uniforms and place them in 3-5 day layers, alternating uniforms with long underwear/sweaters/thermo in cold environments.
b. Place boots around the sides toward the top for quick retrieval.
c. Pack the long bags with T-shirts etc., last, and slide them around the edges of your duffle bag.
d. For flights and travel, ALWAYS set up and fold your LBE and place it on top. Ideally this would be in the ruck sack if you have one. Then your mop gear, then your gas mask. Leave the mask on top regardless of whether you think you'll ever need it. You probably never will, but if you got into a hostile environment, this advice may pay off.

Tip #6: Pack a sandwich bag with three pairs of socks, a bottle of powder and a few candies. Place the bag in the outside pocket of your rucksack (or gym bag). This great for road marches, or wet weather. The powder is

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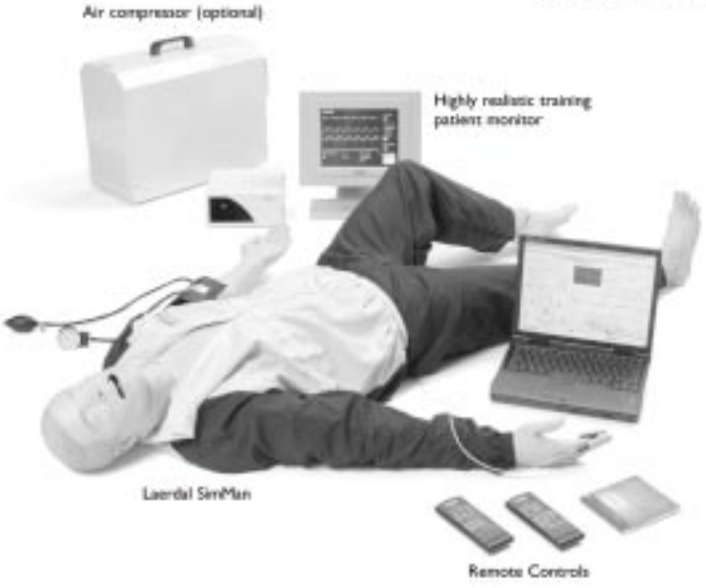

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Keeping Warm and Dry:

Tip #1: Keep your extra boots in your ruck and place your daily boots **under your cot** to air out at night. You can cover the openings with socks if the insides aren't soaked from sweat or water. Carefully check for critters the next morning. But always put them under your cot. The tents tend to leak.

Tip #2: Keeping your bunk dry. Pack a 3-pack roll of painter's drop cloths or inexpensive plastic shower curtain liners, 550 cord and clothes pins. When your tent is set up, attach the 1st cloth to the side of the tent at an angle suspended over the 550 cord. Attach the other two cloths to the first cloth, draping the edges over the string and clipping into place assuring the water runs away from your bed. Roll the sides up and clip into place. Drop sides on rainy nights.

Tip #3: Invest in a gator. A gator is an 8x8, square hood you can purchase at clothing sales. It is most handy in cold weather. It can be worn over your head like a scarf to keep your neck, face and chin warm, or bundled around your neck between your parka and your helmet. When worn this way, it keeps the rainwater from dripping onto your neck, down the back of your sweater and jacket while you're bending over working.

Creating a Cozy Camp Environment:

Tip #1: Bring toilet paper. Share among friends if you must, but make sure you have it. It oddly becomes a hot item in the field if the supply people didn't bring enough. Include hand sanitizer.

Tip #2: Privacy: After a few days in the field, you will long for privacy. Attach a poncho, or shower curtain over the line for a secure changing or rest area.

Tip #3: Invest in a down pillow. If you need a full sized pillow, consider buying a small full-sized down pillow versus a fiber fill pillow. It fits nicely in a two gallon bag that fits perfectly on the top of your ruck sack for quick retrieval, and provides good back support while waiting for transportation. It crushes down and stuffs nicely around your duffle. It can fill in cracks without taking much room. *If space is at a premium take a pillow case and fill it with clothing. While not as nice as a down pillow it is better than nothing. Plus sleeping with your clothes keeps them warm and makes getting dressed in a cold tent all the more appealing in the early dark cold AM.*

Another option is an inflatable bathtub pillow. It launders well in the washer and dryer. Bring two pillow cases for deployments and long exercises.

Also bring two sheets. This is great for hot climates in coed tents. You can roll the edges of your sleep bag, lie on your sleeping bag and cover with a sheet, which rests on the elevated rolls. This keeps the sheet off of you and air circulating. Applies to tiny people best. *A flannel sheet or light fleece blanket are great for lining your sleeping bag during cold trips. No matter how cold they always feel warm and great to wrap around your head/neck to keep the draft out.*

Tip #4: Invest in a snake light with a battery pack. The snake light is handy for everything, to include reading at night. In most exercises or deployment, you'll have electricity so you can charge your snake light when not using it. Keep it dry. Watch Home Depot, Lowe's and K-mart for sales to get a good price.

Tip #5: For long field exercises and deployments, invest in an inexpensive plastic set of drawers. Pack the drawers with snacks and extra supplies and books. Pack a plastic box with extras and ship it with your section's MIL van. At destination, put your snacks in the critter and moisture proof box and place under bunk. It doubles as a card table and dressing table. Put your often used items (toiletries, etc.) in the plastic drawers and use for a night stand. Determine if your drawers are water proof first. If not, elevate it on your box or pallet, and cover with plastic in rain. If you suspect they are not air tight, DO NOT store food items in them unless you like critters visiting you at night.

Tip #6: Invest in a camp chair. For a quick exercise, buy an aluminum folding chair. It fits perfectly in your ruck sack and provides back support – like a back pack frame if padded properly. For longer deployments, buy the folding chairs/recliner/couch and ship it with the hospital. They also have folding tables now. You can find these at K-mart and Wal-Mart.

Tip #7: Pack a couple sports bras and running shorts/tights. This will make changing in a co-ed tent slightly more palatable.

Tip #8: Bring sweats or neutral pajamas to sleep in. I don't recommend crawling into bed with the long underwear you plan to wear the next day because you'll sweat in them while you sleep. Deciding to wear the ones you wore that day is up to you.

General Survival Tips:

Tip #1: Always bring leather gloves with liners for setting up tents, filling sandbags, etc. regardless of the weather and regardless of whether you normally wear work gloves. Keep them handy in your ruck sack for quick retrieval.

Tip #2: Keep hand sanitizer, toilet covers and emergency toilet paper in your ammo pouch. You can find the mini-packs of toilet covers (5/pack), sanitary hand wipes, and a tiny TP roll for .78 cents apiece at Wal-Mart in the sample items aisle.

Tip #3: Surviving the Porta John Lifestyle: Team up with a buddy to watch your stuff. If security is an issue, take it in with you with the following guidelines: Go into stall, lock door, close lid to commode. Unhook your gear and hang it up on door. Close toilet lid and re-don gear. Don gear outside the John if there is a long line. You laugh but there are many flash lights, gas masks, and weapons in latrines all over the world. Nothing alarms one more than the sight of a glowing outhouse – for days if Duracell batteries were used.

The Cycle Theorem:
If it's inconvenient, your cycle will start.
If you don't care it won't.

Tip #4: If deployed, pack a three months supply of feminine hygiene items with you. It may take that long to get your gear shipped to you or for AAFES to set up shop. If you don't have regular cycles, you may be surprised that they suddenly get regular. If you take OCP's, you can skip your odd colored pills (green, white) and start a new pack. This will suppress a cycle. Do this no more than three months. Keep current on GYN guidelines in case this changes.

Staying Fresh and Tidy

Tip #1: No shower? No problem. Baby wipes are great. Select a smell you can stand. Don't be ashamed to wander through Wal-Mart and the Commissary opening packages and sniffing. By the end of the exercise, you will HATE the smell if you don't choose wisely. This will be a problem when you have children, change their diapers and think of the field. For the day, you can purchase travel packs for your ammo pouches or select about five, fold them, and place them in baggies. They're refreshing and keep the grime down. See Tip #5 too.

Tip #2: A basin is better. The plastic surgical basin is the perfect size if you can get your hands on one. Pack your items into it to save room.

Tip #3: Befriend the OR staff in a CSH – they are sometimes the only ones in the hospital with hot water and a sink big enough to wash long hair properly. Bring easy rinse shampoo and cream rinse.

Tip #4: Use bar soap. Consider Irish Spring, it rinses better and leaves you feeling cleaner. Liquid soap is wonderful – in garrison, and feels soft and luxurious. However, it doesn't rinse well and tends to leave you feeling slimy in the field. Again, select the scent carefully.

Tip #5: Bring a pack of Pond's face cleaning cloths – they're pre-moistened, and designed to remove make up. They're great for removing camouflage makeup. Good for sensitive skin and less harsh than baby wipes. An alternate, if you battle adult acne, is Noxzema face cleansing cloths you can rinse

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ZOLL M Series

under your canteen. They're refreshing and designed to keep acne at bay which creeps out with chin straps and having your face grimy all day. You can pack a few or invest with friends and share a pack.

Tip #6: Buy slightly elevated but stable shower shoes. This will keep your feet out of mud and the water that invariable pools in the shower and creeps you out – especially if you see hair and foreign objects floating around in it. New styles allow you to go up to 3 inches out of the water. Stop at about 1.5 inches. $12.00 at Kohl's and K-mart.

Tip #7: Women Only – Men won't care: Buy underwear for deployments and the field. Your overriding desire when you return from a trip longer than a week is to immediately burn your underwear because you are so sick of looking at it. Invest in cotton underwear and bras in fun colors from K-mart, Wal-Mart, or Target. White gets really grimy looking. Don't bring the Body by Victoria for $12.00 a pair.

Keeping Entertained

Tip #1: Confer with a group of friends who have similar reading interests. Everyone bring three different paperbacks. Trade off. Pack more in the mil vans. *If your camp doesn't have an exchange library start one. I greatly expanded my reading interests while deployed.*

Tip #2: Invest in a Game boy. Bring lots of batteries for them. If you like to play competitively, find a buddy who has a Game boy and invest in a connecting cord.

Tip #3: Computer – Risky in sand! But, worth it. If you're shopping for a travel lap top, find one that will connect into your LAN line. Many computers have wireless capability, but you may not have a signal center at your destination. When you get to the field, befriend the signal guys – feed them quality snacks and promise them all the medical care they desire (may have to get the NP's or FP docs to help you carry this out) and ask them to configure your phones with your computers in mind. They'll know what to do. Expect EVERYONE in the hospital to ask to use your computer. Make a decision before you deploy if that is acceptable. If so, remove all private data, Quicken, letters, etc. from the computer because people get bored at night and go snooping through your computer. In El Salvador we swiped each other's pictures from the MEDCAPs and emailed them home. Make sure your picture collection is G rated. That goes for email as well. Let your friends and family know this.

Tip #4: Digital Camera – Again, risky in sand, but worth it. It is amazingly satisfying to send real time photos home. If you don't want to risk a digital camera, buy no less than 5 disposable cameras. When full, mail them home to family to develop onto a disc and email back to you to share with friends. *Know the local rules before you click. Pictures of the front gate were off limit at Incirlik AFB Turkey – with the armed guards who had no sense of humor compliance was a 100%. One of my colleagues incited what almost turned into an international event at another Middle East base when he took pictures of a base sign several miles away from camp as they returned from taking a patient downtown. And do be careful of what you email – big brother is watching and what we may accept as okay in our country can be offensive in other countries. On the bright side a digital camera can be very helpful as you shop. I used to send my husband pictures of the rugs I thought of buying so he could tell me his preference and remind me what my home looked like – funny how quickly one can forget the colors of the walls.*

Tip #5: Cards and games will appear mysteriously and everyone will play. Bring what you enjoy. Crafts – cross stitch and knitting. *We even got the orthopedic surgeon deployed with us to cross-stitch something for his soon to be new baby.*

Fine Dining in Austere Conditions:

Tip #1: **See MRE menus**. Learn to barter. Know your buddy's weakness. Most people can be divided into: hate cheese, love peanut butter, hate Tabasco, need more sugar, hate pound cake, must have M&M's. Use the heater – but don't open the package before you warm your food. The water will spill into the MRE and spoil the taste.

Tip #2: Dealing with nausea – Try to take antimalarials at bedtime if you aren't required to take them in formation. If required to take them in formation, eat a handful of Cheezits first. They coat the stomach and prevent nausea. Ginger snaps are great for general nausea related to change of environment and strange foods, but Cheezits are better for nausea associated with Primaquin and Doxycycline.

Tip #3: Speaking of anti-malarials – never, NEVER take an antimalarial tablet with a carbonated soda. Never. It comes back up quickly and violently.

Tip #4: This isn't the time to diet. You'll lose weight naturally by working like a dog, being too anxious to eat and of course, the trots associated with traveler's diarrhea. If trots aren't your problem… See Tip #5. Eat what you want and drink lots of fluids. If you don't have patients, you'll find yourself spontaneously exercising regularly out of boredom.

Tip #5: Take a fiber supplement in tablet form if MRE's are rough on you. Bear in mind that most constipation occurs when people don't feel like facing the smelly latrine. If this is the case, take a toilet cover, a good book, and a clothespin for your nose. Don't forget the hand sanitizer and toilet paper. I continue to be STUNNED by the lack of hand washing stations in a field hospital.

Tip #6: Facing caffeine addiction: The first step is acknowledging your powerlessness over caffeine. The second step is to fight signs of physical addiction. If your hospital is shipped, you may not have hot meals or real coffee for several weeks to months or the heat makes the thought of hot coffee seem, well, hot. This scenario can be a disaster for the caffeine addicted. The fix: Mix 1/2 strength lemon flavored iced tea with water. This prevents caffeine withdrawal headaches and temperament changes usually associated with heat injuries. It's important to know the difference. You don't want sepsis from an IV over caffeine withdrawal. The signs are the same. Really.

Tip #7: Handling Chlorinated Water: The PM guys kinda over do it - for good reasons of course. Warm chlorinated water is even more awful. To motivate myself to stay hydrated; I mix 1/2 strength Capri Sun or Gatorade in my water in a separate water bottle I keep in my cargo pocket. I make a couple batches a day. Adjust the amount of mix for the heat. Dilute in hotter weather or less if you aren't eating regularly. Other options: Boxed concentrated juices such as grape, apple, cranberry. Be cautioned that you may not be able to refrigerate these once opened, but if refrigerators are an option, go for it.

Tip #8: Bring a slender water bottle that fits into your cargo pocket for this purpose. Each night, empty it out, rinse it with chlorinated water and let it drain. Do not reuse fluids from day to day because of the sugar content.

Do not, do not, DO NOT, put anything other than water in your canteen. This is an offense punishable by UCMJ for the enlisted soldiers. They'll be watching you. Set the example. Mix your juice in a water bottle and keep your canteens filled with fresh water even if you only consume from your water bottle. As a medical professional you can make an educated choice about your fluid and electrolyte choice. The 11B sharing your camp site may not be able to make that same educated choice.

Tip #9: Still No Hot Coffee: If you're lucky, you have hot water, but can't stand instant coffee another day or you can't imagine life without Starbucks. The fix: Bring flavored teas and flavored creamers to dress up your caffeinated beverages. Don't forget your private stash of sugar. Like toilet paper, it can quickly become a premium item.

Tip #10: If you have more than 1 MRE a day, bring snacks. You'll be profoundly tired of MRE's in no time.

Special Thanks to my Nursing colleagues who reviewed this list and offered their suggestions:Major Tammie Boeger, Major Joe Candelario, CPT Lisa Ford, CPT Tony Leonard, CPT Jana Ortiz, CPT Meryia Windisch

And extra special thanks to my Mom who taught me how to tell when it's going to rain; and my parents who dragged me out on my first hike when I was three and encouraged us to hike the Grand Canyon every Spring Break.

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Adjuncts to the Packing List
(For deployments and field exercises)

Waterproof notebook with waterproof pen and pencil
Flashlight with blue/green/red/clear lens
Painter's drop cloth/3 shower curtains
550 cord
100 MPH tape
Leatherman
Batteries

Canvas or aluminum folding chair/table

Elevated shower shoes

Hand lotion – choose scent wisely
Bug Spray
Sun Screen
Kleenex packets
Chapstick with sunscreen
Fiber tablets

Hand Sanitizer
Toilet Paper
Toilet Seat Covers

Extra glasses
Mask Inserts – order them now
Extra contacts/solution/case

$10.00 in one dollar bills
$ 3.00 in change

First Aid Kit:
- Mole skin
- Bandages
- Ankle brace
- Tylenol/Motrin
- Cortisone cream

Hair cutting items
Hair implements – pack extras

Sunflower seeds – keep you awake on guard duty
Coffee beans

Good clinical pocket references. *Consider a computer and then you can bring a reference library on CD-ROM. Don't expect much where you are going.*

[1] On the first night of a deployment to El Salvador, I went to bed to the sound of demonstrations in a nearby city. I was awakened a short time later choking from smoke rolling into the tent. Thinking we had been involved in a riot and were under attack, I jumped up, donned my gas mask and awakened and evacuated the tent. We were disoriented and confused. When the smoke cleared, we found an MRE bomb under the cot of the Chief Nurse who was next to my cot. The prankster was never found and no one was hurt. But it taught me not to pack my gas mask too far away and the mask allowed me to quickly and safely evacuate the tent.
[2] I woke up one morning and found that one boot had crept out from under my cot in the night. It was filled with two inches of water!
[3] Don't let anyone tell you it NEVER rains where you are. In El Salvador we got to experience the only rain they've ever had in December in 20 some odd years. It lasted 15 minutes, but soaked everything because no one (except me) was prepared. How did I know it was going to rain? When the barometric pressure changes, leaves will flip up, curl over and take on a silver appearance, even if there isn't a cloud in the sky. Look at the trees. If they appear silver from a distance, look closely and immediately secure your site. It WILL rain within three hours. My tent mates who thought I was crazy when I started dropping my tent flaps, thought I was magic when they had to dry their gear. It's not magic, just science, but they pestered me every day for the rest of the deployment for a weather report! It was 80, sunny and warm. It never rained again.

Just Do It!
Survival Tips for PROFIS Officers

by CPT Ilse Alumbaugh, RN

You may have the experience of being assigned to a unit as a PROFIS officer. This will happen just when you think your life will be all clinical and you're well established in your practice. Then you'll get that email or phone call – you've been assigned to a CSH or FH. While your initial instinct will be to hide in your clinic and pray the phone never rings for an FTX or deployment, resist!! Accept your assignment, and do some research to find out what your role will be.

Tip #1: **Know your mission.** Find out what your unit's mission is, who they typically support, what geographic region your tactical unit supports, how often your medical unit trains, and how many times the unit has been deployed in the last five years.

Tip #2: Take the time to get to know your team. Don't slink away and bury yourself with appointments when you hear an exercise is coming up. Use the opportunity to go to the field to meet your team; most helpful if your unit isn't in your state.

Tip #3: Befriend the NCOs. If you're lucky enough to be in the same location as your unit, find out who the NCO's are that support your section. Befriend them. Feed them quality snacks, and train them. They will love you for it. Train them to the level you expect from your support staff. Your expectations and their experience will be surprisingly different. Teach them ATLS, especially primary and secondary assessment, resuscitation, mascals, and how to manage specific cases appropriate to your unit. Coordinate with your Nurse Corps staff and senior NCO's who may already be training. Evaluate and join in the training.

Tip #4: Befriend your professional colleagues in the unit. Remember, you'll be spending long hours in a tent with them, possibly in war. This is time to find out whom to avoid, who to befriend, and who to play chess, run or swap books with. This doesn't seem important now, but it will be.

Tip #5: Learn how to procure. If assigned to a ward or unit, get to know your Ward Master and Head Nurse. Go with them at least quarterly to unpack and inventory the chests. You will be stunned at how outdated your equipment is. Ask for supply input from the head nurse. She is working full time on the ward and knows the latest supplies and equipment. Your NCO is likely to have spent the last 8-15 years in a tactical unit and hasn't touched a patient in three years but he/she knows exactly how to get their hands on the supplies you need. They may ask you to use your authority to request and justify the supplies. Make the time to do it. Encourage your senior NCO's to rotate supplies about to expire and keep current with technology. If have problems with getting current supplies, make a wish list, give a copy to your NCO and Head Nurse and bide your time. During deployments, coffers dramatically fly open and money will suddenly be available for all the supplies you need.

Tip #6: Packing snacks. When getting deployed, collect quality snacks and bulky supplies such as a chest and pack them in the chests being shipped to your deployment area. Get a plastic chest with drawers and pack the drawers with snacks you'll need for a long deployment. It doubles as a water proof night stand to store your things in when you get to your assignment.

Live out of state from your unit? Remember the friends you made? This is the time they'll help you. You're assigned to Walter Reid and you're told your unit, stationed in New York, North Carolina, Georgia or Kentucky is being deployed. How to get your snacks packed? Quickly purchase and ship your box to your friend, or call them, send them a check and ask them to purchase and pack the items for you. See, you need good friends for these kinds of favors. Remember, these items may be shipped and can take MONTHS to get to you. Do NOT ship anything you don't need within two months. This includes intemperate weather clothing.

Tip #7: Lead by example. When deployed or training, never be heard complaining by a subordinate. Ever. It decreases morale (including your own) and quickly establishes you in the minds of the unit regulars as a whiny, spoiled PROFIS officer. When setting up sleep tents and the hospital, do not hide, be the first to pick up a mallet. Do not reason about the necessity of filling, emptying and refilling sandbags. Just do it. Be first to do it. Step forward and lead by example with a positive spirit. This can be surprisingly hard. Especially when you're tired, hot, cold, sleep deprived or scared. However, a positive attitude quickly becomes contagious. Leadership by example is one of the most effective methods of leadership. This will most be most important when you've set up your 12th sleep tent or filled your 25th sandbag or been sitting in your empty CSH wondering where the heck the patients are and reflecting sadly on the backlog of patients in your clinic. Patients in your clinic will fill your head with woe before you leave – "But gosh Doc! Who's going to take care of me while you're gone? You're a _____ist, why do YOU have to go? You should be here taking care of me. I need you more." At the moment, you may feel glad for the break. Within days or weeks, you'll be thinking fondly about that patient and wishing you were home.

Tip #8: Choose who sleeps next to you very carefully. You do not want to be next to the unit commander, chief nurse, or first sergeant. You also don't want to be next to your NCOIC, OIC, or anyone that quite frankly annoys you. Oddly, these people can be your bunk mates and you need to let your hair down at some point and vent. Avoid snorers. Prior to deployment, liberally write referrals to ENT for people you suspect may have a snoring problem. Think I'm kidding? Nights can be very long.

Tip #9: Understand heat categories and be an advocate for your soldiers and staff. Bring up the question of limiting training in extreme hot weather. Sometimes your MSC officer is inexperienced and isn't aware that such a thing as a wet bulb exists. They take the news more seriously from a physician.

Tip #10: Bring your own role of toilet paper and hand sanitizer. Oddly enough, you can't count on a hand washing station even in a hospital!

RECIPES TO ENHANCE YOUR MRE'S

by CPT Ilse Alumbaugh, RN

Ranger Pudding
1 MRE cocoa beverage powder
1 MRE creamer packet
1 MRE sugar packet
water.

Directions: Mix creamer, powder and sugar. Add water and stir to desired consistency.

Ranger Bread Pudding
1 batch Ranger Pudding
1 half MRE pound cake.

Directions: Crumble pound cake into Ranger Pudding

Peanut Butter Cup Poundcake
1 MRE cocoa beverage powder packet
1 MRE creamer packet
1 MRE sugar packet
1 MRE peanut butter
1 MRE vanilla pound cake
1 MRE coffee (optional)

Directions: Divide poundcake. Slice top of peanut butter packet open. Add cocoa, creamer, sugar, and coffee to the peanut butter one at a time, mixing well. Spread onto _ pound cake and top with other half.

If you need the caffeine, mix a tiny amount of coffee into the peanut butter mix.

Mocha Frosting
1 pouch of MRE cocoa
1 packet of instant coffee (optional)
Water as needed.

Directions: Add just enough water to the cocoa mix to resemble frosting. Add coffee granules as you wish to create a mocha flavor. Spread this frosting on such items as MRE pound cake, cookies and crackers.

Ranger Cobbler
1 MRE pouch of peaches or apples or strawberries
1 packet of sugar
2 crackers,
Water as needed (hot water makes it more cobbler-like)

Directions: Add more water to the pouch of peaches than usual. Add the packet of sugar and stir. Crumble the crackers and add to the contents of the pouch. Add more water if necessary and gently stir.

Ranger Mocha Latte
1 pouch of MRE cocoa
1 packet of instant coffee
1 packet of sugar
2-3 packets of cream
Hot Water

Directions: Stir ingredients together in hot water and enjoy.

Cheese Dogs
1/2 packet of cheese
1 packet of hot dogs

Warm hot dog bag. When able to safely handle, slice hot dogs lengthwise with a clean knife and pour in cheese. Accompany with crackers. Season with Tabasco.

Hint: Reserve rest of cheese and a cracker for a late night snack.

Peanut Butter and Jelly Sandwich
1 packet of peanut butter
1 packet of jelly/jam
1 packet of A rat bread (snag at breakfast and put in pack)

General MRE Guidelines
Adding cheese, crackers to any meal immediately enhances the flavor and texture.

Learn to barter. Know your buddy's weakness – find out who hates or loves cheese, coffee, tea, sugar, peanut butter, pound cake, crackers, and that yummy gum.

Detainee Medical After-Action Report

by CDR. James Ritchie, MD, MC, USN

Editor's Note: While this article is a little on the longer side long I believe a condensed version would not be as beneficial. This may be a new area for many of us being deployed. If time is of the essence then skip to the end to the special issues section to view some critical lessons learned. Otherwise I encourage you to read this very interesting and highly educational after action report in totality.

The 26 MEU Medical team, consisting of command element, MSSG, and augmentee personnel, was tasked on arrival with providing medical care for incoming detainees to be received at the Kandahar Airport Temporary Holding Facility (KATHF). Many lessons were learned, as no written guidance was available to us, and from the outset, the detainee medical tasking was to be accomplished with no additional personnel or material. This AAR is arranged as following: first, a basic sequence of events regarding the initiation of detainee medical service; second, a description of the team's parts, functions, and interactions; third, a compilation of various statistics regarding detainee illnesses and injuries; fourth, a consideration of selected issues likely to impact future similar operations. Medical issues not germane to detainee care are included in a separate AAR. However, for perspective, the reader should be aware that the 26 MEU Medical team was selected and fielded to provide combat casualty support. This remained the primary mission, and casualties were received, treated, and medevac'd throughout the deployment. Nonetheless, due to sheer volume of need, the great preponderance of medical effort was spent in detainee care.

SEQUENCE OF EVENTS

December 16-18: Three medical personnel, the MEU Surgeon, an Emergency Physician, and an Intensive Care Nurse, arrived at Kandahar. No medical facilities exist. The BLT physician, a GMO who had arrived two days prior, has established a Battalion Aid Station in an alcove in the terminal. First word is received that Kandahar will be receiving as many as 200 detainees, and orders are received to prepare a holding facility. Medical planning begins, with plans to obtain large amounts of medical information from each detainee, including lab samples. Plans were made to contact the Red Cross and CDC to ascertain their interest in medical data. However, these plans were halted by higher authority, due to more pressing needs, such as expeditious ingress, security, and interrogation requirements.

No information existed regarding any medical needs the detainees might have. Medical screening was the only service known to be needed. A data set for screening was agreed upon by the medical staff. Each detainee would be asked if he was ill, and whether he wanted to see a doctor. He would be assessed for general nutritional status and state of dental repair. His pulse would be counted. He would be examined visually, and any lesions, marks, scars, or other identifying information would be recorded. Based on the detainee's requests and any findings apparent on visual exam, further examination could be carried out at the discretion of the provider on the screening team. Should any detainee be found to be seriously ill, another team would be summoned to care for him while screening continued.

The Medical Team is seriously concerned about the ability of our small group to care for a large number of potentially medically needy detainees while continuing our primary mission of casualty support. The Team also was transported with a very limited medical equipment supply. Resupply was questionable. Issues of triage of medical equipment between detainees and U.S. casualties were debated. (See special issues, below.)

December 18. Received first 15 detainees. Approximately two hours before arrival, the screening team spoke with personnel who had visited the prisons from which the detainees were being shipped. These personnel told us of many seriously wounded and critically ill prisoners who might be sent to us. The screening team obtained a supply of dressing materials.

Two of the first 15 detainees were wounded. The first was very malnourished, and had sustained a gunshot wound to the upper right humerus approximately one month prior. The wound was infected, and the fracture had not healed. The second injury was a simple gunshot wound to the posterior thigh, which was granulating well and healing. Both detainees' wounds were dressed appropriately. The remainder of the detainees had no active wounds, though two had complaints or findings requiring further evaluation.

The wounds of the first detainee could not be definitively treated at KATHF. Orthopaedic operative intervention would be necessary. A debate ensued regarding the proper course of action in keeping with the Geneva convention. See the "Medevac Controversy" section below. Ultimately, we provided the best care available to us within KATHF, but did not medevac detainees until their trip to the holding facility at Guantanamo Bay, Cuba.

December 19. Recognizing that, should we receive injured detainees in the same proportion as our first shipment, a large daily medical effort would be necessary, we began to prepare. KATHF commanders were asked for dedicated medical space within the camp. Some suggested that we bring injured detainees out of the camp to casualty receiving area to treat. We rejected that suggestion due to difficulty of movement, potential interference with receiving U.S. casualties, and potentially providing the enemy with weapons, as the treatment tent was full of instruments, needles, scalpels, etc.

Concerned about the cold nights (lows in the upper 30's, Farenheit) and the poor nutritional status of the first detainee, warmer blankets and more meals were provided.

December 20. General Surgeon and Anesthesiologist arrive from Rhino. Daily, we are encountering difficulty in obtaining guard and translator support to conduct sick call. Priority is being given to interrogation, and we often have to wait hours to treat a few patients. The detainees begin asking to see physicians, and the guards begin passing their requests to us.

December 21. Single detainee arrives, healthy.

December 23. Single detainee is brought from Kandahar Hospital, where we learn that approximately nine Al Qaeda are barricaded in a seige. They are all hospitalized, significantly ill patients. This detainee has a head injury and a femur fracture, which has been treated with traction by way of Steinman pin. He was initially delirious, but after resuscitation, pain control, and building a new traction apparatus out of available materials, his thoughts become coherent. A separate room in a small adobe building in the detainee facility is commandeered to house this detainee, as he is litter-bound.

Again, requests are made for a dedicated medical treatment area within the compound. We calculate that if we receive all nine of the hospitalized patients, plus a similar percentage of ill patients scattered among the 200 detainees planned to be housed here, we can expect 40 daily medical contacts. Medical planner asks for more personnel and more equipment. We are husbanding supplies. Through our persistence in reliably requesting guard and translator support, the guards have begun arranging for our support.

December 26 and 27. Forty-five detainees arrive, eight with significant injuries. One had sustained a penetrating wound to the head, which had been treated by craniotomy, but the wound was infected. The medical team was concerned about a possible epidural abscess, and issues regarding medevac were revisited. We had no neurosurgeon. We were directed to provide the best care available within the facility, but were again told that no detainee would be medevac'd. Seabees began construction of "hardback" tents, one of which was designated as our treatment area. We request a second tent to shelter litter patients. Some detainees complain of lice, and the diagnosis is confirmed. We inform the camp commander, and recommend shaving and de-lousing the detainees.

The Army 250th Forward Surgical Team arrives. They are willing to help out with surgical cases with the detainees, but otherwise "have not been tasked" with detainee care.

December 29. Surgical "Grand Rounds," with the entire team evaluating

injured patients, debriding as possible, and selecting patients likely to benefit from surgical debridement or washout under anesthesia.

December 30. An operating table and anesthesia machine are moved into the KATHF, and plans are set to provide operative intervention the following day.

December 31. Four surgical cases are carried out in the KATHF medical tent. The suspected epidural abscess is explored and found to be a subcutaneous small infection. One hand and two leg explorations, debridements, and washouts are performed.

Heading Out of Town – What Needs to be Done

by CPT. Robert Blankenship, MD, MC, USA

Editor's Note: CPT Blankenship shared the following tips as he prepared in Feb 2003 to deploy with his unit for an unknown amount of time. While the success of these tips has yet to be personally measured, those with prior experience found them to be all reasonable and many essential. Given the short notice you may get prior to a deployment it is probably good to complete some of these tasks now as those final days before leaving can be quite stressful and all you want to do is spend them with family.

1. Get a hard-shelled case / footlocker to pack coffee pot, extra food, books, etc. ENSURE YOU CAN LOCK IT! I packed a coffee pot, soup cooker, tea pot to boil water, snacks, pasta, extra soup, razors, toothbrushes, books, music CDs, extra socks, t-shirts, etc.
2. Get a protective case for you laptop. I recommend ruggedcases.com
3. Consider palm books from Handheldmed.com
4. Will, Power of Attorney, Special Power of Attorney
5. Pay as many bills as you can via electronic bill pay. Less stamps, no thought needed, it is automatic.
6. Ensure you do not have a leased car that will need to be turned in while you are away.
7. Consider changing you insurance policy from what you have to storage only. I am doing that and will save about $300 / 6 months.
8. Ensure your bank card will not expire while you are gone.
9. Paperback books.
10. Ensure you give out your deployment address to your buddies who will send you stuff each month...like more paperback books.
11. Rosen, Tintinnali, and other medical texts come on CD-ROM and they are easier to carry than the real texts.
12. Some airlines are offering discounted tickets for your parents to visit before you deploy. Mine saved $400 last weekend by using that policy. I am unsure if everyone is offering it, but Delta was.
13. Increase your life insurance. USAA and USPA IRA life-insurance companies allow the clause of war - ENSURE YOURS DOES. If not, you will pay and then get nothing if something happens during war. I know not fun to talk about, but ensure you look into it fully.
14. Ensure your taxes are filled before you go. If not, when you deploy you are automatically granted an extension.
15. Save all your receipts for items you buy to deploy with. They are considered a job expense and are therefore tax deductible.
16. Security system. May wish to get your home monitored while away by friends, family, or a security company.
17. Ensure you plan for someone to keep up your house and yard while away.

December 31-January 02. Detainees pour in, up to 62 in one night. Total number is 225. Some groups of detainees arrive in good physical condition. Some arrive with multiple old battle wounds, having received little treatment. Some arrive with prior treatment, even Orthopaedic external fixeters, having been transported from prison hospitals.

Previously, the "Detainee medical team", consisting of four or five people, was able to provide all necessary care every day. During this influx, the team was overwhelmed, and during one short period, dressings were not being changed regularly. A multiple-team approach was adopted, including dressing change, medication administration, sick-call, and ingress teams, with a surgical team as needed. Obviously, more personnel were required, but prompt, effective care was returned.

Medics attached to the Military Police company are recruited to begin dispensing medications.

During sick-call, a 58-year-old detainee is found to be unable to rise due to illness. He is diagnosed with pneumonia and is kept in the medical tent overnight receiving IV antibiotics and fluids. The following day he is greatly improved, and is returned to his cell.

January 02. Fifteen operative cases are performed in the KATHF medical tent. An assembly-line approach proved very effective. IV anesthesia, primarily with ketamine, greatly facilitates efficient evaluation and treatment. Wounds are cleaned, debrided, washed out, and redressed. The patients are recovered for a short time, then returned to their cells. During recovery, the next case is begun.

The International Committee of the Red Cross inspects KATHF, and is very impressed with the level of care provided the detainees. One of the ICRC inspectors is an Anesthesiologist, and actually helps us with our surgical effort, finding charts and assisting with patient movement. He is ebullient.

One very debilitated patient, almost skeletal in appearance, does not regain consciousness after debridement of his foot and perineal injuries. He remains comatose hours after his procedure. Due to his general level of nutrition, a consolidated left lung, and unresponsiveness, the commanders are advised that he may expire. IV fluids, antibiotics, and enteral nutrition by NG tube are begun and carried on through the night. The following day, he awakens and participates in feeding himself.

A corpsman is assigned as "ward clerk," managing charts and assembling medication lists daily.

January 05. The Army Orthopaedist arrives. He examines multiple detainees with orthopaedic injuries, fractures, and non-unions. Unfortunately, since we have no radiology support, he advises that the patients would be better off waiting until they arrive in Guantanamo Bay for definitive care.

January 07. 300 detainees are present. The 555th Forward Surgical Team arrives, in response to the prior request for help with the detainee medical mission. They arrive without any medical supplies, and have been told by their superiors that their mission is to de-louse the detainees. They begin preparations to start de-lousing. They begin to integrate into the daily care of detainees, helping with sick call and surgical cases.

January 07-13. Preparations begin to send detainees to Guantanamo Bay, where a longer-term facility awaits. The medical team collates a list of injured or ill detainees, and prioritizes them for transfer. The KATHF staff attends the sickest detainees first. However, Guantanamo Bay contends that they are not ready to receive these casualties. We argue that we do not have radiology, lab, extended pharmacy, and the ability to treat the suspected malaria and leishmaniasis in some of the detainees. Most telling, the nights in Kandahar are often freezing, and many of our patients have frostbite or other cold injuries. Their injuries may worsen in Kandahar, and would not in Cuba. Even if no further medical action were to occur in Cuba for a few weeks, these detainees would be better off there due to the weather.

The medical effort for the detainees peaks. Dressings are changed every other day for the most part, on about 40 patients daily. Approximately 100 medications are dispensed three times a day. After initial arrival of injured detainees, they are assessed in the Operating Area and debrided or washed out as appropriate. One patient, the debilitated detainee who almost died, has daily dressing changes and packs under anesthesia in the tent.

January 13. 391 detainees are present, the highest number during our tenure. Thirty depart for Guantanamo Bay, Cuba. Those departing are healthy. The next several flights are to have healthy detainees.

January 16. 40 detainees are repatriated to Pakistan. Flights to Guantanamo continue. Also, detainees continue to arrive.

January 20. 15 litter patients depart for Cuba on the 6th flight. The 5th flight contained 30 "walking wounded." The number of dressings to be changed and medications to dispense drops dramatically. The debilitated detainee is not transported to Cuba. He is to be held in Kandahar, expecting repatriation to a hospital in Afghanistan.

> *"Despite life-threatening conditions and serious injuries present on arrival... all patients have improved, and no fatalities have occurred."*

January 22. Give passdown to three representatives of "Charlie Med," the 101st Airborne's medical company. They are introduced to all aspects of the detainee medical effort. As these four are the advance party, they do not plan to take over all care themselves, but do learn the processes and participate in the care.

The supplies ordered to help in detainee care arrive, one month after being requested.

Approximately half of Navy medical team departs Kandahar.

January 24. The remainder of the Navy medical team departs Kandahar. The Army 250th FST personnel join Charlie Med in daily detainee care and data collection. A total of 431 detainees were screened since the beginning. Despite life-threatening conditions and serious injuries present on arrival and profoundly spartan treatment conditions, all patients have improved, and no fatalities have occurred.

DETAINEE MEDICAL TEAM S

Several teams and individual jobs were defined in providing care to such a large number of detainees daily. The teams included: sick call, dressing change, medication administration, ingress screening, egress screening, and surgical. Individual jobs included data manager, ward clerk, and medical director. Descriptions of function and interaction follow:

1. Sick Call Team. Detainees presented a wide variety of medical complaints (see list below), upon initial screening and during their stay at KATHF. A sick call team addressed these complaints promptly. During ingress screening, when a medical concern was identified, the number of the detainee was recorded on a list. This list was placed in a designated area in the MTT (medical treatment tent), where the sick call team would find it next day. Also, when a detainee made a medical concern known to the guards, the guards would leave that sick-call request in the same place.

Typically, when making rounds through the camp, the sick-call team would receive solicitations for care from additional detainees. These were handled as time allowed, as at times virtually every detainee in a cell would have a request, usually regarding a chronic low-acuity condition. Some sick-call providers preferred to accompany the medication administration team during morning rounds, and take requests for care at that time. This method facilitated the addition of prescriptions to the medication administration list. Usually, the provider would ask for the two sickest detainees in the cell, rather than allow everyone to bring their concerns.

Often, the provider could perform sick-call without entering the cell. Many cases of simple diarrhea and constipation, myalgias, or similar complaints could be treated without a physical examination, knowing that followup was guaranteed. In no case did this policy result in an adverse outcome. Due to the prevalence of diarrhea and constipation and the sheer volume of sick call requests, standard prescription packs were prepared and prescribed as a unit. Ciprofloxacin and imodium were prescribed for simple diarrhea, and bisacodyl was prescribed for constipation.

Medical records were maintained on detainees with significant injuries or medical complaints. If a detainee was healthy, no medical record was generated, due to a very limited supply of record folders (80 were brought from the ship) and progress note forms. When a sick-call complaint history was entirely consistent with an uncomplicated case, a note was not generated, but a count was recorded on the medication sheets. The new notes and counts of uncomplicated complaints were reviewed daily by the data entry personnel, and diagnoses were entered into the database. In retrospect, a more complete record-keeping system would have helped significantly in following trends and tallying diagnoses.

When a physical exam was indicated, the cell was opened and either a guard accompanied the provider into the cell (with all other detainees moving to the other side of the cell), or the ill detainee was brought out of the cell for examination.

Few detainees spoke English. However, the MP's tried to place at least one English-speaking detainee in each cell. This English-speaker could be called to translate, in most cases. Periodically, this English-speaker would be unable to translate, as the detainees came from many different countries and spoke different languages. In this case, either a three-way translation was set up with other detainees or a military translator was provided. Very rarely, evaluations occurred without translation.

2. Dressing Team. Upon ingress screening, detainees requiring wound care were identified and placed on a list. Their dressings were changed during screening, as well. The list was delivered to a specified location in the MTT for the Dressing Team to find the next day. The team leaders would manage the list, adding and dropping detainees as their wounds healed. Typically, dressings were changed every other day, with a few exceptions.

All wounds were initially evaluated next day by the surgeons. The management of most wounds was handed over to the Dressing Team. Wounds needing debridement or washout were treated initially in the MTT OR, and followed by the Surgical Team as appropriate, with the Dressing Team's daily involvement.

The MP's were asked to concentrate detainees needing wound care in as few cells as possible. At one time, two cells were full with detainees needing dressing changes. This greatly facilitated the efficiency of the Dressing Teams.

(Detainee Medical Report Continued on page 14)

Coming Soon to Military Emergency Medicine: Basic and Advanced Disaster Life Support Courses

LTC Bruce D. Adams, MD, MC, USA & Richard B. Schwartz, MD

Introduction:
Inspired by the events of 11 September 2001, a consortium of academic and governmental agencies has produced two important new programs: Basic Disaster Life Support (BDLS™) and Advanced Disaster Life Support (ADLS™). Several of these courses have already been presented at national disaster, EMS and emergency medicine conferences. This article outlines the purpose and scope of the courses, and their potential application to military emergency medicine.

Background on ADLS™:
Over the past three decades, nationally recognized and validated training programs for Advanced Cardiac Life Support (ACLS) and Advanced Trauma Life Support (ATLS) have become a standard part of civilian and U.S. military medical training curricula and continuing medical education (CME). During the 1990's, understanding the evolving need for similar advanced training in the recognition and management of "all-hazards" threats (nuclear, biological, chemical, explosive and natural disasters), several academic institutions developed analogous Advanced Disaster Life Support (ADLS)™ courses. These courses target resident-physicians, critical care/emergency nurses, paramedics, primary care providers, and medical students. Like ACLS and ATLS, these courses are designed with both didactic and skills lab format in a schedule that can be accomplished in a weekend.

After the events of the fall of 2001, the demand for a nationally recognized course in all-hazards training increased. A consortium of academic and governmental institutions agreed to assimilate their pre-existing ADLS™ educational programs under a federal appropriation managed by the Centers for Disease Control and Prevention (CDC). To meet this established need, the National Disaster Life Support Educational Consortium was formed. The advisory board consists of international and domestic leaders in disaster management.

Overall Course Concept:
Like its ACLS and ATLS counterparts, the BDLS™ course is primarily didactic in nature and may be presented in lecture form or through distance learning and computer simulation. ADLS™ makes use of interactive scenarios and drills in which the participants treat simulated patients in a disaster. Through the use of high fidelity mannequins the student can gain experience in treating conditions that they would normally not treat even with years of experience. Hands on labs to practice skills such as decontamination will provide education in areas traditionally lacking in healthcare provider education. The training scenarios will reinforce information presented in BDLS™.

BDLS™
BDLS™ (Basic Disaster Life Support) is the didactic component of the training. The BDLS™ curriculum is developed with an all-hazards approach (recognition and management) to disaster response. Individual chapters remain cohesive by the incorporation of a unifying algorithm called the "D-I-S-A-S-T-E-R paradigm*". Also, the concepts of "MASS Triage**" and Disaster Casualty Zones will also be reinforced continually throughout the chapters. Unlike ACLS and ATLS, participants can receive certification for completion of this didactic portion of the course. Those completing the BDLS™ didactic course can then participate in ADLS™.

This BDLS™ (didactic) part of the course can be delivered in two separate formats. The first format follows the typical ACLS/ATLS model utilizing in-person didactic and interactive lectures with standardized slide sets and an accompanying text. The information can be delivered over two days or over multiple days. The material will also be presented in a distance-learning model via the Internet. Computer generated simulation will be utilized to enforce concepts learned in each chapter.

ADLS™
The ADLS™ training program is focused at the "certified" BDLS™ provider. The ADLS™ training will consist of an intensive single day course. This training is focused on the development of "hands on" skills and allows the provider to apply the knowledge learned in BDLS™ using simulated disasters. The ADLS™ core curriculum includes: Casualty Decontamination and Protective Equipment, Essential Disaster Skills Lab, Clinical Scenarios utilizing high fidelity simulation, and a Table Top Disaster Exercise.

*The Disaster Paradigm™ is a mnemonic that organizes the providers' response and planning of a disaster:
D - Detect
I - Incident Command
S - Scene Security and Safety
A - Assess Hazards
S - Support
T - Triage/Treatment
R - Recovery

** M-Move; A-Assess; S-Sort; S-Send: MASS™ Triage is a disaster triage system that utilizes US military triage categories with a system to triage large numbers of casualties quickly in a mass casualty incident.

Target Audience: The target audience for BDLS and ADLS includes: emergency and critical care physicians and nurses, EMT's, paramedics, pharmacists, allied health professionals and medical students.

Conclusions:
How might BDLS/ADLS impact military emergency medicine in the future? With the formation of the DOD Northern Command with the mission of Homeland Security there exists the potential for increased military presence in civilian disasters. This presence represents new challenges in the coordination between military and civilian systems. As the threat of the use of WMD on civilian populations increases there are data that suggests a significant lack of hospital preparedness to meet this threat. A recent survey (Treat, 2001) suggests that 100% hospitals surveyed were inadequately prepared for a biologic incident and 73% were inadequately prepared for a chemical or nuclear incident. It is also evident that adequate training is lacking in our current educational process for the target groups faced with a WMD incident (Waeckerle, et al, 2001). These data suggest that there is a critical need for these kinds of training programs focused at the responders to mass casualty disasters. Additionally, training focused for hospital and municipality administrators is required to develop a uniform approach to mass casualty management. Military physicians regularly prepare for mass casualty scenarios, and possess advanced knowledge of nuclear, biological and chemical disaster management. .The BDLS/ADLS courses effectively bring together the management strategies of all disaster medicine into a consolidated training platform. Just as ATLS provides a "common language" for trauma professionals to communicate treatment plans, BDLS/ADLS will improve communication between military medical personnel and other governmental relief agencies. The implementation of BDLS/ADLS within the military is still in development. However, the US Army's newly conceived Special Medical Augmentation Response Teams (SMART) are one potential mechanism of applying ADLS to the military. One of the primary SMART missions is to provide expertise in disaster response and augmenting existing clinical resources. The BDLS/ADLS program may streamline this process in the near future.

(Detainee Medical Report Continued from page 12)

When a detainee needing dressing change was placed in another cell, the Dressing Team would ask the MP's for his location, then a special trip was necessary, requiring the other detainees to move to the other side of the cell, bringing the injured detainee out for the team to address the wound. When multiple detainees were scattered in this way, efficiency was greatly reduced.

Because of very limited supply and great demand, dressing supplies were carefully husbanded. The wounds were appropriately dressed, but only the minimum adequate supplies were used. For instance, one roll of Kerlix could typically be divided among three wounds.

3. Medication Administration Team. All teams with providers (Ingress Screening, Sick Call, and Surgical) could prescribe medications. When a note was generated with a medication order, it was given to the Ward Clerk, who would then amend the medication list. Also, when the Sick Call provider accompanied the Medication Administration Team, he could amend the list on the spot for uncomplicated conditions.

The Medication Administration Team dispensed medications three times daily, receiving the list from the Ward Clerk. Initially organized by nurses on our Navy team, this team responsibility was turned over to Army MP medics, who performed admirably.

Whenever possible, prescriptions were written for a defined period, to decrease workload on the team.

4. Ingress Screening Team. Detainees were brought to Kandahar from other prisons via aircraft. Upon arrival, they underwent extensive processing, including a strip search, medical screening, brief interrogation and identification gathering, etc. Afterwards, they were provided with new clothing and blankets, and were moved to their cells. Medical screening consisted of ascertaining the need for medical care, recording identifying marks, scars, and lesions, and recording nutritional status and repair of dentition. The team consisted of one provider and one or two corpsmen or techs.

Screening information was recorded on standardized data sheets. For a brief period, directly inputting the information into a laptop computer was attempted. However, due to lack of backup and a loss of files in another part of the operation, the written data sheets were re-instituted. After screening was complete for the night, the data sheets were taken to the data manager for entry into the database. During the first few screening sessions, three reports were generated. Medical record sheets were kept, a tallied list was provided to the MP's, and a narrative report was generated for the intelligence community. This duplication of effort was streamlined into the single database, distributed to whomever needed the information. Medical record sheets were not begun for healthy detainees. Ill and injured detainees were seen the following day, and records were generated at that time.

When detainees presented with wounds, any dressings were completely taken down, for evaluation of the wound as well as to ensure no weapons were present in the dressing. After assessment, the wound was re-dressed appropriately, but debridement or other intervention was not begun at that time. A list of wounded or ill detainees was maintained during screening, and the list was later placed in the MTT for the surgical, wound care, and sick call teams to see the following day and add to their lists.

Rarely, a detainee would be found to be seriously ill upon presentation. At that time, the screening team would either call another team to treat the detainee, or would treat him themselves after completing screening.

Of note, this team worked almost exclusively at night, on little or no notice, for hours at a time. As often as not, advance information on numbers or medical condition of inbound detainees, or even whether any would be coming that night, was very inaccurate. Occasionally, detainees would be brought in by patrols with no warning at all. As many as 62 detainees were delivered in one night, requiring many hours of work. Consequently, the Ingress Screening Team typically was not scheduled for duties during the day.

5. Egress Screening Team. When detainees were transported from KATHF to Guantanamo Bay, a similar screening process was conducted. Additionally, the detainees were de-loused. Members of the Army's 555th FST sprayed new clothing with permethrin several days in advance, and shaved hair and beards during egress. Detainees to be transported would be identified on the prior day, and their medical records would be collected by the ward clerk and brought to the egress area. During egress, after strip search, a screening exam was again conducted and recorded, and the patient's medical records were added to the other documentation accompanying them. If the detainee had been healthy and no record existed, the screening provider wrote a summary note instead.

6. Surgical Team. Many detainee wounds required surgical evaluation, debridement, exploration, and washout. Most of the wounds had been sustained from two to four weeks prior to arrival in Kandahar, and many were infected or had necrotic material present. A few had come from prison hospitals, and had been treated with external fixeters, some of which were infected as well. Many fractures had not healed. Two patients arrived with surgically debrided below-knee amputations that had not been closed.

On the day after arrival, the surgical team would review information from the screening team. Patients with wounds would be brought into the MTT OR for dressing change and evaluation. If the wound warranted surgical intervention, this would be performed on the spot. The Anesthesiologist or Anesthetist would provide intravenous anesthetic, usually with ketamine, and the Surgeons and OR Techs would perform necessary procedures. Dressings were re-applied while the patient was still anesthetized. Anesthesia recovery occurred inside the MTT, under the care of an Intensive Care Nurse. A highly organized Circulating Nurse proved indispensable, in having the next detainee ready, with chart present, and moving the patients and records through accurately and expeditiously. Records were completed by the Surgical Team and given to the Ward Clerk for filing.

The Surgical Team followed their post-operative patients, all of whom were housed in the medical ward tent. They re-assessed these patients regularly with the Dressing Team during their rounds. Three patients had non-union of both-bones fractures of the forearm or lower leg with significant tissue defects, and the Surgical Team recommended amputation. All of these patients refused amputation.

An Orthopaedic Surgeon was available for consultation from the Army's 250th FST. Due to absence of radiologic support, he felt that surgical intervention for the variety of fractures and non-unions should wait until the patients were transferred to Cuba. The only exception was one patient with a tibia fracture, which the Orthopaedist externally fixed.

7. Data Manager. An individual received data sheets from the Ingress Screening Team, and entered the information into a database. The database contained: detainee number; pulse; dentition repair; level of nutrition; medical requests or injuries; marks, scars, or lesions; need for followup. Daily sick-call complaints were recorded on a separate database, but in the future, this information would be best managed by the data manager. The database was provided to the KATHF staff and Military Intelligence officers to include in their information. The database was used to provide current information to a variety of commanders, and served in prioritizing detainees for transport to Guantanamo. Computers were in short supply during our tenure, and officers of the Air Force AirEvac Liaison Team volunteered to manage the database on one of their computers.

8. Ward Clerk. An individual was given the job of managing the charts and documentation of detainee medical care, as well as preparing the daily medication dispensing sheets. He organized the charts, pulled them for surgeries or when the detainees were scheduled for departure, and filed new notes. When notes were generated during sick call or surgery, he would review them, note new prescriptions, and transcribe them onto the medication sheets. He also was responsible for maintaining an adequate supply of consumables and pharmaceuticals in the MTT. As detainee medical care did not have a separate supply chain, he obtained these materials from the combat support supplies.

9. Medical Director. An individual senior officer coordinated medical efforts and relationships with interested parties. He negotiated appropriate workspace and ward space. He served as liaison with MP's to reliably obtain guard support and establish reasonable practices by guards when accompanying medical teams. He also served as liaison with interpreters. The Medical Director represented the medical needs of detainees to policymakers, and recommended actions such as medevac to the MEU Surgeon. He was responsible for prioritizing detainees for medevac and working with airevac planners as the schedule and priorities changed daily. He maintained a "low tech" paper database of medical conditions upon ingress and from sick call according to detainee number, which backed up the computer database and served as a more accurate, if more cumbersome, record of medical conditions. The data below are from this database.

STATISTICS

These statistics apply for the period of 18 December 2001until 20 January 2002

Number of incoming detainees screened: 431
Number of wartime penetrating, blunt, or environmental injuries: 116
Patients with medical complaints on ingress screening: 184
Patients with traumatic findings on ingress screening: 75
Approximate number of dressing changes: 1,500
Approximate number of medications dispensed: 3,000
Total number of "detainee days" (each detainee's duration of stay was calculated, and these were summed): 6,638
Litter patients: 15

The following table reports numbers of traumatic or environmental injuries found during detainee ingress screening. "Penetrating" injury is one caused by a missile or knife, penetrating the skin. Gunshot wounds and fragmentation injuries are included. "Blunt" injuries are sustained by falls, automobile accidents, or other non-penetrating causes.

Traumatic Injuries on Ingress Screening

Anatomic Location	Penetrating	**Penetrating (% of total)**	Blunt	**Blunt (% of total)**	Total
Lower Extremity	**42**	**42.4**	**4**	**4**	**46**
Upper Extremity	**20**	**20.2**	**5**	**5.1**	**25**
Back/Flank/Buttock	9	9.1	0	0	9
Chest	8	8.1	0	0	8
Head	1	1	5	5.1	6
Abdomen	3	3	0	0	3
Eye	2	2	0	0	2
Total	85	85.6	14	14.2	99

Fractures (penetrating)	17
Fractures (blunt)	7
Amputations	4
Neurologic injury	4
Wound infections	18
Prior operative ortho intervention	6
Fracture non-union (not including fractures with hardware)	5
Cold injuries	16

Regarding the table, gun shot Wound's (GSW's) with entry and exit wounds were counted as one wound. If the GSW traversed two anatomic regions, the entry wound was listed. If the bullet reentered, a second wound was counted. Both bone fractures of the forearm or of the lower leg were counted as a single fracture. Multiple fragment wounds to one region were counted as one wound. Isolated pain or sprains were not counted. Significant abrasions and lacerations were counted. Incidental abrasions were not counted. Amputations were not counted as fractures.

The following table reports numbers of non-traumatic, non-environmental conditions found during detainee ingress screening.

Nontraumatic Conditions on Ingress Screening

Complaint	Total
Somatic Pains/ "Rheumatism"	34
Abdominal Pain/PUD/Dyspepsia	16
Diarrhea	13
EENT Complaints (Headache, Nose Bleed, etc)	11
Chest Pain	4
Fever	4
Episodic fever consistent with malaria	4
Kidney Pain	4
Constipation	3
Skin Lesions consistent with leishmaniasis	3
Mental instability, psychiatric disturbance	2
Weakness/fainting	2
Diabetes	2
Hemorrhoids	2
Dental pain	1
Fleas	1
Hypertension	1
Dysuria	1

Detainees complained of a large number of medical conditions during their stay at Kandahar. Every complaint was addressed by the Sick Call team. Evaluations of medical conditions requiring followup or further evaluation, or those of interest, were recorded in the patient record. Conditions that were found to be routine, with no likelihood of further intervention, were usually not recorded, especially if no intervention was begun at all. This was done due to the sheer volume of complaints and paucity of supplies and personnel. Unfortunately, this practice precluded an accurate count of sick-call complaints, especially very common ones such as somatic aches and diarrhea. However, all significant conditions were recorded.

Of conditions recorded, the largest category was somatic pain, accounting for 31%. Some complained of generalized aches, especially when cold. Others had localized pain in joints, muscles, chest, or abdomen. These patients were evaluated carefully, especially when complaining of abdominal or chest pain. Every detainee with chest pain was found to have history and physical findings entirely consistent with chest wall pain. However, neither radiography nor electrocardiography were available at Kandahar. No adverse outcomes were noted. One detainee with abdominal pain was felt to have possible biliary disease. Our general surgeon evaluated and followed this patient. The pain resolved slowly over the course of several days with symptomatic treatment.

The second most common symptom recorded was diarrhea, accounting for 15%

of complaints. Very widespread among inbound detainees, this condition was promptly treated with three days of ciprofloxacin and imodium as needed. The prevalence of diarrhea gradually decreased, and by January 19, no further cases were brought to our attention. Approximately 8% of recorded complaints were of constipation. This was treated with bisacodyl with near-universal success.

One detainee was found to be too ill to rise during morning rounds. He had arrived two days prior and had no complaints at that time. On evaluation he was weak and breathing rapidly, with a pulse of 140. This detainee was diagnosed with pneumonia and was treated with IV antibiotics and hydration in the medical treatment tent overnight. He was dramatically improved the following day, and was returned to his cell. He continued to improve on followup.

SPECIAL ISSUES

1. Medevac. Several detainees had medical conditions exceeding our ability to definitively treat. For instance, several had fracture non-unions requiring operative Orthopaedic intervention. We had no radiology support, and our operating area was located in an open-air tent. Medically, these detainees rated evacuation to another facility able to perform the indicated procedures. Medevac was not time-critical, as the injuries had occurred about a month prior to arrival, on average. The wounds were treated with immobilization and standard wound care, and the soft tissues continued to heal. One patient was critically ill upon arrival, and we expected him to expire. In every instance, upon recommending evacuation to treat, we were directed to provide the best care using available assets, but were denied permission to medevac. Rationale was based on the dangerous behavior of prior similar prisoners in other facilities, stabbing guards and physicians, and detonating hidden explosives. As no secure transport or medical facility was available, the detainees were kept at KATHF until such transport and facilities became available.

> *"Predictions of how many detainees we would receive in any given night were notoriously unreliable."*

2. Ethics of treating detainees. Upon being notified of the detainee medical mission, some members (a minority) of the medical team expressed a reluctance, or even resistance, towards "using our gear to treat those people instead of our guys." Some did not wish to treat enemy personnel at all. Others were very concerned about expending our very limited supply of dressings and medications, leaving us with little or nothing for U.S. or coalition casualties. Some also were willing to use the designation of "detainee" as an excuse to ignore Geneva Convention requirements for medical care.

   The final decision: the detainees would be treated appropriately using available medications and supplies in a frugal fashion. For instance, no extra gauze would be used for padding. Non-soiled elastic wraps would be reused on the same patient. Medications would be prescribed for limited duration when appropriate. Resupply was requested right away, anticipating rapid supply use. Personnel were informed of Geneva Convention requirements, and were instructed in the ethics and pragmatic benefits of treating enemy personnel with compassion. We're the good guys, after all.

3. Detainee "Doctors". Three detainees identified themselves as "doctors." These individuals were questioned regarding their training and experience, and were questioned regarding their approaches to certain conditions common to the detainees. One individual was evasive about his formal training, and when asked how he would treat an infected gunshot wound, responded that he would use accupuncture. If that wasn't successful, "In Shallah." The second "candidate" did not wish to participate in medical care. The third had some months of formal training and verbalized a competent functional knowledge in basic outpatient care.

   The Geneva Convention was reviewed. This document stated that prisoners who were medical personnel could be required by the detaining authority to treat other prisoners. The Convention did not require the detaining authority to allow these personnel to treat other prisoners. Neither the KATHF commanders nor we wished to allow the detainee to walk the camp going from cell to cell. As he could then only be allowed to treat personnel in one cell and not others, we determined that the potential benefit would be insignificant and could even cause disquiet in the other cells. Therefore, we did not allow detainees to act as medical personnel.

4. Use of assets. As mentioned above, medical supplies were very limited. Though we were frugal with supplies, they were consumed at a rapid rate. Some medications and bandaging materials were completely expended in approximately three weeks. Though we requested expeditious resupply, these supplies arrived almost exactly one month after request, after most of the medical effort was completed. The Army's 250th FST provided supply for U.S. and coalition combat casualties, when necessary.

   To supply a similar effort in the future, we recommend a surgical and anesthesia block, and a BAS block. Our detainees came from other facilities, and no fresh traumatic wounds were encountered. Consequently, the trauma-receiving emphasis present in STP blocks would be unnecessary to supply a detainee medical system.

5. Predictions of detainee number and injury. Predictions of how many detainees we would receive in any given night were notoriously unreliable. On some nights, anticipated flights wouldn't show up at all. On other occasions, large numbers of detainees would arrive without warning. Similarly, number and type of injury anticipated in an incoming group usually had little accuracy. Therefore, our detainee ingress screening teams stood watch regardless of anticipated ingress, and would proceed to the ingress tent only when the detainees had physically landed at the field. Also, they always brought bandages and similar supplies.

6. Body Cavity Search. During ingress screening, every detainee was strip-searched. As part of this search, a body-cavity search (rectal) was carried out. Initially, the security personnel understood that this was not a medical examination; it was a security exam. We were not looking for prostate cancer; we were looking for grenades. Security personnel were briefed on appropriate methods of examining the rectum by the medical provider, and performed the exam under observation of the provider and security officers.

   When the Army took over security screening, their personnel refused to perform the rectal search, and our medical personnel were required to perform this search. Finally, after many discussions about this issue, a compromise was reached; the medical personnel would perform the search on ingress, and the Army security personnel would conduct the exam on egress. Soon afterwards, the exam was no longer required on egress.

   This exam is entirely appropriate in screening potentially hostile detainees who have been known to conceal weapons. However, for perspective, none of the 431 detainees had any objects in their rectums, and the reaction displayed by most of them during the exam suggests that the rectum is not likely to be used by them for smuggling weapons. Further debate and decision is requested on this issue.

7. Security Concerns. Opinion varied among both medical and security

personnel regarding safe conduct of medical personnel during care of detainees. Some were willing to have medical personnel moving freely among a large number of detainees with minimal guard. Others preferred to have every detainee removed from the cell by two guards and brought to a secure location for medical evaluation and care. Ultimately, a compromise was reached. When caring for detainees in the Ward Tent, who required regular dressing changes and many of whom were not able to walk, medical personnel were allowed to move freely among the detainees, with two guards standing by. However, when caring for ambulatory detainees from another cell, all other detainees were sent to the far end of the cell and the one to be treated walked to the gate and knelt. At that time, either the provider entered the cell, or the detainee was brought outside for evaluation or treatment. When another detainee was used to translate, he was allowed to stand close enough in the cell to allow communication.

With this method of insuring secure care, no detainee attempted to harm any medical personnel. We cannot know whether they would have done so if given the opportunity, but one prisoner at another facility is known to have attacked and killed a physician caring for him. Further, a variety of sharpened sticks or pieces of metal were occasionally found among the detainees at Kandahar.

Respectfully submitted,

CDR James V. Ritchie MC

With input from LCDR Michael Harrison, MC, CDR Robert Hinks, MC, LCDR Gus Carreno, MC, LT Timothy Wilks, MC, LT Paul Villaire, NC, LT Michael Pike, NC, LT Alan Heffner, MC, LT Bradley Buchanan, NC, LTJG Michael Terp, MSC , and LTJG Michael Oviatt, NC.

Legal & Financial Planning

By LtCol. Linda Lawrence, MD, USAF, MC

One of the most stressful aspects about preparing to deploy can be making all the necessary financial and legal arrangements necessary. The best time to prepare is NOW. Yes I say that for those of you who don't even have orders in hand. Deployment is a fact of life for the military and none of us ever know for sure when we may be called to serve. I can also tell you those final days you will not want to spend making these arrangements.

I have gathered the following information from personal experience, USAA website and Military.com website. For those of you who are new to the military and not familiar with USAA insurance and financial services company I encourage you to check it out. Only military members and their families are eligible. Because the company deals only with military members they are deeply familiar with the unique aspects of military life and tailor programs to support military members. In addition I have to personally say I have been impressed over the years with their customer service. I say this not as an add for USAA but just my two cents for what it is worth – yes some who know me may say two cents is over priced. Check them out at www.usaa.com .

Another resource you may want to become familiar with is the Military.com a website with wide variety of military information to include military benefits and recent news. I registered at work and get weekly emails with headlines. Amazing what deals you may find in the civilian sector that you didn't know you were eligible for while in uniform. In addition there are updates on issues and news that don't seem to trickle down the information chain that well. You can register for free at www.military.com .

Now for the nuts and bolts of what you need to do pre-deployment to get your affairs in order. At the end I have attached the USAA pre-deployment and deployment checklist from their website.

Make a Will: The military has already required you to name beneficiaries in the event of your incapacity or death in the line of duty. However, this is not meant to replace a legal will which is much more detailed and inclusive. Some units require those who are eligible to be deployed to create a will just in case. Makes good sense as this can take a little time and at least two trips to the legal office. Plus discussing such issues with your spouse on the eve of the deployment can be quite a downer. If you have children hopefully you and your spouse have already created a will.

Power of Attorney: Unlike a will you often will not have an open standing power of attorney for all your financial and legal affairs. Whether you will need one while gone depends on how you have your finances established and what may occur during your absence – such as selling a home or car. A power of attorney document can be very specific or more general but basically gives an agent authority to act on your behalf in your absence, depending upon the scope and terms of the document.

This agent or "attorney-in-fact" can be your spouse, a relative or a trusted friend. Best to do this under the guidance of your local military legal office who can draw up the forms for you and provide you with legal advice to suit your situation. USAA provides a limited power of attorney restricted for USAA business and transactions only that can be downloaded from website and completed under notary signature.

Taxes: While the word taxes makes many of us want to run screaming and can lead to staffing shortages on April 15 when it comes to deploying there is a lot of good news. While you still have to eventually pay taxes you will be pleased to learn there are a lot of exclusions you qualify for while deployed. You also can be eligible for an extension if your deployment is over the mandatory Apr 15 deadline. Definitely take the time to speak to the representative at your base legal office who can outline all your benefits and responsibilities. Also if you didn't read your LES monthly before most definitely start reading them once you are deployed and be sure you are getting everything you are entitled.

Here are a few of the exclusions from your taxable income while serving in a combat zone. These apply for each month you are in the combat zone even if only for one day that month. Took me awhile when I was deployed to figure out why so many VIPs visited our base at the end of the month and it can make that week delay returning all the more palatable if you have to flip the calendar to the next page to find your departure date.

- Active-duty pay
- Imminent-danger or hostile-fire pay
- Your re-enlistment bonus (if it occurs in a month you serve in a combat zone). A part of medical pay bonuses may be eligible and amount depends on your rank – see below.
- Awards for suggestions you made when you served in a combat zone.
- You can also exclude military pay earned while you are hospitalized as a result of wounds, disease, or injury incurred in the combat zone. The exclusion of your military pay while you are hospitalized does not apply to any month that begins more than 2 years after the end of combat activities in that combat zone. Your hospitalization does not have to be in the combat zone.

As commissioned officer, you may exclude your pay according to the above rules. However, the amount of your exclusion is limited to the highest rate of enlisted pay (plus imminent danger/hostile fire pay you received) for each month during any part of which you served in a combat zone or were hospitalized as a result of your service there. Currently the highest is $4757.40 for an E9 with 26+ years and $5703.30 for warrant officer. I am not clear which

they use to calculate. More information can be found at www.military.com .

Paying Bills: At this point in our careers most if not all of us have established bank accounts, credit cards and significant loans and bills. While you probably won't need to run out and open a credit card account for personal expenditures you will need to worry how to pay your bills. You may want to consider paying your bills online. There are services that allow you to do this for automatic payment.

Banking: If you don't regularly use an ATM card be sure you know how to when deployed. Not a time to forget the pin # or how to access. The fees for a cash advance off your government credit card or ATM card can be filed on your travel voucher. Check your account to see if you can perform electronic fund transfers. It is more and more common to have computer access while deployed. Also may want to consider obtaining a debit card. It is like a plastic check and one less bill to pay. Also USAA gives members cash back on qualified purchases.

USAA credit card lists some special advantages when deployed.

- When you're deployed on a military campaign, USAA will rebate all the interest on your card for the entire length of your involvement.
- On all other deployments, even training exercises or sea duty, we'll lower the annual percentage rate (APR) on your card to 6% for up to nine months.

If you are going to an established base you may find banking services available. You will need a personal check to open an account. This can be very beneficial as ATM machines aren't as reliable away even on military bases as in the US. Always save your ATM receipts and be sure to count your money when you do get it from a machine. And don't wait until you are down to your last five dollars – for sure that will be the week the machines don't work.

Life Insurance: Many insurance benefits are available while deployed or opportunities to reduce expenses. To begin with you want to ensure you have adequate life insurance coverage before you depart and benefits are eligible if event occurs as a result of war.

The military provides life insurance, up to the limits of your Servicemembers' Group Life Insurance (SGLI) policy, usually $250,000 for you, $100,000 for your spouse and $10,000 for each child. In addition, your family is eligible for a monthly benefit paid to your spouse and minor children by the Veteran's Administration if you die while on active duty. This benefit is called Dependency and Indemnity Compensation (DIC). (Taken from USAA website)

Does this amount seem adequate for your family if you fail to return? It might be a good time to sit down with a representative and learn more about what is considered appropriate coverage. USAA has contracts that do not have war exclusions in their base contracts. The number for more information is USAA Life at 1-800-531-8685. Check your contract if you use another carrier.

Property Insurance: Whether you live in government quarters, rent or own a home, you may need to make changes to your property insurance coverage before you leave on deployment. This is especially important if you are single or your spouse spends time away from home, leaving your possessions vulnerable to theft. If you are single and concerned about leaving your home unattended consider having one of the techs or nurses you trust live in your home while you are gone. This can also be a way to take care of your pet while gone. If you do this be sure you have appropriate property and casualty insurance coverage in case someone has an accident in your home and is injured.

Might also be the time to get that home security system you have debated about purchasing. Homes that are protected by professionally monitored security systems are three times less likely to be the target of a burglary per USAA. In addition installing a monitored home security system can also make you eligible for a credit of up to 15% on your property insurance.

Auto Insurance: If you're putting your car in storage during your deployment, or lending it to a friend or relative, be sure to contact your carrier to see what coverages apply. Since some storage facilities carry their own insurance, you may need less coverage. If the storage facility does not carry insurance you may want to continue your own coverage to protect your vehicle. Also, in some states you may reduce or delete your liability and collision coverage if the vehicle will not be driven for an extended period of time.

Another auto benefit I found while deployed was access for my spouse to have free oil change at the base auto garage. Be sure you attend the family services outbrief before you depart to find out what benefits like these and others your family may be eligible for regardless of whether you reside in base housing or off base.

Medical Benefits: While yours will be taken care of while you are deployed be sure your family is properly enrolled in DEERS and TRICARE before you depart. If you haven't accessed the system recently probably best to check status prior to departure. I know in my region we have had many problems the past several months and several who thought they were enrolled found themselves no longer enrolled or not where they planned. Also if your family plans to move away to be closer to other family members while you are gone be sure you switch them to the new region.

On a medically related note go ahead and learn about medical retirement for imminent death if you aren't already aware of how it works. As emergency physicians we should all know about this but I learned about it while deployed. If an active duty member appears they are going to die you can through the local chain of command get them medically retired so there family receives better benefits. There are exclusions and rules and don't assume those around you will know all the details.

While the above is by no way an all-inclusive guide hopefully it provides some things to think about. Attached are checklists from USAA, which you can use to help you with some other details. GSACEP is developing an operational medicine web page and this and other information will be placed on that web page. If you have other information that would be beneficial to be included or pearls of wisdom please share them by contacting the chapter at webmaster@gsacep.org .

Pre-Deployment Checklist

Copied from USAA website at www.usaa.com

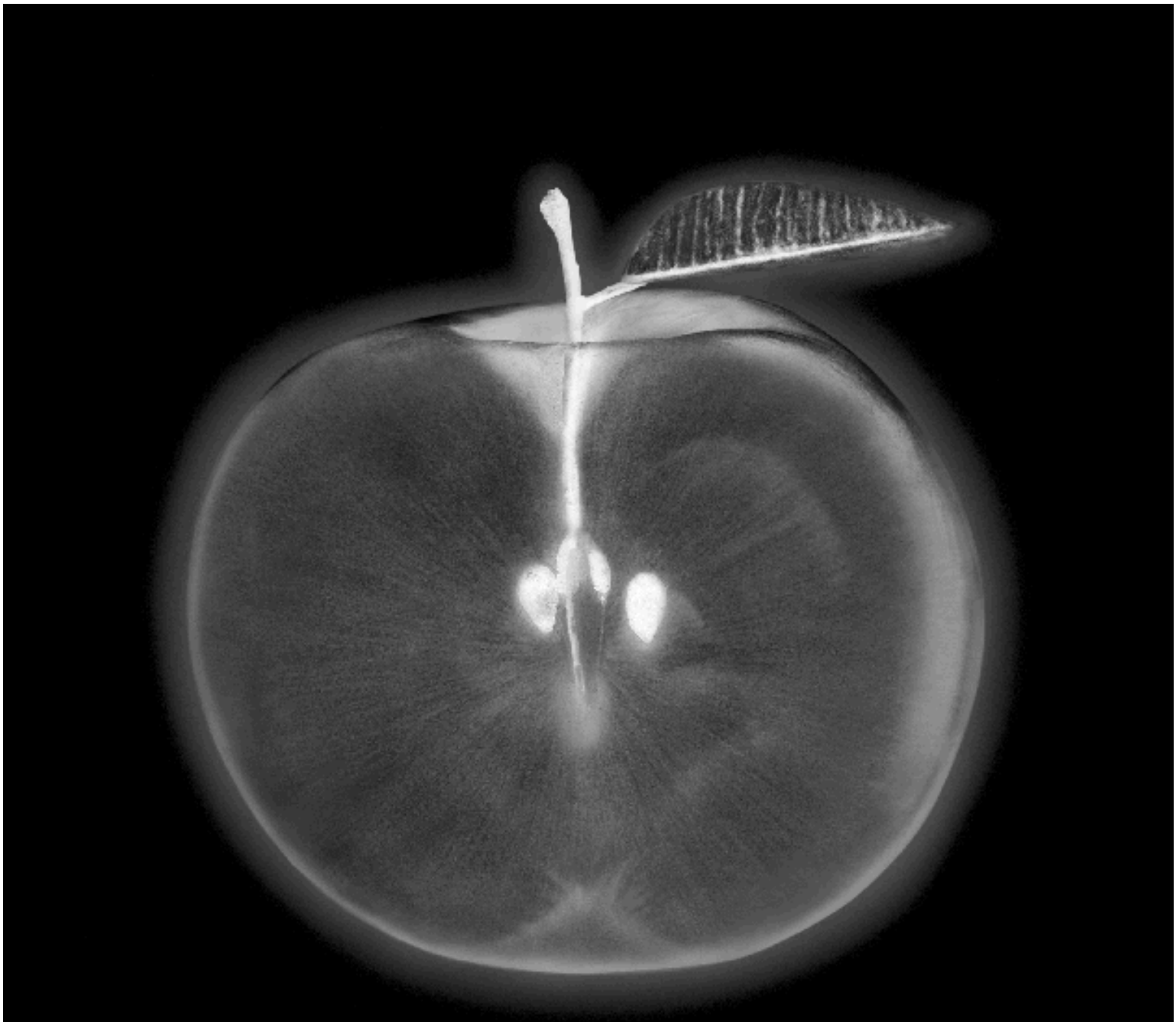
___ Set up a folder to hold receipts and financial documents in your absence.
___ Consider developing a financial plan to make sure your legal, financial and insurance needs are in order.

Legal

___ Consider giving your spouse, relative or trusted friend a legal power of attorney to handle affairs in your absence.
___ See your legal office about making a will.
___ Consider a living will for you and your spouse and make sure your spouse, relative or friend is aware of its contents and location.
___ Place valuable documents that you don't use regularly in a safe-deposit box.

Financial

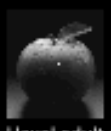
___ Review your financial arrangements and, if necessary, make sure all financial accounts are shared with your spouse.
___ Record financial account numbers and be prepared to bring that record with you when you deploy.
___ Review your financial needs now and ensure that any loans that may be needed are pre-arranged.
___ Review investment options and consider tax-exempt income from deployment.



See pneumonia. Think ROCEPHIN.

Adverse clinical effects in adults occur at levels similar to those of other cephalosporins: diarrhea (2.7%), rash (1.7%) and local reactions (≤1%). ROCEPHIN is contraindicated in patients with a known allergy to cephalosporins and should be used cautiously in penicillin-sensitive patients.

Please see adjacent page for summary of complete product information, which includes a list of indications, susceptible organisms and adverse reactions.



Once-a-day

Rocephin® IV·IM
ceftriaxone sodium

Usual adult daily dosage: 1 to 2 g once a day

Strength. Longevity. Trust.

roche

Rocephin IV·IM
ceftriaxone sodium

Before prescribing, please see complete product information, a summary of which follows:

INDICATIONS AND USAGE: Rocephin is indicated for the treatment of the following infections when caused by susceptible organisms:

LOWER RESPIRATORY TRACT INFECTIONS caused by Streptococcus pneumoniae, Staphylococcus aureus, Haemophilus influenzae, Haemophilus parainfluenzae, Klebsiella pneumoniae, Escherichia coli, Enterobacter aerogenes, Proteus mirabilis or Serratia marcescens.

ACUTE BACTERIAL OTITIS MEDIA caused by Streptococcus pneumoniae, Haemophilus influenzae (including beta-lactamase producing strains), and Moraxella catarrhalis (including beta-lactamase producing strains).

NOTE: In one study lower clinical cure rates were observed with a single dose of Rocephin compared to 10 days of oral therapy. In a second study comparable cure rates were observed between single dose Rocephin and the comparator. The potentially lower clinical cure rate of Rocephin should be balanced against the potential advantages of parenteral therapy.

SKIN AND SKIN STRUCTURE INFECTIONS caused by Staphylococcus aureus, Staphylococcus epidermidis, Streptococcus pyogenes, Viridans group streptococci, Escherichia coli, Enterobacter cloacae, Klebsiella oxytoca, Klebsiella pneumoniae, Proteus mirabilis, Morganella morganii,* Pseudomonas aeruginosa, Serratia marcescens, Acinetobacter calcoaceticus, Bacteroides fragilis* or Peptostreptococcus species.

URINARY TRACT INFECTIONS (complicated and uncomplicated) caused by Escherichia coli, Proteus mirabilis, Proteus vulgaris, Morganella morganii or Klebsiella pneumoniae.

UNCOMPLICATED GONORRHEA (cervical/urethral and rectal) caused by Neisseria gonorrhoeae, including both penicillinase- and nonpenicillinase-producing strains, and pharyngeal gonorrhea caused by non-penicillinase-producing strains of Neisseria gonorrhoeae.

PELVIC INFLAMMATORY DISEASE caused by Neisseria gonorrhoeae. Rocephin, like other cephalosporins, has no activity against Chlamydia trachomatis. Therefore, when cephalosporins are used in the treatment of patients with pelvic inflammatory disease and Chlamydia trachomatis is one of the suspected pathogens, appropriate antichlamydial coverage should be added.

BACTERIAL SEPTICEMIA caused by Staphylococcus aureus, Streptococcus pneumoniae, Escherichia coli, Haemophilus influenzae or Klebsiella pneumoniae.

BONE AND JOINT INFECTIONS caused by Staphylococcus aureus, Streptococcus pneumoniae, Escherichia coli, Proteus mirabilis, Klebsiella pneumoniae or Enterobacter species.

INTRA-ABDOMINAL INFECTIONS caused by Escherichia coli, Klebsiella pneumoniae, Bacteroides fragilis, Clostridium species (Note: most strains of Clostridium difficile are resistant) or Peptostreptococcus species.

MENINGITIS caused by Haemophilus influenzae, Neisseria meningitidis or Streptococcus pneumoniae. Rocephin has also been used successfully in a limited number of cases of meningitis and shunt infection caused by Staphylococcus epidermidis* and Escherichia coli.*

*Efficacy for this organism in this organ system was studied in fewer than ten infections.

SURGICAL PROPHYLAXIS: The preoperative administration of a single 1 gm dose of Rocephin may reduce the incidence of postoperative infections in patients undergoing surgical procedures classified as contaminated or potentially contaminated (eg, vaginal or abdominal hysterectomy or cholecystectomy for chronic calculous cholecystitis in high-risk patients, such as those over 70 years of age, with acute cholecystitis not requiring therapeutic antimicrobials, obstructive jaundice or common duct bile stones) and in surgical patients for whom infection at the operative site would present serious risk (eg, during coronary artery bypass surgery). Although Rocephin has been shown to have been as effective as cefazolin in the prevention of infection following coro-nary artery bypass surgery, no placebo-controlled trials have been conducted to evaluate any cephalosporin antibiotic in the prevention of infection following coronary artery bypass surgery.

When administered prior to surgical procedures for which it is indicated, a single 1 gm dose of Rocephin pro-vides protection from most infections due to susceptible organisms throughout the course of the procedure.

Before instituting treatment with Rocephin, appropriate specimens should be obtained for isolation of the causative organism and for determination of its susceptibility to the drug. Therapy may be instituted prior to obtaining results of susceptibility testing.

CONTRAINDICATIONS: Rocephin is contraindicated in patients with known allergy to the cephalosporin class of antibiotics.

WARNINGS: BEFORE THERAPY WITH ROCEPHIN IS INSTITUTED, CAREFUL INQUIRY SHOULD BE MADE TO DETERMINE WHETHER THE PATIENT HAS HAD PREVIOUS HYPERSENSITIVITY REACTIONS TO CEPHALOSPORINS, PENICILLINS OR OTHER DRUGS. THIS PRODUCT SHOULD BE GIVEN CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS. ANTIBIOTICS SHOULD BE ADMINISTERED WITH CAUTION TO ANY PATIENT WHO HAS DEMONSTRATED SOME FORM OF ALLERGY, PARTICULARLY TO DRUGS. SERIOUS ACUTE HYPERSENSITIVITY REACTIONS MAY REQUIRE THE USE OF SUBCUTANEOUS EPINEPHRINE AND OTHER EMERGENCY MEASURES.

Pseudomembranous colitis has been reported with nearly all antibacterial agents, including cef-triaxone, and may range in severity from mild to life-threatening. Therefore, it is important to consider this diagnosis in patients who present with diarrhea subsequent to the administration of antibacterial agents.

Treatment with antibacterial agents alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by Clostridium difficile is one primary cause of "antibiotic-associated colitis."

After the diagnosis of pseudomembranous colitis has been established, appropriate therapeutic measures should be initiated. Mild cases of pseudomembranous colitis usually respond to drug discontinuation alone. In moderate to severe cases, consideration should be given to management with fluids and electrolytes, protein supplementation and treatment with an antibacterial drug clinically effective against Clostridium difficile colitis.

PRECAUTIONS: General: Although transient elevations of BUN and serum creatinine have been observed, at the recommended dosages, the nephrotoxic potential of Rocephin is similar to that of other cephalosporins.

Ceftriaxone is excreted via both biliary and renal excretion. Therefore, patients with renal failure normally require no adjustment in dosage when usual doses of Rocephin are administered, but concentrations of drug in the serum should be monitored periodically. If evidence of accumulation exists, dosage should be decreased accordingly.

Dosage adjustments should not be necessary in patients with hepatic dysfunction; however, in patients with both hepatic dysfunction and significant renal disease, Rocephin dosage should not exceed 2 gm daily without close monitoring of serum concentrations.

Alterations in prothrombin times have occurred rarely in patients treated with Rocephin. Patients with impaired vitamin K synthesis or low vitamin K stores (eg, chronic hepatic disease and malnutrition) may require monitoring of prothrombin time during Rocephin treatment. Vitamin K administration (10 mg weekly) may be necessary if the prothrombin time is prolonged before or during therapy.

Prolonged use of Rocephin may result in overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Rocephin should be prescribed with caution in individuals with a history of gastrointestinal disease, especially colitis.

There have been reports of sonographic abnormalities in the gallbladder of patients treated with Rocephin; some of these patients also had symptoms of gallbladder disease. These abnormalities appear on sonography as an echo without acoustical shadowing suggesting sludge or as an echo with acoustical shadowing which may be misinterpreted as gallstones. The chemical nature of the sonographically detected material has been determined to be predominantly a ceftriaxone-calcium salt. **The condition appears to be transient and reversible upon discontinuation of Rocephin and institution of conservative management.** Therefore, Rocephin should be discontinued in patients who develop signs and symptoms suggestive of gallbladder disease and/or the sonographic findings described above.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Carcinogenesis: Considering the maximum duration of treatment and the class of the compound, carcinogenicity studies with ceftriaxone in animals have not been performed. The maximum duration of animal toxicity studies was 6 months.

Mutagenesis: Genetic toxicology tests included the Ames test, a micronucleus test and a test for chromosomal aberrations in human lymphocytes cultured in vitro with ceftriaxone. Ceftriaxone showed no potential for mutagenic activity in these studies.

Impairment of Fertility: Ceftriaxone produced no impairment of fertility when given intravenously to rats at daily doses up to 586 mg/kg/day, approximately 20 times the recommended clinical dose of 2 gm/day.

Pregnancy: Teratogenic Effects: Pregnancy Category B. Reproductive studies have been performed in mice and rats at doses up to 20 times the usual human dose and have no evidence of embryotoxicity, fetotoxicity or teratogenicity. In primates, no embryotoxicity or teratogenicity was demonstrated at a dose approximately 3 times the human dose.

There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproductive studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nonteratogenic Effects: In rats, in the Segment I (fertility and general reproduction) and Segment III (perinatal and postnatal) studies with intravenously administered ceftriaxone, no adverse effects were noted on various reproductive parameters during gestation and lactation, including postnatal growth, functional behavior and reproductive ability of the offspring, at doses of 586 mg/kg/day or less.

Nursing Mothers: Low concentrations of ceftriaxone are excreted in human milk. Caution should be exercised when Rocephin is administered to a nursing woman.

Pediatric Use: Safety and effectiveness of Rocephin in neonates, infants and pediatric patients have been established for the dosages described in the DOSAGE AND ADMINISTRATION section. In vitro studies have shown that ceftriaxone, like some other cephalosporins, can displace bilirubin from serum albumin. Rocephin should not be administered to hyperbilirubinemic neonates, especially prematures.

ADVERSE REACTIONS: Rocephin is generally well tolerated. In clinical trials, the following adverse reactions, which were considered to be related to Rocephin therapy or of uncertain etiology, were observed:

LOCAL REACTIONS—pain, induration and tenderness was 1% overall. Phlebitis was reported in <1% after IV administration. The incidence of warmth, tightness or induration was 17% (3/17) after IM administration of 350 mg/mL and 5% (1/20) after IM administration of 250 mg/mL.

HYPERSENSITIVITY—rash (1.7%). Less frequently reported (<1%) were pruritus, fever or chills.

HEMATOLOGIC—eosinophilia (6%), thrombocytosis (5.1%) and leukopenia (2.1%). Less frequently reported (<1%) were anemia, hemolytic anemia, neutropenia, lymphopenia, thrombocytopenia and prolongation of the prothrombin time.

GASTROINTESTINAL—diarrhea (2.7%). Less frequently reported (<1%) were nausea or vomiting, and dysgeusia. The onset of pseudomembranous colitis symptoms may occur during or after antibacterial treatment (see WARNINGS).

HEPATIC —elevations of SGOT (3.1%) or SGPT (3.3%). Less frequently reported (<1%) were elevations of alkaline phosphatase and bilirubin.

RENAL—elevations of the BUN (1.2%). Less frequently reported (<1%) were elevations of creatinine and the presence of casts in the urine.

CENTRAL NERVOUS SYSTEM —headache or dizziness were reported occasionally (<1%).

GENITOURINARY—moniliasis or vaginitis were reported occasionally (<1%).

MISCELLANEOUS—diaphoresis and flushing were reported occasionally (<1%).

Other rarely observed adverse reactions (<0.1%) include leukocytosis, lymphocytosis, monocytosis, basophilia, a decrease in the prothrombin time, jaundice, gallbladder sludge, glycosuria, hematuria, anaphylaxis, bronchospasm, serum sickness, abdominal pain, colitis, flatulence, dyspepsia, palpitations, epistaxis, biliary lithiasis, agranulocytosis, renal precipitations and nephrolithiasis.

OVERDOSAGE: In the case of overdosage, drug concentration would not be reduced by hemodialysis or peritoneal dialysis. There is no specific antidote. Treatment of overdosage should be symptomatic.

DOSAGE AND ADMINISTRATION: Rocephin may be administered intravenously or intramuscularly.

ADULTS: The usual adult daily dose is 1 to 2 grams given once a day (or in equally divided doses twice a day) depending on the type and severity of infection. The total daily dose should not exceed 4 grams.

If *Chlamydia* trachomatis is a suspected pathogen, appropriate antichlamydial coverage should be added, because ceftriaxone sodium has no activity against this organism.

For the treatment of uncomplicated gonococcal infections, a single intramuscular dose of 250 mg is recommended.

For preoperative use (surgical prophylaxis), a single dose of 1 gram administered intravenously 1/2 to 2 hours before surgery is recommended.

PEDIATRIC PATIENTS: For the treatment of skin and skin structure infections, the recommended total daily dose is 50 to 75 mg/kg given once a day (or in equally divided doses twice a day). The total daily dose should not exceed 2 grams.

For the treatment of acute bacterial otitis media, a single intramuscular dose of 50 mg/kg (not to exceed 1 gram) is recommended (see INDICATIONS AND USAGE).

For the treatment of serious miscellaneous infections other than meningitis, the recommended total daily dose is 50 to 75 mg/kg, given in divided doses every 12 hours. The total daily dose should not exceed 2 grams.

In the treatment of meningitis, it is recommended that the initial therapeutic dose be 100 mg/kg (not to exceed 4 grams). Thereafter, a total daily dose of 100 mg/kg/day (not to exceed 4 grams daily) is recommended.The daily dose may be administered once a day (or in equally divided doses every 12 hours). The usual duration of therapy is 7 to 14 days.

Generally, Rocephin therapy should be continued for at least 2 days after the signs and symptoms of infection have disappeared. The usual duration of therapy is 4 to 14 days; in complicated infections, longer therapy may be required.

When treating infections caused by Streptococcus pyogenes, therapy should be continued for at least 10 days.

No dosage adjustment is necessary for patients with impairment of renal or hepatic function; however, blood levels should be monitored in patients with severe renal impairment (eg, dialysis patients) and in patients with both renal and hepatic dysfunctions.

Revised: September 2000
ROB1

Pharmaceuticals

Roche Laboratories Inc.
340 Kingsland Street
Nutley, New Jersey 07110-1199
www.rocheusa.com

___ Set up automatic deposit and payment services in your absence.
___ Consider obtaining a calling card with preferred country rates.
___ Discuss budgets for home and deployment expenses.

Property
Review your insurance needs:

___ Homeowners or condominium insurance
___ Renters insurance (includes liability and personal property)
___ Personal Articles Floater
___ Fire insurance
___ Flood insurance
___ Auto insurance. (Check to see if rates can be lowered.)
___ Life insurance
___ Arrange for a home security system which may reduce your homeowners insurance rates.
___ Update your property inventory by recording all serial numbers.

Medical

___ Make your living will part of your medical records.
___ Make any necessary changes to your TRICARE program option if family members are away from a military installation.

Deployment Notification Checklist

Copied from the USAA website at www.usaa.com. This is meant to complement the pre-deployment checklist above.This checklist should help you tie up those loose ends before you deploy.

___Finalize financial, legal and insurance decisions.

Financial

___ Notify your credit card company if you will be taking your card overseas.
___ Make sure your spouse is aware of financial and computer passwords and, if necessary, write them down and store them in a safe place.
___ Notify creditors who may offer deployment benefits.
___ Contact your financial planner to discuss issues concerning your deployment.

Medical

___ Make sure your Defense Eligibility Enrollment Reporting System (DEERS) form is updated.
___ Make sure your spouse understands the military's Family Member Dental Plan.
___ Verify the TRICARE status for your family.

Property

___ Check your major appliances — stoves, washing machines, dryers and so on — to make sure they are in good working order.
___ Replace filters on heating and air-conditioning systems.
___ If there are any repairs needed to your electrical, climate-control and water systems, have them done now.
___ Make sure your spouse knows how to turn off the well pump, the water heater, water and gas mains and any other major systems. Leave written instructions, just in case.
___ Check your smoke detectors.
___ Label fuses and circuit breakers and show your family members how to use them.
___ Make an extra set of house keys.
___ If you have a home security system, make sure it works properly.
___ Complete a temporary change-of-address form if your home will be unoccupied.
___ If you are renting a home or apartment, notify your landlord that you will be gone.
___ Cancel your newspaper delivery if your home will be unoccupied.

Have the following on hand for household emergencies:

___ Flashlight
___ Extra batteries
___ Candles
___ Matches
___ First-aid kit
___ Electrical tape
___ Fire extinguisher
___ Bottled water

Auto

___ Notify your insurance company if your car will be placed in storage while you are deployed. Adjust your coverage as necessary.
___ Make sure your registration, insurance and inspection stickers are up to date.
___ Ensure car systems have been serviced.
___ If you use any special gas and oil, make sure your family knows about it.
___ List repair facilities, including tire and body shops.
___ Make a maintenance schedule for oil changes and tire realignments.
___ Prepare an emergency kit:
___ Flares
___ A spare tire
___ A jack
___ Flashlight or lantern and spare batteries
___ Jumper cables and directions on how to use them
___ A tool kit
___ A first-aid kit
___ A snow and ice scraper
___ A tire gauge
___ Maps
___ Some way to seek help, like a cell phone, calling card or proper change
___ Blanket or plastic sheet

Personal

___ If your deployment is international, notify your calling card provider.
___ For members using the USAA/Sprint card, call 1-800-755-8722.
___ Make sure your family's military identification cards are current and will not expire while you are gone.
___ Notify your children's school of your deployment.
___ Contact your place of worship.
___ Secure any weapons you may have in your home.
___ Make a list of important e-mail addresses to bring with you.

Arrange care for your pets:

___ Make sure all shots are up to date.
___ Notify your veterinarian that someone will be taking care of your pet.

Notify your credit card company if you will be taking your card overseas.

Saying Goodbye - Leaving the Family

By LtCol. Linda Lawrence, MD, USAF, MC

One of the hardest things about being deployed is saying goodbye to family. Both sides have concerns and these can put a strain on even the healthiest of relationships. Here are a few tips to help survive. You may also receive information from your local Family Support Center and be briefed by Mental Health staff. Even if you don't think you need help, take the time to listen. The rest of it seems to fall into place but your family will always remember how this was handled and for already strained relationships it can be the final straw.

> *"Sit down and talk about the new responsibilities your spouse will have with your absence. Develop a plan to cover these duties..."*

1. **Start talking to your spouse today.** Yes I mean today even before you may be tasked to deploy. It is not a matter of IF but WHEN. You and your spouse should expect for you to be deployed and a plan to handle it. This is especially true if you will need to add additional childcare support.

2. **Identify what your spouse needs to know to manage without you.** Sit down and talk abut the new responsibilities and duties your spouse will have with your absence. Develop a plan to cover these duties and don't just assume he/she can do everything. Think of things you can get other family or friends to help with or consider hiring out some duties. If you have small children, consider extra childcare.

3. **Keep routines and don't let go of discipline.** Especially when children are involved it is important to keep the same routine at home even when one parent has departed. Also keep discipline – that is part of the kids routine. Still celebrate holidays and birthdays. You can always do them again on your return. My family still went on scheduled vacations while I was gone and made a videotape for me. The kids also sent postcards each day of the trip – of course they arrived weeks later and out of sequence. I almost felt like I was there and they felt I was still part of their experience.

4. **Encourage your spouse to take private time while you are away.** When children are involved the tendency is for the spouse to think they have to always be available for the children. If you went out as a couple before the deployment, encourage your spouse to do the same. Encourage him/her to go out to see a movie, dinner with friends or shopping. The feeling can be:Hhow can I go out and enjoy myself when my husband/wife is working hard and doesn't have the same options? This isn't true. You will have some R&R time while deployed. While maybe not much, there will be activities planned as well as all the impromptu gatherings you and your colleagues will have to help blow off steam.

5. **Communicate with your family.** There are the standard ways to communicate – phone, email, letters. Also consider ahead of time writing out some letters to be opened throughout the deployment in case there are periods you won't be able to contact family. This way they can open a card and be reminded of your expression of love. I had a 2 & 3 yr old I left behind. Before I left, I bought several small toys. Then I would have my husband pull one out the next day after a call when the kids got up from a nap. They were always so excited to know that Mommy sent them something from Turkey. We also shared pictures through email and tons of the email cards. One website is www.bluemountain.com . My kids would send me pictures they drew. By the time I returned, my walls were papered with their artwork.

6. **Making the transition back home.** Start talking about it before you return. Remember your family's life went on and your spouse may not have been able to keep you apprised of every detail. Don't be surprise to see some changes you didn't expect. For some it can be hard to realize their family did just fine without them. When I returned, one thing I found especially hard was having to reassure my daughter every time I walked out the door that I wasn't leaving "forever" as she feared and not be overcome with guilt. Talk to your children and spouse about what their concerns are and don't feel guilty about being gone.

7. **Remember people will come and go in the military and the military will do just fine, but our families are with us forever.** Take time before, during and after to prepare your family and talk about your concerns. We spend so much time on the military planning yet forget the family planning aspect of a deployment. Make this a family event, not a personal event.

Revised ACEP Status for Reservists

In early 2002, The ACEP Board approved a recommendation from Dr. Brian Baxter, who was then ACEP Membership Committee Chair, to include reservists called to active duty in the category of inactive members.

Dr. Baxter submitted the following recommendations to the Board: "That the Board of Directors amend the Guidelines for Inactive Members to include members in the reserves called to active duty for 90 days or greater as a result of war or other national security issues, whether for stateside or overseas service."

Active membership dues are presently $515.00; inactive dues are $172.00. GSACEP agues that reservists called to active duty for an extended period can anticipate a reduction in personal income. During Operation Desert Storm in 1991, the ACEP Board also approved a one-time reduction for reservists called to active duty.

Dealing With Stress and Deployment: How Will I Cope?

by MAJ John McManus, MD, MC,USA

Critical Incident (CI):

"any significant emotional event that has the ability to produce unusual distress in a healthy person"

Working as a professional dedicated to physical, mental or spiritual health has never been more challenging. Caring for a diverse population of patients who are feeling ill from the stresses of separation, uncertain safety, the unfamiliar risks of war and terrorism, etc. can easily cause burnout or compassion fatigue in the well-meaning professional who keeps striving to meet the needs of his or her patients, without taking time to meet his or her own needs for rest and nourishment of body, soul and mind. There are many ways to cope with stressors and to relieve the pressures of a demanding and inherently stressful situation and position. Here are a few tips to help deal with these stressors and keep one on the right track.

1. Modify your time management and work habits. Although, not completely in control of your schedule, it may be wise to change your routine up to break up monotony. Also, have colleagues send you teaching aids to help in peer and subordinate medical teaching (pulling 'sick-call" shouldn't be your only duty).
2. Be flexible and prepared for change. This is a must in the deployment situation. Rather than complain about the lack of information and constant change, try to make the best of it and expect the unexpected. The soldiers look to you for leadership and helping set the morale.
3. Practice what you preach to your patients! Get enough sleep and eat a well balanced diet (this is possible even in the field). Avoid the deployment junk food.
4. Commit to or revitalize an exercise program that involves activities 20-30 minutes daily. I can't recall how many times I walked around the sands of Kuwait in full gear. It's hard to get started, but getting the routine down becomes second nature.
5. Schedule daily leisure time and protect it! Have family and friends send you non-job-related books, music, movies, etc to break up work-related topics. This is a great opportunity to finish a correspondence course or polish up the foreign language you always wanted to perfect.
6. Write frequent letters to friends and family (don't assume they know you are fine). The mail service does do a great job and people love to hear how things are going.
7. Commit to one or two goals that you want to accomplish while deployed.
8. Remain upbeat and focus on the positive. Acknowledging any negative feelings you might be harboring does improve your ability to remain optimistic. However, do this privately among peers.
9. Get creative! One of the best ways to improve morale and cope with the deployment is to "rev up" your natural powers for creative intervention.
10. Learn from the experience of others. Two very common mistakes people make when undergoing change are: 1) they try to cope on their own; and 2) they fail to benefit from the experience of others.

Finally, it is important to remember that feeling out of control or experiencing stress is not uncommon. Nor are they signs of weakness or failure. Physicians who commit to improving their own well-being, not just that of their patients, can prevent excessive stress from diminishing their professional performance, their satisfaction with work, and their personal lives. Good luck and God speed a safe return to your family and friends.

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Fall 2003

The EPIC

Operation Iraqi Freedom: A Reservist's Perspective

Brad S. Goldman, Maj. USAF(R), MC, FS

It was a typical "day" for me, about 3:30 P.M., when I woke up from the night shift and was getting ready to begin anew. I kissed Ruby, my nearly somnolent mini dachshund on the pillow next to me, and headed to the kitchen. I grabbed a snack and checked the answer machine. Something caught my eye. There was a "10" flashing under Messages Waiting. Somebody is *really* trying to reach me. After playing the messages, eight were from my unit urging me to call ASAP on "important matters." It was February 26th.

The ensuing 24 hours were a nervous blur of hectic packing, shopping, sending e-mails, calling people and saying goodbye. I was being activated. I had had a good idea that activation and deployment were possibilities considering current world affairs and my UTC. Within those 24 hours, with tremendous support from family, friends and especially my employers/ partners, I was on base, in uniform and ready to go wherever they needed to ship my team. Now, this is where the old saying, "Hurry up and wait," comes into play. For the next four months, my team was assigned to home station awaiting further deployment orders.

One weekend a month and two weeks a year. Perhaps you've seen the somewhat flip e-mail attachment from a transport truck in the AOR with that admonition in the front windshield. I guess this is what I had coming to me when I finished active

Continued on page 3

During many of our missions into Iraq we take US flags to give later as gifts of appreciation. Here is my team: (L to R) Maj. Brad S. Goldman, Maj. Kimberly Heller and TSgt Ernie Lilly Jr. Note our flight suits are sanitized for travel into the AOR.

Day-by-Day in Iraq

By CPT. Robert Blankenship, MD, MC, USA
President Elect, GSACEP

In February, I received orders to deploy with the 4th Infantry Division, 1st Brigade, 66th Armor Battalion – the "Iron Knights." I became assigned to the unit on the 25th of February, but we didn't start deploying to theater until the 4th of April – exactly six days after the birth of my youngest child.

We left Kuwait and entered Iraq at 0300 on the 17th of April. Our unit rapidly moved deep into Iraq stopping at Baghdad to download our tanks. We moved north to Tikrit and within hours moved even further north to Mosul to help the 101st Airborne secure the airfield there. After that, weeks went by, and I decided the worst scars from the battlefield I would see would be those from our smallpox immunizations. I was wrong. My unit moved from Mosul down to Samarra on the 5th of May. It only took one day before my medical platoon was tested.

The morning of May 6 went by like most: we ate what we could of our MREs, and we started working on setting up our aid station in our new hardstand. At noon, a truck pulled up to our gates with a man who was in an

Continued on page 6

President's Column: What A Year!

By CDR. David S. McClellan, MD, FACEP, USNR

Wow! What a year. Six months into my term as your President, it has so far been a tumultuous year. When faced with the realities of our current status, we, the leadership, have had to make some tough decisions. I hope they've been the right decisions.

This year has seen a large percentage of our membership deployed to Iraq, Afghanistan or other theaters.
Those of us left behind were faced with extra duties supporting those deployed physicians. We were required not only to provide patient care, but to cover extra clinical work shifts

Continued on page 5

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For more information about GSACEP, please call our office at 877-531-3044. Our office hours are 0900 to 1700 EDT, or visit our website at www.gsacep.org
We welcome advertising queries as well.

Don't Miss Our Panel at Scientific Assembly

Emergency Medicine on the Frontlines: Lessons Learned and Future Implications
Tuesday, October 14
4:00-5:50 PM
2 credit hours
TU-319

Throughout history several important advances in medicine have come from the battlefield. In this panel discussion, a group of military emergency physicians who participated in Operation Iraqi Freedom will share some of the highlights from this recent battle. They will describe the vital role emergency physicians played in providing medical support from the Special Forces at the heart of the battle to the movement of critically injured patients back to the US by the Critical Care Air Transport Team. Medical treatments that have relevance to your practice such as the use of Chitocin dressing, fentanyl lollipops, and the new tourniquet will be discussed.

Describe the impact of emergency medicine during Operation Iraqi Freedom. Identify treatments from the battlefield with potential implications to the everyday practice of emergency medicine.

Course Instructors
Troy R. Johnson, MD, MAJ, MC, FS, USA
Linda L. Lawrence, MD, FACEP, LtCol, USAF, MC
Lynn Welling, MD, FACEP, CAPT, MC, USN
Robert Wood, MD, Capt., USAF, MC

GSACEP at Scientific Assembly

GSACEP will hold a Board of Directors Meeting open to all members at ACEP's Scientific Assembly on Monday, October 13, from 0730 to 0900 Orleans Room, Boston Marriott. Please look in the ACEP onsite program.

Be sure to visit us at the GSACEP Booth at Scientific Assembly as well.

Save Monday evening, October 13th, from 1800 to 1930 for the GSACEP Reception at SA Regis Room, Boston Marriott. (ED. Note: This may change. Please watch our website and check our booth to confirm.)

Operation Iraqi Freedom: A Reservist's Perspective

Continued from Page 1

duty without ever being deployed.

In my unit (445th ASTS) at Wright-Patterson AFB, OH, I wear two hats: I'm a Flight Surgeon and a Critical Care Air Transport Team (CCATT) physician. I've found, in my travels, many ED docs wear these hats as well. For those who may not be familiar, CCATT in essence is "military medflight". About 10 years ago, the Air Force realized that more mobile critical care capabilities were required to augment the Aeromedical Evacuation (AE) system. CCATT was the solution to that

My CCATT Tech and Nurse preflighting two ventilated RPG ambush victims from Iraq. Notice close quarters.

problem. A CCAT Team consists of a respiratory therapist, nurse and physician. All team members have extensive ER or ICU experience. Additional training is given to provide critical care in the potentially hostile environment of military aircraft during flight and familiarization with the AE environment. All equipment and supplies are to be carried by the team. CCATT has been used operationally for almost a decade in both military ops and military operations other than war (MOOTW). Mostly the active duty CCATT's were used for this purpose.

My team had known and trained with each other on UTAs [Unit Training Assemblies] for at least three years. This would prove to be a huge advantage when we actually did deploy to "the box" as the Operation Iraqi Freedom AOR is affectionately known. We had trained extensively and flew many missions with mannequins and simulated patients but not one actual "live" mission was under our belt. Each CCATT member is trained to perform the functions of the entire team should one of us be busy, unavailable or injured/killed during combat operations. Trust and communication are fundamental to mission readiness. A lot of issues I've heard about in the AOR are a direct result of a problem with either of these. Being an emergency physician, I am a "naturally born" team player. This was right up my alley, and working and flying as a team fit perfectly. We only needed a place to go and missions to fly. Soon enough, this would happen.

I guess the prospect of being deployed didn't really hit me until I was tucked onto a rotator heading to the Middle East for 120 days. Luckily, I read, re-read and shared the Spring 2003 Deployment Issue of The EPIC with my team and unit. There is much wisdom in those pages; heed it well.

Despite a short two-day stint in a locale which we were expecting to settle in for the duration, we were moved to Camp Wolf, Kuwait, as our base of operations. We got off the C-130 (my first time flying in one), greeted the admin folks, were shown a tent and dropped off for a quick afternoon nap. Within less than six hours and with all our gear still packed, our team was alerted that we were to fly our first "real-world" mission into Iraq. My mind was racing. We had the proper training; we also all had the proper civilian experience. However, this was still something new and different. That day was alarming, exciting and stressful just like internship, except compressed into a few short hours. The mission went smoothly and my team performed flawlessly. I'm so proud of them. They made me look good and gave me time to focus on the patients.

We have since flown many missions into Iraq and to Germany. Most of our patients are intubated and multi-trauma from IED (Improvised Explosive Devices) or RPG (rocket propelled grenade) attacks. There are some patients with a diagnosis of pneumonia of unclear etiology. We have endured long waits, flightline temps exceeding 140+ in idling planes (affectionately known as "the tube of pain"), communication snafus, extra patients springing up from nowhere, enemy fire, equipment failures, lack of paperwork, etc. Yet, our teams in the

Patience is a virtue. Nowhere will that be truer than in the AOR. Here troops deal with a 10-hour flight from Germany to Kuwait on a C-17.

AOR have managed to provide top quality care to these troops and wounded/ill civilians. This is especially true with the recent UN headquarters bombing in Baghdad. One day you are looking at a CNN newscast in the dining tent. Next day, you're flying a

Iraq: A Reservist's Perspective

mission picking-up the critically injured UN workers.

Being busy is vital to your physical and mental wellbeing. The time passes quicker and you feel more productive. Below are a few cogent observations this flight doc has made during our 47 out of 120 days deployment to the desert.

Everyone—and I do mean everyone—counts! We count the days in the AOR, we count the days until we can go home. It's almost a pick-up line anywhere in the AOR, "Hey, how long you been in country?"

Be patient and flexible. Despite having the perspective of a "spoiled" Air Force doc, there are many things that require adjustment. This is more so since we are stationed with the Army. Different rules, but all in all, we play along well together.

Respect privacy, share your goodies from home and find out who is in charge of the air conditioning. All are vital to a smooth and more comfortable deployment.

Never, NEVER complain about how hard a time you feel you're having to anyone besides your team. There are always folks out there in the AOR who have it much worse, much hotter, more Spartan and more dangerous. I respect them and we see them when we fly into "the box". We provide care packages on every flight possible. It's our way of saying thanks to those closer to the war than we are.

Tent life is like sleep-away camp for those of us whose parents flushed us out of the house for two months during the summer. But there are no counselors! Ponchos, clothespins and blankets make nifty walls. Empty water bottles with ends cut off make fabulous air ducts for the central tent vent. Digital cameras and laptops are everywhere, and many Bx's, even tactical bare-base ones, have batteries and some sort of essentials.

Like many others, I packed way too much stuff. Lighten the load, contact folks deployed before you and find out what the mission and weather really dictate you need to bring. Moving several times is a huge hassle with a ton of stuff.

Ensuring all your equipment and gear is ready before the mission is critical to its success. Here we load and stow weapons preflight for mission into Iraq. (Maj. Goldman & TSgt Lilly)

Consider reviving the lost art of writing. Write real letters and postcards. They are free when mailed in the AOR. Keep a daily journal. This will serve you well for personal reasons as well as a record of what you did and accomplished during your deployment (OPR's, medals, unit presentations, etc).

Bring only a few books; most folks will swap with you. CDs are easier to carry than a lot of books/manuals. Most units here have computers and all tents have somebody with a laptop who will share (this is where the goodies come into play).If there is any PME lingering, this is the perfect time to do it. I finished ACSC tests 3-6 in less than one month before finally deploying. Catch up on journals and professional CME readings.

I would like to close with perhaps the strangest personal realization I've made in the past 15 years. I've been activated for seven months and deployed for one and one-half. In this time, I have gone through extraordinary financial and personal challenges. I have been sent to hot desert climes, lived in tents, used latrines in all shapes and configurations, flown into combat zones, donned body armor in 125 degree weather, carried weapons while treating injured military and civilians alike. I have endured separation from family, loved ones and friends. Yet, I have never felt more alive, more at peace and less stressed.

I know. I hear you saying-"What, are you crazy?" Maybe. Maybe not. Until this time, I've been so busy building a career, home and family that I've never taken the time to just sit, think and ponder the great mysteries of life and love. Deployment forced me to look at myself and re-evaluate what is truly important. Don't get me wrong, I'm no Hemingway in search of the glory of combat and war, but serving here and now has truly given me a perspective I otherwise would never have. There is an amazing sense of inner peace that many here have come to know and share (they just don't talk about it freely).

Just like in our ER residency training, a deployment is what you make of it. Come prepared with an open mind, and a willingness to work. Everything else will truly take care of itself. I don't know how the other half of our deployment will go, but the camaraderie and friendships I've made here will endure long after I put down the Kevlar and pick up the white lab coat. I'm proud of my team, unit and all the armed forces here in the AOR. The medical care given here is second to none.

A weekend a month and two weeks a year, indeed.

New Members

Moved into Chapter	Institution	From
Peter E. Clemens, MD	SAUSHEC	San Antonio, TX
Scott Dickson, DO	Malcolm Grow Med. Ctr.	Andrews AFB, MO
Thanh Do, DO		Ft. Hood, TX
Robert Donovan, MD	Naval Medical Center	Portsmouth, VA
Andrew L P Houseman, MD		
Michael D. Jones, MD	SAUSHEC	San Antonio, TX
Robert Kulantzick, MD, FACEP	Walter Reed	Washington, D.C.
Greg Lepkowski, MD	Naval Medical Center	San Diego, CA
John Mastalski, DO,FACEP		Florida
Michael Miller, MD	Darnall	Ft. Hood, TX
Devin Rickett, MD		San Antonio, TX
Jon K. Riggs	Wright State Univ.	Kettering, OH
Alex Rosin, MD	Darnall	Ft. Hood, TX
Steven Ross, MD	Nellis AFB	Nevada
Vance Rothmeyer		Bethesda, MD
Dustn Shawcross, MD	Darnall	Ft. Hood, TX
Joel Schofer	Naval Medical Center	San Diego,CA

President's Column: What A Year!

Continued from Page 1

and other responsibilities of the deployed. It was true even in the reserves as one of my partners was deployed.

Understanding that a majority of our committee members and some of our Chairs and Board members were directly effected, we had to reduce our activity level. But don't despair. We're gearing up again on a number of committees, such as the Research Committee, under the leadership of LTC. Bob Gerhardt, MD, FACEP.

Perhaps the most painful decision was to cancel the Joint Services Symposium 2003, scheduled for March, in San Antonio, TX. We had never canceled this meeting, but we knew our members wouldn't be able to attend due to the situation at that time. We thank the St. Anthony Hotel for being so understanding of our unique circumstances. We do have an excellent program in the works for Spring 2004 again at the St. Anthony in San Antonio. I urge everyone to set aside March 22-March 25th for this outstanding conference. MAJ. John McManus and his program committee have blended cutting edge medical care with review of Topics on the ConCert exam while still focusing on operational aspects of military emergency medicine. For many, our next annual conference will be the first time in two years they'll even see each other. This is very, very special. I urge you to help us make this the best meeting ever.

On a related topic, most of you are aware that we have been able to keep our dues among the lowest in ACEP. Apart from very, very tight fiscal management, the chief reason we have been able to do this is because of the income we utilize from our conferences. We did raise dues a few years ago, and branched out to other income-producing areas, to help make us less dependent on conference income. (Incidentally, there is still no fee to our resident or candidate members which is not true of other chapters). However, we still need conference income to fully fund our operations.

We would love to fund more members to come to our Board and Strategic Planning Meetings, and to develop our young leadership in other ways as well, but we simply haven't had the money this year. If we get a good result from JSS 2004, I anticipate restarting this process.

I also want to note that we're currently trying to get funding for our reception at Scientific Assembly, scheduled for Monday evening, October 13. As we go to press, we have not yet gotten a sponsor. If we don't get one, we'll hold a reception off site. Please watch the GSACEP web site (www.gsacep.org) and visit our booth at SA for confirmation of the reception location.

Over the past year, we have also had a slight decline in membership. We have been working hard to reverse this trend. We've discovered, for example, that most resident non-members have heard of GSACEP, but don't really know anything about it. It's our job to get that message out. We're doing that through residency visits, but I would also ask every member of GSACEP to talk to a co-worker or friend who is not a member. Please explain to them why it's important that there be a military chapter of ACEP, and what this chapter provides them. We have excellent resources on our web site or through the GSACEP office extolling the virtues of our group. I know it can be hard at times to do this, but it is very important.

On our part, we're contacting everyone we can whose membership has expired, or who has been transferred to another chapter. It's understandable if you've left the military, but this could also just be a glitch in the ACEP computer. If it is, let them know that the fact that you transferred to another state doesn't mean that you've left the military.

I want to thank all of our deployed members, some of whom speak of their experiences in this issue of EPIC. The people of the United States and your fellow military members appreciate your sacrifices and the sacrifices of your families. We all understand that, if these problems are not addressed in other parts of the world, we will be facing them to a greater extent here at home. We're proud to be part of your effort, in whatever way we serve.

Day-by-Day in Iraq

Continued from Page 1

automobile accident. He had significant thoracoabdominal trauma. Despite all our efforts, he died. For many of my medics this was the first time they had even seen a chest tube or intubation. They also saw a person who came in talking and died a few minutes later. It was a tough day, but it was just beginning.

Four hours later an Iraqi ambulance brought a child who had been playing with unexploded ordinance. It had exploded causing many injuries including a penetrating skull injury. We quickly prepared him for a MEDEVAC flight. The birds came in, but as they were flying over the river one helicopter went into the water. We rushed a medical team down to the river, but the injuries sustained by the crew were immediately fatal. The other helicopter, containing the boy, dropped him off. We then decided to evacuate him via ground to Baghdad, but he died enroute. Hours went by as our unit's soldiers and medics retrieved our soldiers from the downed helicopter in the middle of the river and brought them ashore. We were exhausted both mentally and physically – surely the night would bring us the rest we needed.

> *"...one helicopter went into the water... the injuries sustained by the crew were immediately fatal."*

0300 I was awakened by a runner from the battalion TOC. There were four badly burned Iraqi children at the Samarra Hospital and the doctor there was requesting I come out to help. The scouts got a convoy together and we raced to the hospital. Upon arrival, I met a father of six children – five boys and one girl. His children had brought unexploded ordinance into their home and it went off. Two children were immediately killed in the house, and his remaining four children were at the hospital. While evaluating the children at the hospital, one child died. We radioed back to our Forward Operations Base to have a bird come for the three remaining children. While waiting at the LZ we lost another child. It was a frustrating experience because we had no pediatric equipment in our aid station so all we could do was treat the pain and pray the bird came quickly. We evacuated both remaining children, but only one survived to the next day. We understand the daughter – the sole survivor – was ultimately evacuated to the United Arab Emirates. She is still in rehabilitation there.

CPT. Rob Blankenship, MD, at left, 25 lbs. thinner then when he left the States, with SFC Garcia (med platoon sergeant) and GEN. Peter J. Shoomaker, Army Chief of Staff.

I wish I could tell you this is all we have seen in my little aid station here in Samarra, but it is not. All together we have seen over 38 traumas involving civilians, US soldiers, and the paramilitary forces. In addition to the deaths noted above, we had another three die of injuries in our aid station – the most recent being a two-year-old girl. It is so sad to see these children die. However, most of the deaths we see were in paramilitary forces trying to kill us.

Back in the spring, as I prepared to deploy with 1-66 Armor, many senior medical officers told me this would be the most rewarding experience of my career as a physician. I thought they were crazy. I already had many rewarding experiences such as serving as the chief resident of Darnall Army Community Hospital Emergency Medicine Residency Program, publications, national lectures, and was currently serving as the Assistant Program Director for Darnall's EM residency. I was proud of the accomplishments in our residency the past few years – how could this deployment top all of that?

Well, my senior medical officers were right. The experiences of the last few months, while very difficult, have helped me realize what is really important in my life – God, my marriage, my family, and the freedom I enjoy as an American. It doesn't take long here to realize just how expensive that freedom is. So, how exactly is this freedom obtained? It's not in writing book chapters that we secure our freedom. It's not in serving as the assistant program director or in lecturing at conferences. It's the grunts who risk their lives day in and day out on patrols, raids, and checkpoints that secure our freedom for us. And, when they get injured in the line of duty, they come to me. Of all the things I've accomplished as a physician, nothing has been more rewarding than caring for our soldiers in a combat zone. I doubt anything ever will be.

Resident Rep From SAUSHEC Elected

In a very close election, in which over 45% of all resident or candidate members voted, Capt. Julio Lairet, DO, USAF, of the San Antonio Uniformed Services Health Education Consortium (SAUSHEC) was elected GSACEP Resident Representative. Dr. Lairet was opposed by CPT. Andrew Morgan, MD, USA, of Madigan Army Medical Center at Ft. Lewis, WA. Capt. Lairet's term of office begins immediately and is a two-year position. He will join the Board of GSACEP at its meeting in Boston during ACEP's Scientific Assembly.

In his campaign statement, Dr. Lairet, who is also active in EMRA, said that he believes the GSACEP position enables military residents in the chapter to have a strong voice in GSACEP. In addition, echoing past resident reps, Dr. Lairet said that it was his goal to help bring all military emergency residents closer together. One of the ways he hopes to achieve this is by starting a newsletter with contributors from all residencies.

"I believe that we have a very talented group of individuals within all the emergency medicine residency programs," Dr. Lairet said. "Unified, we can address all the issues which affect us not only as residents, but as future staff within the different services."

Dr. Lairet began his military career in 1989 when he enlisted in the Oklahoma Air National Guard and served as an in-flight Medical Specialist for eight years. Last year, he completed a Transitional Internship at Malcolm Grow Medical Center at Andrews AFB. He is currently an EM-2 at SAUSHEC.

ACEP Bookstore To Carry Core Lecture Series

At this year's Scientific Assembly, look for GSACEP's Core Lecture Series to be on sale at the ACEP Bookstore. ACEP is offering it at the rate of $50.00 to ACEP members. We'll also be accepting orders for the product at our GSACEP Booth.

Congratulations To:

LTC. (sel) Frank Christopher, MD, named Division Surgeon to the 82nd Airborne Division. The 82nd was being deployed to Iraq at the time we went to press.

Have You Signed In on the Web?

A few months ago, GSACEP introduced a new sign-in form at our website which enables members to supply an email address and check off areas of interest in order to receive helpful information. We promised that we would not SPAM you and would not sell the list. The service was designed to make us more helpful to you and keep us current with the things that are important to you on a continuing basis. So, why is that only half of all GSACEP members are signed in? Probably, it's because of deployments which sent more than 50% of all members overseas, or possibly it's because you didn't even know about it.

If you can, go to our website now at www.gsacep.org and fill out the sign-in form. This could be a fantastic service, but you have to help make it one. Thanks.

GSACEP CHAPTER OFFICE
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FALL
2005

A Chapter of the American College of Emergency Physicians
Government Services
EPIC

The President's Column:
BRAC and Emergency Medicine

By LTC. Robert A. DeLorenzo, MD, FACEP, USA

In my last column, I wrote about the changing environment of military medicine and how it affected emergency physicians. In keeping with the "change" theme, this column will focus on the Department of Defense's (DOD) Base Realignment and Closure (BRAC) plan. In addition to highlighting the proposed closures and realignments, I will speculate on the implications for military medicine in general and emergency medicine in particular.

Abbreviations

AFB — Air Force Base
BAMC — Brooke Army Medical Center
BRAC — Base Realignment and Closure
ED — Emergency Department
EP — Emergency Physician
GME — Graduate Medical Education
NAS — Naval Air Station
NMC — Naval Medical Center
NS — Naval Station
WHMC — Wilford Hall Medical Center
WRAMC — Walter Reed Army Medical Center

BRAC Process

BRAC is a federal law passed by Congress as part of the fiscal year 2002 Defense Authorization Act. During the past 2 years, as part of the Act, the DOD has been gathering data on all installations, and in May of this year released the now well-publicized "BRAC list." Compared to previous BRACs (there have been four previous rounds since the late 1980's), this one moves particularly fast and is less subject to alteration by the presidential-appointed BRAC Commission. In fact, by the time you read this, the public hearings will have concluded and the Commission's recommendations will be transmitted to the President. After approval by the President, the Commission's recommendations become final a mere 45 working days after being sent to Congress for a straight up-or-down vote. Since this column is being written as the BRAC commission holds its hearings, it is possible there will be changes not reflected herein. News accounts of the hearings, however, suggest that few if any changes will greatly affect the medical infrastructure.

In deciding which medical facilities to recommend for closure or realignment, the DOD used several criteria including support for the warfighter, maximizing military value while reducing infrastructure footprint, maintaining or improving access to care, enhancing jointness, maximizing consolidation synergies, and examining outsourcing opportunities. The BRAC commission, in its deliberations, used a similar set of factors. The result is a list of medical treatment, training, research, and administrative facilities recommended for closure or realignment.

DOD's Recommended Changes

DOD (Table 1) has recommended nine major realignments and consolidations. At least 10 hospitals will convert to outpatient-only clinics including the medical centers at Keesler and Andrews AFBs (Table 2). Even the venerable Armed Forces Institute of Pathology is recommended for outsourcing. Additionally, the BRAC commission itself added the service medical commands and office of the surgeons general to its list of possible realignment. Notably, these tallies do not include medical facilities (mostly clinics) located on bases and posts recommended for complete closure, such as the Naval Station, Groton, CT.

One outstanding feature of the BRAC recommendations is the creation of six medical research centers of excellence: a) trauma and battlefield health, San Antonio, TX, b) infectious disease, Bethesda, MD, c) aerospace medicine, Dayton, OH, d) biological defense, Fort Detrick, MD, e) chemical defense, Aberdeen Proving Ground, MD, and f) regulated medical product development and acquisition (e.g., vaccines) , Ft Detrick, MD. By consolidating related but geographically scattered researchers under one roof, the DOD plans to enhance collaboration and reduce the considerable overhead associated with scientific endeavors.

Continued on page 7

In This Issue

Time to Stand Up and Be Heard

By Col Linda Lawrence, USAF, MC

For years we have been discussing the issues impacting emergency medicine – crowding, liability reform, reimbursement. Well Sept. 27 is your chance to stand up and be heard by joining your colleagues in a Rally on the West Lawn of the US Capitol. These issues affect us now – even in our military emergency departments. Think about the last time you had to transfer a patient and couldn't find the appropriate on-call specialist or there was no bed available in the local community to admit the patient your hospital couldn't keep due to lack of capability. Even if you don't think these issues affect you today, there is always tomorrow. Most military emergency physicians leave military practice sooner or later, and choose to continue to practice in civilian emergency departments. So, do plan to come out to the Rally if you're attending the ACEP Scientific Assembly.

> *"The healthcare environment in the civilian sector does significantly influence our practice in the military."*

For those close by to DC – you don't even need to be attending to participate. You can still register for the rally or even show up that day.

For the past three years as a member of the Board of Directors we have worked hard to increase our advocacy and get the message heard – we need reform and NOW! We have three goals with the Rally. First – get our message out to our patients and get them engaged. Too many Americans assume we will be there when they need us and all will be fine. Time to wake up and smell the coffee and hopefully with a large attendance we will get the ear of the press who will carry our message across the newswires to many local stations far from DC. Second, we want Congress to hear us. Tied to the Rally will be a bill we plan to introduce to Congress – Access to Emergency Care Act 2005. In that bill there will be three focused "asks" – End boarding of "admitted" patients in our EDs, support emergency medical care as an essential public service and solve the professional liability crisis in emergency care. Third, we hope to energize all emergency physicians to get more involved in advocacy. This is just the beginning of our aggressive external campaign for reform. Later, in the fall, ACEP will be releasing the Emergency Medicine Report Card and early 2006 should bring the release of the IOM report on emergency care in America. These events present excellent opportunities to capitalize on what we will begin on Sept. 27.

Hopefully, you will join us in what is sure to be a memorable event and just the beginning of some exciting times ahead. For those of you on active duty like myself, I have obtained the opinion of legal counsel

> *"The healthcare environment in the civilian sector does significantly influence our practice in the military."*

and this is an activity we CAN participate in even though we work for the government. Only restriction – don't wear your uniform. But you can come out as an emergency physician and let your presence be heard. Our numbers will speak volumes – the greater the number of us standing on the lawn the louder the message. I do hope to see you on the Capitol Lawn for what I promise will be an energizing and engaging event. Time we stop complaining and start pushing for solutions.

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

GSACEP Plans for Online Job Bank

For the last 28 years, GSACEP has been working diligently to serve military emergency physicians. Affter much discussion, the GSACEP Board of Directors has decided to begin work on an online job bank for GSACEP members. While we do not wish to encourage military emergency physicians to leave the military, we feel we should provide quality employment information for those who independently decide to stop serving in the military.

Once completed, the job bank will consist of a database of potential employers wishing to recruit former military emergency physicians. We also hope to compile a list of resources helping you select which type of practice you wish to be involved in. Lastly, the job bank will be designed in such a way that it protects our member's identity. It will be up to our member to disclose your personal information to a potential employer. If you are interested in placing an ad, please contact Bernie Carr at the GSACEP office: 877-531-3044.

We hope this new resource will become a valuable asset to our members who are concluding their service in the military. Look for this new service towards the end of this year.

GSACEP Receives Chapter Development Grant

A grant proposal submitted by LTC John McManus, MC, USA, was approved by the ACEP Board of Directors for $3625. The grant, Tactical and Basic Emergency Combat Casualty Care Educational Compact Disc for Deployed Military Physicians, will be officially announced at the ACEP Council luncheon in September in Washington, DC.

Free CME For Deployed Physicians

The Young Physicians Section of ACEP (YPS) and Government Services Chapter ACEP (GSACEP) have worked with ACEP in an effort to obtain free CME for the many service members currently deployed and unable to attend CME events. ACEP wants to provide all deployed emergency medicine physicians with a free subscription to Critical Decisions. If you are a deployed physician, please provide GSACEP with: full name, e-mail address, institution deployed to, e-mail address overseas, date deployed and anticipated return date. (Contact carr@gsacep.org)

GSACEP will send this information to ACEP who will send Critical Decisions via e-mail. Once the soldier has read the issue, there is a way for him/her to complete the CME via the Internet or to print the CME questions, answer them, and mail them back to ACEP for CME credit.

GSACEP at Scientific Assembly 2005 in Washington, DC

This is a big year for GSACEP with Col Linda Lawrence, MD, FACEP, running for re-election to the ACEP Board of Directors, and LTC Marco Coppola, DO, FACEP, running from the floor for Vice-Speaker. Come celebrate with us at GSACEP's annual reception. Only GSACEP members and guests are invited. The reception is on Tuesday, Sept. 27th, from 1800 to 1930, at Farragut Square, Grand Hyatt. There will be a bar and buffet provided, thanks to Sonosite, our sole sponsor.

The GSACEP Board of Directors will meet on Wednesday, September 28 from 1000 to 1130 AM at the Renwick Room of the Grand Hyatt. All members are invited.

GSACEP will participate in the joint chapter booth again at Scientific Assembly. The booth is located in the main ACEP area.

Talking Paper on Discontinuation of Aminoglycoside Ear Drops for OIF/OEF Casualties

Background:

Landstuhl Regional Medical Center (LRMC) Otolaryngology Department cares for 99% of all OIF/OEF casualties with otologic injuries sustained by IED blasts. Significant numbers of these casualties have tympanic membrane ruptures. These types of injuries may cause membrane tears which lead to direct communication through the tympanic perforation, to middle and inner ear.

Currently many corpsman and medics are treating these casualties with eardrops containing aminoglycoside. Aminoglycoside exposure to the inner ear has been proven to be toxic and has been reported to cause cochlear/vestibulopathies. The American Academy of Otolaryngology, Head/Neck Surgery has strongly recommended that otic drops containing aminoglycoside **not** be used in any type of surgery or in patients with tympanic perforations

All three service consultants recommend discontinuing the use of aminoglycoside ear drops in theater for these casualties. Medics should be advised to use quinolone ear drops containing dexamethasone instead(like ciprodex). When these are not available, aminoglycoside ear drops should still not be used due to risk of further harm to our warfighters.

Recommendation:

AFMSA/SGOC work with CENTCOM/SG to develop effective means of communicating this to the medics in theater.
Three services modify their curriculum for medic training to include this information.

President's Column - Continued From Page 1

Another major feature of BRAC is the establishment of two "supercenters" for graduate medical education (GME) in San Antonio, TX and Bethesda, MD. The former will be a joint Army-Air Force venture, while the Army and Navy will run the latter. Both centers will be huge by current DOD standards and if com-

> *The healthcare environment in the civilian sector does significantly influence our practice in the military.*

ments by military medical leaders are taken at face value, will rival such academic giants as Johns Hopkins University in size and scope. To provide a sense of scale, consider the San Antonio Military Regional Medical Center's nearly $1 billion in planned (and fully funded) patient care, research and support construction. This mammoth upgrade will begin as soon as 2006 and should be complete several years later. A new emergency department (ED) is part of the plan and is being designed for an annual census of 80,000 – 100,000. A similarly sized construction project is expected for the new Walter Reed National Military Medical Center.

Lastly, but perhaps just as significantly, the BRAC plan establishes a joint training location for all enlisted training. This massive shift of medical technician training will effectively double the size of Fort Sam Houston, TX, and create the world's largest school of allied health. It is not by coincidence this all-service enlisted school will be co-located with the new San Antonio Military Regional Medical Center with its robust medical education and research missions.

Implications for Military Medicine
The true impact of BRAC is at once far-reaching and uncertain. There are no doubt the closures and realignments will reshape military medicine for years to come. In fact, BRAC can be seen as part of a larger DOD effort to focus on the warfight, reduce infrastructure footprint, and increase efficiency in general. Viewed in this light, the creation of centers of research excellence, consolidation of educational missions, and elimination of smaller facilities become important components of a larger military transformation.

It is easy to focus on the hospital closures and draw negative conclusions for the future of military medicine. Without doubt, there will be fewer inpatient facilities (and consequently, fewer EDs) after BRAC. This will reduce assignment opportunities and decrease practice variety for all medical specialties including emergency medicine. With over two-thirds of the hospital closures (including two medical centers - Wilford Hall and Keesler), the Air Force is most affected. Combined with the prior decision to eliminate most GME at David Grant Medical Center, Travis AFB, CA, a reduced commitment to military medicine is suggested. However, it is important to keep such downsizing in perspective. For example, prior years have seen the closure of two large Army Medical Centers (Fitzsimmons and Letterman) as well as several smaller Army and Navy hospitals.

Opportunities and Risks for Emergency Physicians
BRAC affords tremendous opportunities for the military emergency physician (EP). Perhaps the greatest benefit of BRAC will be an increase in joint staffing and training opportunities. The joint supercenters in San Antonio and Bethesda afford unprecedented integration for Army-Air Force and Army-Navy staffs, respectively. These jointly run medical centers will have jointly staffed EDs. Both EDs will train large numbers of medical students and off-service residents; the ED in San Antonio will be a Level I trauma center and host to one of the largest residencies in the military. Emergency physicians with an academic interest will find boundless opportunities in these new medical centers.

Other big opportunities resulting from BRAC include faculty and staff positions at the co-located enlisted medical training center in San Antonio. The current Army combat medic program is headed by a Colonel-level EP and assisted by two mid-grade EPs. Army EPs have held other faculty positions in the school including the physician assistant and cardiovascular-respiratory specialist programs. In the future joint school, equivalent Air Force and Navy positions can be expected to become available to the education-focused EP.

The joint medical research laboratories, particularly the trauma and battlefield health, chemical defense and biological defense labs will provide outstanding opportunities in a broad array of military-relevant topics. EPs in at least two services currently serve in all these areas and BRAC-driven enhancements will work to expand the opportunities.

Despite the many opportunities created by BRAC, there will likely be some offsets, too. Most obvious is the closures of EDs as nine hospitals convert to clinics (Table 2). Most of the facilities were staffed, at least in part, by military EPs. Their closure will reduce practice opportunities and limit some geographic assignment preferences. The consolidation of NMC-Bethesda and WRAMC, and BAMC and WHMC will reduce some opportunities (even as others are created). Counteracting these negative trends are some potential expansion opportunities not directly related to BRAC. As part of the greater military transformation, thousands of troops in South Korea and Europe will return to bases and posts in the U.S. Among others, Forts Bragg, NC, Hood, TX, Bliss, TX, Campbell, KY, and Stewart, GA are each likely to expand by at least one brigade of about 5,000 troops. Accompanied by 5 – 10,000 family members, the military EDs can expect to see an increased census and thus, an increase in staffing needs. Combined with possible joint billets at co-located bases (e.g., Fort Lewis and McChord AFB, WA; Fort Carson and USAF Academy, CO; and Fort Bragg and Pope AFB, NC) these new opportunities may partially counteract the EDs lost in the BRAC process.

Summary
BRAC affords tremendous opportunities for military emergency physicians. Joint hospital opportunities will increase, as will joint training and research billets. These new opportunities will help to offset the few ED closures planned under BRAC. The resourceful and flexible EP will continue to find exciting and varied opportunities in military medicine.

> *The healthcare environment in the civilian sector does significantly influence our practice in the military.*

Table 1
Major Realignments (Relocations)

1. Walter Reed National Military Medical Center, Bethesda, MD
Close current WRAMC and re-establish new joint facility on grounds of National NMC-Bethesda

2. San Antonio Military Regional Medical Center, San Antonio, TX
Close current WHMC and merge inpatient services at BAMC, keeping some ambulatory services at new facility on grounds of WHMC

Continued on page 6

President's Column - Continued From Page 7

3. Joint Enlisted Training Center at Fort Sam Houston, TX
Move virtually all enlisted medical training from NS Great Lakes, IL, Sheppard AFB, TX, NMC San Diego, and NMC Portsmouth to Fort Sam Houston (San Antonio), TX

4. Joint Center of Excellence in Aerospace Medicine Research, Wright-Patterson AFB, OH
Move the USAF School of Aerospace Medicine, Brooks City-Base, TX, and the Naval Aeromedical Research Laboratory, NAS Pensacola, FL to Wright-Patterson AFB, OH

5. Joint Center of Excellence in Chemical Defense Research, Aberdeen Proving Ground, MD
Consolidate all chemical defense medical research labs

6. Joint Center of Excellence in Biological Defense Research, Fort Detrick, MD
Consolidate all biological defense medical research labs

7. Joint Center of Excellence in Infectious Disease Research, WRAMC (Forest Glenn), MD
Consolidate all infectious disease research labs

8. Joint Center of Excellence in Battlefield Health and Trauma Research, Fort Sam Houston, TX
Consolidate all battlefield health and trauma research labs

9. Joint Center of Excellence in Regulated Medical Products and Devices, Ft. Detrick MD
Consolidate all research & development on regulated products (e.g., vaccines)

Table 2
Hospital Closures (Conversions to Clinics)

1. Army
   - Fort Eustis, VA
   - Fort Knox, KY

2. Navy – Marines
   - Naval Station Great Lakes, IL
   - Marine Corps Air Station Cherry Point, NC

3. Air Force
   - USAF Academy, CO
   - Andrews AFB, MD
   - MacDill AFB, FL
   - Keesler AFB, MS
   - Scott AFB, IL
   - McChord AFB, WA (Clinic will close)

4. Other Closures
   - Armed Forces Institute of Pathology

Please Save These Important Dates in 2006!

ED Director's Course—March 19th
Wyndham St. Anthony Hotel
San Antonio, TX

Joint Services Symposium —3/20-3/22
Wyndham St. Anthony Hotel
San Antonio, TX

Watch the GSACEP website for further information.

New Members

Welcome! Please make sure that you register your e-mail address at our website, www.gsacep.org. If you don't, you won't receive breaking news from GSACEP.

Nicholas Allan	USUHS, MD
Jeffrey Dickson, MD	
Brian Dimmer	USUHS, MD
Phillip Goebel, MD	SAUSHEC, Ft. Sam Houston, TX
Ryan Harris, MD	NMC, San Diego, CA
Gary Hurwitz, MD, FACEP	Davis-Monthan AFB, AZ
Robert Jones, MD	SAUSHEC, Ft. Sam Houston, TX
Jon Juhasz, MD	USHUS, MD
Nicholas Lezama, MD, FACEP	Travis AFB, CA
Matthew Lippstone, MD	Keesler AFB, Biloxi, MS
David Masneri, DO	Darnall, Ft. Hood, TX
Todd McArthur, MD	Darnall, Ft. Hood, TX
Marie McDonough, MD	SAUSHEC, Ft. Sam Houston, TX
Jeffrey McInturff, MD, FACEP	Granite Bay, CA
Paul Morton, MD	US Air Force Academy, CO
Paul Nystrom, MD	NMC, Portsmouth, VA
Joseph Roarty, MD	SAUSHEC, Ft. Sam Houston, TX
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Micah Schmidt, MD	Sheppard AFB, TX
Inai Lee Shin, MD, FACEP	APO, AP Seoul, South Korea
Cristine Stehman, MD	San Diego, CA
W. Duayne Storm, MD, FACEP	US Embassy, Nairobi, Kenya
Deron Warren, DO	CA
Margrethe Weston, MD	NMC, Portsmouth, VA
William E. Zoesch, MD, FACEP	APO, AE Germany

The Balanced Scorecard in Military Medicine Practice

By LTC Robert A. DeLorenzo, MC, USA

Introduction

The military health system (MHS) is comprised of all the service medical departments of the Army, Navy, and Air Force, as well as that portion of the Tricare managed care system that is controlled by the government. The deployable medical assets, fixed medical treatment facilities, and all of the medical infrastructure of the military, to include most of us, can be considered part of the MHS. Like all large organizations, the MHS needs a system of management. In the late 1990s, the Office of the Assistant Secretary of Defense for Health Affairs, in conjunction with the three surgeons general, flowed the lead of the Department of Defense by adopting a management tool called the Balanced Scorecard (BSC). (For those interested in the fundamental concepts of the balanced scorecard please read the appendix entitled "The Balanced scorecard – A Primer.")

The chief benefits of using the BSC relate primarily to organizational alignment and focus. In particular, the BSC can focus a healthcare entity's strategy, improve decision-making, help management set priorities, and improve accountability. Leaders at all levels, and certainly this includes all military emergency physicians, should have a basic appreciation for the BSC and how it fits with the MHS mission. The BSC validates what we do on a daily basis in the emergency department (ED), in line units, and in other military settings. It offers the opportunity for junior and mid-level medical managers (captains through colonel, or the naval equivalent) to understand the motivations and directives of senior leaders and help position their service, department or unit to best serve the organization.

Making Sense of the Balanced Scorecard in the MHS

The MHS is one of the largest healthcare organizations in the world with 9 million beneficiaries and an annual budget of $21 billion. To fully appreciate the mission and scope of the MHS and understand the role of the individual in executing the larger mission, it is useful to review the MHS mission statement:

"To enhance DoD and our nation's security by providing health support for the full range of military operations and sustaining the health of all those entrusted to our care."

In turn, the MHS vision statement is:

"A world-class health system that supports the military mission by fostering, protecting, sustaining and restoring health."

Together these two statements are used to build the MHS strategy architecture (Figure 1). The learning and growth perspective forms the base of the strategy and focuses on the military personnel and support systems. The military GME system, USUHS, the various military medical research laboratories, the military unique curriculum, and other elements of the training and research base directly reflect this foundation. The internal perspective is characterized by three themes: readiness (for war and military contingencies), quality (healthcare), and efficiency (budget and productivity). Many junior and mid-grade medical officers are focused on this perspective in their daily jobs of patient care and running the ED.

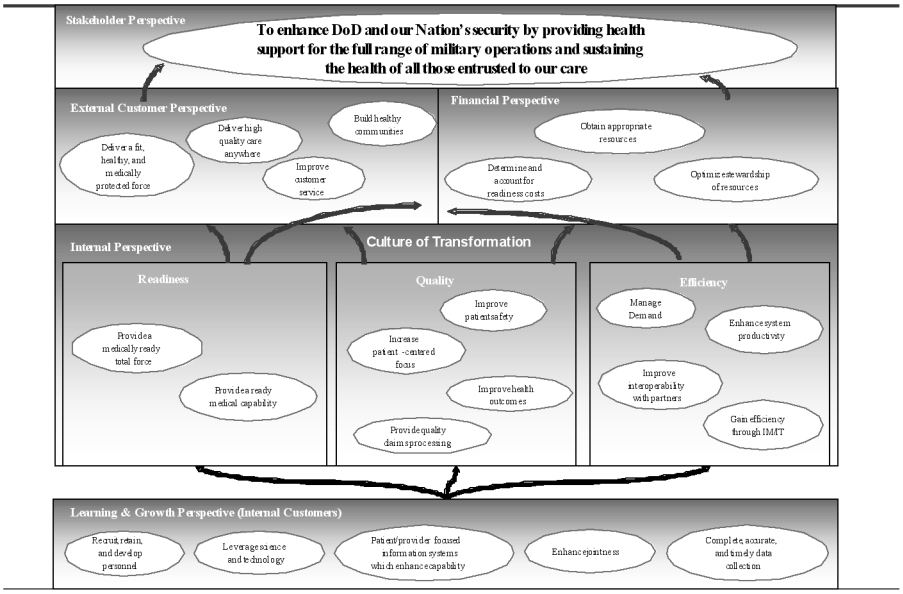
The customer's perspective is represented by the military service members the MHS serves. It is important to reflect that a critical population we serve – beneficiaries and retirees – are not explicitly present on the strategy map. This lack of strategic focus on our most frequent customer may help explain the ambivalence the system seems to have for retirees and beneficiaries. The financial perspective reflects cost-effectiveness, transparency, and accountability. In an era of budget constraints, cost concerns, in particular, seems to take special emphasis and at times seems to overshadow the other perspectives in the strategy map but is in reality only one portion of one component of the strategy map. Finally, the stakeholder perspective at the pinnacle is represented by the congress, the commander-in-chief, and ultimately, the American public. Interestingly, not represented amongst our stakeholders are the commanders, their unit members, and the servicemembers' families we serve. This reminds us that ultimately we respond not to the market force of our customers (patients and military units), but rather to the political will of the civilian leadership in charge of the military.

With the architecture (Figure 1) established, the MHS strategy map is assembled, as depicted in Figure 2. Prominent on this map is the emphasis on people and personnel, systems, and customer focus. While not

Continued on page 8

MHS Strategy Architecture Figure 1

Strategy Map for the MHS Figure 2



explicit, the left-hand portion of the map focuses on the chief business of the MHS, providing a capable medical force and sustaining a fit fighting force. At the top of the map, the stakeholder position is held by the MHS mission statement.

Utilizing the MHS Balanced Scorecard

With the strategy map in hand it is easy to identify the MHS priorities and drivers, even for personnel located relatively deep within the organizational chart. Collectively our priorities start with the readiness theme: personal readiness (e.g., weapons qualifications, physical fitness, etc) as well as medical readiness of the servicemembers in our care. It also encompasses training to provide a capable medical force . This latter component is the leverage needed by military GME, military medical centers, USUHS, and other institutions trying to justify their existence. Quality is the management theme for excellence in patient care – something we can all appreciate and strive for. The quality theme validates our effort to ensure all emergency patients in the military receive the best possible emergency medical treatment by board-certified emergency physicians. The cost-effectiveness theme represents everyone's efforts to achieve what the tired cliché implores: do more with less. While every leader needs to be cost conscious, not every aspect of this theme swings the budget ax. The renewed interest in third-party collections, for example, offers significant opportunity for those emergency departments able to capture this revenue stream.

One critical aspect of the BSC not discussed here is the use of metrics to measure and define success. While implicit in the design of the BSC, it is important to realize that accurate, valid data coupled with realistic and achievable benchmarks provide the feedback necessary to make the BSC work as a management tool.

Conclusion

Personnel at all levels can begin to think of their daily activities in terms of the MHS BSC. Customers, whether they are soldiers, sailors, or airmen as part of a fit, healthy and medically protected force, or as beneficiary patients, can easily determine the outlines of benchmarks that define the MHS productivity and effectiveness. In short, the MHS BSC links all the components and perspectives into a unified strategy for the entire organization.

APPENDIX The Balanced scorecard – A Primer

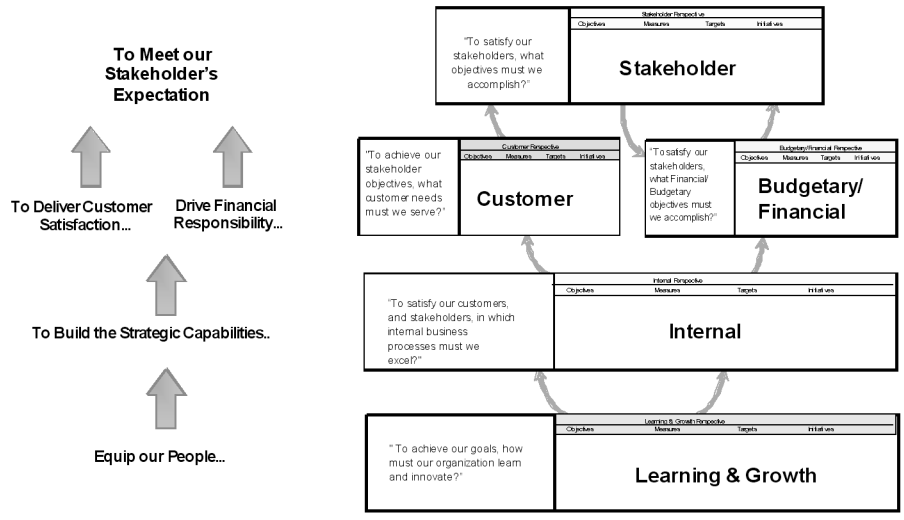
The balanced scorecard (BSC) is a management approach to measuring all aspects of an organization's performance. The balanced scorecard was developed by Robert S. Kaplan and David P. Norton in 1992 when their concept was published in the Harvard Business Review.[1] A decade later, about 50 percent of Fortune 1000 companies use the technique, along with many departments and agencies of the US government.[2]

Fundamentally, the scorecard balances traditional financial measures of success with non-financial measures that ultimately affect organizational performance in the future. In the basic model, four perspectives, financial, customer, internal, and learning and growth are linked together as depicted in Figure 1. Each of these perspectives' measures is derived from the organization's vision, strategy and objectives.[3]

The BSC was originally intended for use in traditional for-profit enterprises and not

Continued on page 9

Balanced Scorecard Framework Figure 3



surprisingly finds its greatest application there. The company's vision and mission statements provide the foundation for developing a BSC.[4] The vision and mission statements drive the company strategy, which the BSC will exploit in terms of the four perspectives and their inter relationships.

Organizations other than private, for-profit firms can also take advantage of the balanced scorecard. Both governmental and private nonprofit organizations make extensive use of the technique; however, financial performance is replaced by measures of effectiveness in providing services to constituents or the public.[4] The four perspectives are described below.

Financial Perspective. In for-profit enterprise, the financial perspective gets the primary emphasis since it is the ultimate measure by which companies are measured. Indices of profitability are central to the financial performance of the company as measured in the BSC. Such measures typically fall into three broad categories: a) revenue growth, b) cost management, and c) asset utilization.[5] Together, cost management and asset utilization are sometimes categorized together as measures of productivity.

Customer Perspective. The Customer perspective represents those customer-focused areas where the company competes. Typical examples fall into five subcategories of which customer satisfaction is perhaps best known. The other subcategories are market share and customer acquisition, retention, and profitability.[4]

Internal Perspective. This aspect of the BSC pertains to the internal business processes of the company. While managers at all levels should be concerned with the internal perspective, typically it is middle and lower management that is immersed in the details. Four subcategories may be considered including operating, customer management, innovation, and regulatory and social processing.[4] In a traditional manufacturing process this may be conceptualized as the market identification, design, build, deliver, and post-sales service steps.[5]

Learning and Growth Perspective. The learning and growth perspective is concerned with personnel, organization, and support systems of the enterprise. The components of this perspective, therefore, are competencies, organization, and technology.[3] Alternatively, these components may be viewed as employee capabilities, information technology, and motivation and alignment, respectively.[5] The learning and growth perspective provides measures for a company's employees and their ability to help the enterprise remain profitable.

Strategy Map. The strategy map shows how each of the four perspectives drives one another and ultimately drive increased profits and improved shareholder value. Figure 3 depicts a very generalized form of a strategy map.

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5. Amaratunga D, Baldry D, Sarshar, M. Process improvement through performance measurement: The balanced scorecard methodology. *Work Study* 2001; 50(4/5): 179-188.

Useful Website

Office of the Assistant Secretary for Health Affairs, U. S. Department of Defense (OSD (HA)), Washington, DC. www.ha.osd.mil.

2005 GSACEP Members on ACEP Committees

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Robert DeLorenzo, MD, FACEP
Arthur French, MD, FACEP
John McManus, MD, FACEP
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Winter 2006

A Chapter of the American College of Emergency Physicians

Government Services EPIC

President's Message

LTC John McManus, MC, USA

Mentorship 101: Why Become a Mentor, or Seek a Mentor?

Mentoring is a tool and or trait that organizations and individuals use to nurture and grow their future leaders. It can be an informal practice or a formal program. Protégés observe, question, and explore. Mentors demonstrate, explain and model. Mentorship is a learned process and often takes years to perfect. Furthermore, mentors may be sought in any variety of organizations and stages of life regardless of their 'true" profession. I am a firm believer that mentorship is essential, not only for our future leaders, but also our present leaders. Mentorship is vital to professional and personal success. In this article, I will reveal some basic traits and concepts involved in mentorship, as well as discuss its importance.

Characteristics of a Good Mentor: Who should I Seek?

All successful people do not necessarily make effective mentors. Certain individuals are more effective in the role of developing others. Whether or not an individual is suited to the role of mentor may depend on his or her own stage of development and experience. For example, a fairly successful individual may have had a specific, or limited, background and may not have enough general experience to offer. Prior to entering into a mentoring relationship, the protégé should assume the responsibility of assessing the mentor's potential effectiveness. The qualities which are essential in an effective mentor include:

HAVE HAD POSITIVE EXPERIENCES: Individuals who have had positive formal or informal experiences with a mentor tend to be good mentors themselves.

GOOD REPUTATION FOR DEVELOPING OTHERS: Experienced people who have a good reputation for helping others develop their skills.

TIME & ENERGY: People who have the time and mental energy to devote to the relationship.

UP-TO-DATE KNOWLEDGE: Individuals who have maintained current, up-to-date technological knowledge and/or skills.

LEARNING ATTITUDE: Individuals who are still willing and able to learn and who see the potential benefits of a mentoring relationship.

DEMONSTRATED EFFECTIVE MANAGERIAL (MENTORING) SKILLS: Individuals who have demonstrated effective coaching, counseling, facilitating and networking skills.

A DESIRE TO HELP: Individuals who are interested in and willing to help others.

Roles of Mentorship

Within the mentorship process, a mentor often assumes multiple roles to bring about the enhancement of the protégé's professional, personal, and psychological development. At different times, the mentor may be a role model, advocate, sponsor, adviser, guide, developer of skills and intellect, listener, host, coach, challenger, visionary, balancer, friend, sharer, facilitator, and resource provider. Along with these roles comes a responsibility to consider the psychological dimensions of the relationship, for example, accepting, confirming, counseling, and protecting. The role that best describes the mentor may be decided as a result of how well the mentor understands the total mentorship process. Clearly, the mentor role does not suit all people.

Phases of Mentorship

There has been little investigation of mentoring phases or stages from a conceptual and theoretical perspective, except for the work of Kram (1985). Kram examined the phases of a mentor relationship from the perspective of psychological and organizational factors that influence career and psychological functions performed. She suggests that developmental relationships vary in length but generally proceed through four predictable, yet not entirely distinct, phases.

THE INITIAL PHASE is the period in which the relationship is conceived and becomes important to both mentor and protégé. This phase may last for a time span of six months to one year. From the military physician perspective, this would occur during the residency years. Given the apparently overwhelming challenge of residency to most new officers, one can imagine the mentor on the team finding himself or herself in great demand. Yet, most students learn best in a supportive environment, and having a designated mentor on the team will give students much easier access to faculty and military leaders. The mentor team member would be willing, able and desirous of this

(continued on page 4)

In This Issue

GSACEP ELECTIONS 2007

The following GSACEP Board of Directors openings occur in 2007:

President Elect

Councillor

Councillor

In accordance with our Bylaws, ballots will be mailed to Active Members in mid-January.

Active Members will also be able to vote online at gsacep.org.

If you are an Active Member interested in any of these positions, please submit your name with a brief description (three paragraph maximum) of your contributions to GSACEP and ACEP. Please contact the office by December 22 at gsacep@aol.com.

Only members who have actively participated in the chapter in some way, as committee members or chairs, lecturers at our annual meeting, contributors to our newsletter or contributors to GSACEP projects, such as the Core Lecture Series, etc., will be considered for elected office.

The time commitment for President Elect is three years. After one year, the President Elect assumes the office of President for a year, then Immediate Past President for a year.

The Councillor position is for two years.

All elected Board Members are expected to participate in all GSACEP conference calls, to respond in a timely manner to Board inquiries via e-mail, and to attend the GSACEP Board of Directors Annual Meeting (to be held in 2007 on March 18, in San Antonio). The GSACEP Board also meets during Scientific Assembly. In 2007, the Board will meet in September in Seattle. Board members are frequently assigned tasks, or asked to volunteer for projects.

If you're interested, please contact gsacep@aol.com. If you have questions, call 877-531-3044.

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.

MILITARY NEWS

LCDR Buddy Kozen, MD has been awarded $42,000 in grants supportig his ongoing work in hemostatic agents.

CDR Andrew Johnson, MD, was promoted to Chair of EM at NMC Portsmouth.

Col Linda Lawrence, MD, FACEP, was the 2006 recipient of EMRA's Joseph F. Waeckerle Founder's Award. The award is given to a physician who made an extraordinary, lasting contribution to the success of EMRA. It was presented at the EMRA Reception at Scientific Assembly.

LTC John McManus, MD, FACR, FACEP, has been named to the Board of The National Association of EMS Physicians. He assumes office in January, 2007.

CAPT(sel) Joel Roos, MD, was promoted to Associate Director of Outpatient Medicine at NMC Portsmouth.

CAPT James Ritchie, MD, FACEP, received national ACEP teaching award.

IMPORTANT GSACEP DATES

December 22, 2006: Notify GSACEP office, gsacep@aol.com if you are interested in running for elected office.

January 31, 2007: Last day to nominate someone for GSACEP Military Excellence Award.

Sunday, March 18: ED Directors Course, The Crowne Plaza Hotel, San Antonio, TX

Sunday, March 18: Tactical Ultrasound Course, The Crowne Plaza Hotel, San Antonio, TX

Sunday, March 18: GSACEP Board of Directors Meeting, The Crowne Plaza Hotel, San Antonio, TX. Time and Room TBA

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

LINDA LAWRENCE ELECTED PRESIDENT ELECT OF ACEP

GSACEP President LTC McManus with Dr. Lawrence shortly after her election.

Congratulations to Linda Lawrence, Col, USAF, MC, for her election to President-Elect of ACEP. This is the first time an Active Duty Military Emergency Physician has held this post, and we are very proud.

Dr. Lawrence is a former President of GSACEP. In her history with the chapter, Dr. Lawrence also chaired our Education Committee for two years. She was the chair of the committee to develop the original Core Lecture Series and, more recently, chaired The ED Directors Course held in conjunction with the annual Joint Services Symposium.

At ACEP, Linda served as Vice-President, Secretary-Treasurer, Editor of ACEP New and EM Today. She also visited many residency programs, including almost all of GSACEP's programs. She has been deeply involved in policy making at ACEP.

Dr. Lawrence is Chief of Medical Staff, David Grant Medical Center, Travis AFB, CA; Attending Physician, Emergency Department, Travis AFB, CA; Emergency Medicine Consultant to Air Force Surgeon General; Associate Professor, Department of Military and Emergency Medicine, Uniformed Services University of the Health Sciences, Bethesda, MD.

JSS 2007 EMERGENCY MEDICINE ON THE RIVERWALK CALL FOR ABSTRACTS

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

Abstract Submission Requirements:

Original research: Abstracts should represent original basic science or clinical research. Residents and students may submit on-going projects or projects that have previously been presented within the last calendar year (April 2006 – March 2007). Attending faculty may submit only previously unpublished or unpresented material. Abstracts must include the following subsections, consistent in style with those appearing in *Annals of Emergency Medicine*: title, study objectives, methods (design, setting, type of participants), results and conclusions. The abstract should fit on a single page of 8.5 x 11inch paper, typed double-space with margins, with a minimum font size of 12 point, Times New Roman or Tahoma preferred. Tables and figures should not be submitted during the initial review. Submission in electronic format is required. The file should contain names of all authors, appropriate institutions, main point of contact, title of abstract, text of abstract, and statement of IRB oversight if applicable. Primary investigators should also identify themselves as in-training (medical students and house staff) or attending staff. Entries should be submitted to LTC John McManus (john.mcmanus@amedd.army.mil) with a firm deadline of 1700 hours (5:00 pm) EST on 29 January 2007. Abstracts will undergo screening by peer review. Those that are accepted will have been judged scientifically valid and as yielding important information which will ultimately affect patient care. Abstracts will be reviewed for oral presentation or poster exhibition. If accepted for oral presentation, one of the authors will have 15 minutes (10 minutes for presentation and 5 minutes for discussion) to present their work on 20 March 2007. A copy of your PowerPoint presentation must be sent to LTC McManus at the above email address no later than 10 March 2007.

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

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

NOMINATIONS FOR EXCELLENCE IN MILITARY EMERGENCY MEDICINE

In 1997, The GSACEP Board of Directors developed a Chapter Award to recognize a member of the Chapter who has made outstanding contributions to emergency medicine. Distinguished past winners include Col. Ray Ten Eyck, COL Matthew Rice, CAPT David Munter, COL Cloyd Gatrell, COL Glenn Mitchell, COL James Pfaff, Col Linda Lawrence, and CAPT Lynn Welling. We are now seeking nominations for this year. Below are listed the eligibility and selection criteria. Please submit your choice by January 31, 2007, to the GSACEP Board c/o GSACEP, 328 Eighth Avenue, Suite 142, New York, NY 10001 or e-mail us at gsacep@aol.com. If you have any questions, please contact the Chapter office at 877-531-3044

Eligibility

a. General. Any ACTIVE GSACEP member may be nominated.
b. Departing/former members. An individual nominated for the Award who transfers from or otherwise leaves GSACEP before the award selection process has been completed remains eligible for one calendar year from the date of nomination.
c. Exceptions: Resident, student, affiliate, honorary, or corporate members do not meet the eligibility requirements, but may be considered on an exception basis. Such an exception requires the consent of two thirds of the voting members present at a duly constituted meeting of the **Board of Directors**

Criteria: Each nomination must document that the nominee has contributed to the advancement of Emergency Medicine in one or more of the following categories.

a. Sustained Chapter Leadership and Service. Individual leadership and service while a member of GSACEP that have brought growth to the Chapter, improved Chapter services to members, or enhanced the reputation of the Chapter within ACEP and/or organized medicine over a period of at least three years.
b. Advancement of Federal/Military Emergency Medicine. Service as an emergency physician that has advanced the specialty within the Federal/Military Medicine. This may include contributions specific to Emergency Medicine, or more general contributions to Federal/Military Medicine that have brought favorable recognition to an individual noted as a representative emergency physician. This could include high visibility service in non-Emergency Medicine positions.
c. Emergency Medicine Education/Research. Conspicuous contribution to the specialty through research, teaching, publications, or other significant academic endeavors while serving as a Federal/Emergency Physician.
d. Clinical Emergency Physician. Singular achievements related to direct patient care, such as responding to disaster or mass casualty situations; unusual clinical acumen resulting in life-saving diagnosis or intervention with one or more individual patients, or patient care involving personal heroism by Federal/Military emergency physicians.

Nominations: Each nomination must be submitted by an ACTIVE member of GSACEP, or be accompanied by an endorsement from an Active Member of GSACEP. Each nomination will consist of a cover letter, a narrative justification, and a curriculum vitae of the individual being nominated.

a. The cover will identify the nominee and the category or categories for which nominated, and a means to contact the nominator (telephone and e-mail, please).
b. The narrative will be no longer than two pages, double-spaced, in 12pt font.

Preview of GSACEP Conferences 2007

The GSACEP Conference Committee, chaired by Maj James Eadie, MD, and Cpt Julio Lairet, DO, and supervised by our President and Board, is planning an outstanding curriculum for ***The Joint Services Symposium 2007***, March 19-March 21 at The Crowne Plaza Hotel in San Antonio, TX.

Guest faculty will include national ACEP speaker James G. Adams, MD, FACEP, and Navy Surgeon General, Vice-Admiral Donald Arthur, MD, among over 25 nationally known invited faculty.

The conference also includes The Consultants Lunch on Tuesday, March 20, which will feature all three consultants to the Surgeons General: LTC Ian Wedmore, MD (Army) Col Linda Lawrence, MD, (Air Force) and CAPT Joel Roos, MD (Navy).

Once again, LTC John McManus, MD, MCR, FACEP will offer his enormously popular ***LLSA Review*** and Drs. Rob Blankenship and Marco Coppola will head up ***The Oral Board Review*** *Course* on Tuesday, March 20.

Sunday, March 18:

In its third year, ***The Ed Directors Course***, chaired by LTC Curt Hunter, MD, FACEP, and Lt Col Shawn Varney, MD, FACEP, GSACEP is an intense one-day course to teach you the essentials of how to run your emergency department effectively and efficiently. You will learn critical skills including how to interact with hospital leadership and other departments, how to improve emergency department patient throughput and reduce length of stay, how to run an emergency medical services team, and how to meet your patients' needs and expectations while maintaining staff morale. The course focuses on key metrics, staffing issues, and balancing your mental welfare with the rigorous demands placed upon the ED Director. The course is open to everyone. Realize that once you graduate from residency you are expected to know how to lead change in your ED. This is your chance to review these principles and discuss how to apply them to your particular situation.

NEW THIS YEAR on Sunday, March 18th:

GSACEP Tactical Ultrasound Course This is an intense one day course that will teach you how to successfully incorporate ultrasound on the battlefield. The course will cover topics such as pneumothorax, fracture, and foreign body detection, central and peripheral line placement, CVP estimates, and much, much more. The course features interactive lectures, to include 3D animations, and concentrated hands-on lab experience. The lab uses live models and phantoms for a realistic training experience. This course will be limited to the first 25 registrants to guarantee a significant hands-on experience for each participant. If you want to learn battlefield ultrasound, this is the only course in the US that currently teaches it – so sign up now. We look forward to taking your ultrasound skills to the next level.

Look for the brochure which details these excellent courses in your mail within the next six weeks. We will also have schedules and registration available online by mid-December. If you have any questions, please contact GSACEP at 877-531-3044, Monday-Friday 0900-1700 ET. Or e-mail us at gsacep@aol.com

President's Message *(continued from page 1)*

kind of interaction with students, instead of faculty whose academic preparation and research sometimes makes them offer "limited office hours."

THE SECOND PHASE, called the cultivation phase, and usually lasts from two-to-five years. For the military physician, this phase usually consists during the first couple of assignments out of residency. During this phase, the positive expectations that emerged during the initiation phase are continually tested against reality. The mentor and protégé' discover the real value of relating to each other and clarify the boundaries of their relationship.

PHASE THREE, separation, is marked by significant changes in the relationship and might happen during or soon after the military physician has become independent (or even has assumed a mentor role him or herself). It is a time when the protégé experiences new independence and autonomy, as well as turmoil, anxiety, and feelings of loss. The separation phase lasts from six months to two years.

THE FINAL PHASE is redefinition. In this phase, the relationship takes on significantly different characteristics and becomes either a more peer-like friendship or one that is characterized by hostility and resentment. In general, during the redefinition phase, both the mentor and protégé recognize that a shift in developmental tasks has occurred and that the previous mentorship process is no longer needed or desired.

Getting out of sync with the developmental phases of the mentoring relationship could result in a less-than-positive experience for both mentor and protégé. Although everyone will not experience the phases at the same rate, it is essential that they go through all of them, and in sequence. If one accepts the stage theory of mentoring, it is obvious that the time commitment required precludes this being accomplished in a single year. Mentoring is not a short-term relationship. If the expectation is for all faculty/officers to mentor all students, it does not fit the higher education model of taking a series of courses with different professors or teachers. One rotation or assignment does not provide sufficient time to move through the total process. It is, however, reasonable to expect that if the mentor team members are given the responsibility for educating and interacting with entry-level officers, then they may begin to establish a relationship with future protégé's early in their military careers. This would be accomplished, in part, through active listening and questioning that establishes a psychological climate of trust. This lays the foundation for a more engaging mentoring relationship. Without this kind of connection, the likelihood of a meaningful mentor-protégé experience is limited.

Concluding Thoughts

Good mentoring is a distinctive and powerful process that enhances intellectual, professional, and personal development through a special relationship characterized by highly emotional and often passionate interactions between the mentor and protégé. Although we can assume that all officers in higher education and leadership engage in some level of instructional activity, it cannot be concluded that all are actively involved in mentoring, nor should they be. The complete mentor role does not fit all individuals: some officers are less inclined toward developing close relationships with students or subordinates and with nurturing the students' development. Not all officers are capable of, or willing, to take on this role and if required to do so would be inadequate or "incomplete" mentors. That is why the faculty/officer team concept has the promise of improving the quality of education and leadership. Even if all officers are not mentors, understanding the role of the complete mentor can be a template for the good instructor. The essence of mentoring is grounded in the concept of one-on-one teaching. If one is engaged in mentoring, one is engaged in teaching. Thus, in addition to having the responsibility of mentoring students, the team mentor could also be asked to share his or her expertise regarding the mentor role with colleagues. The function of the effective mentor, which include building a relationship, providing information, being facilitative and challenging, serving as a role model, and co-constructing a vision, are not far removed from what good teachers do. If one also examines the role of a skillful instructor, it will become clear that there is high correlation between the two roles. Regardless of the academic or military discipline or subject, the instructional process can be enhanced by understanding and incorporating aspects of the complete mentor role.

2006 National ACEP Council Actions

The national ACEP Council met just prior to the Scientific Assembly conference in New Orleans. Military and Government Service interests were met by GSACEP's six Councillors and two Alternates. The Council considered 36 resolutions: 30 were adopted , two were not adopted, and four resolutions were not discussed. Following is a list of council resolutions with disposition.

Summary of 2006 Council Resolutions

Resolutions Not Discussed by the Council

Resolution 1 Once a Fellow, Always a Fellow (Bylaws Amendment)
Resolution 2 Member of Distinction as a Life Fellow (Bylaws Amendment)
Resolution 3 Definition – Member of Distinction (College Manual Amendment)
Resolution 6 Fellowship Designation for Maturing ACEP Leadership

Resolutions Defeated (D) or Withdrawn (W)

Resolution 15 Young Physician Position on the ACEP Board of Directors (D)
Resolution 18 Availability of On-call Specialists (D)
Resolution 19 Withdrawn prior to meeting (W)

Non-Bylaws Resolutions

Requires a 3/4 vote is required to amend or overrule.
Resolution 7 LLSA "Readings" Member Benefit (as amended)
Resolution 8 ACEP's History (as amended)
Resolution 16 Universal Basic Health Care (as amended)
Resolution 17 Restoration of ED On-call Services (as amended)
Resolution 20 Psychiatric & Substance Abuse Patients in the ED (as amended)
Resolution 21 Selective Triage for Victims of Sexual Assault to Designated Exam Facilities (as amended)
Resolution 22 Egregious Testimony (as amended)
Resolution 23 Advocating for CENs in Departments of Emergency Medicine (as amended)
Resolution 24 Emergency Department Leadership (as amended)
Resolution 25 Redefining the Front End Process to Optimize ED and Hospital Flow (as amended)
*Resolution 26 Deferral of Care for ED Patients (by substitution)
*Resolution 27 Responsibility for Admitted Patients (as amended)
Resolution 28 Psychiatric Bed Availability (by substitution)
Resolution 29 Procedural Sedation (as amended)
Resolution 30 In Memory of Daniel T. Schelble, MD, FACEP
Resolution 31 Commendation for John D. Bibb, MD, FACEP
Resolution 32 Commendation for Arthur L. Kellermann, MD, FACEP
Resolution 33 Commendation for Robert E. Suter, DO, MHA, FACEP
Resolution 34 In Memory of Russell Keith Miller, Jr., MD, FACEP
Resolution 35 Commendation for Disaster Responders
Resolution 36 Commendation for Emergency Physicians of the Gulf Coast Region
Resolution 37 Commendation for Sonja Montgomery

Board action on Res 26(06) & 27(06) was deferred until the January Board meeting, therefore these are not as yet official College policy. All other Council adopted resolutions, including those that follow, were ratified.

Bylaws Resolutions

Requires a 2/3 affirmative vote of the Board of Directors for adoption.
Resolution 4 Fellow Emeritus (as amended)
Resolution 9 Executive Committee (as amended)
Resolution 10 Nominating Committees & Housekeeping Changes Re: Chair
Resolution 11 Number of Officers – Housekeeping Change
Resolution 12 Board Chair – Housekeeping Change
Resolution 13 Chair Recall and Vacancy
Resolution 14 Annual Council Meeting Notice

College Manual Resolution

Requires a simple majority vote for adoption.
Resolution 5 Eligibility Criteria for Fellow Emeritus

The following resolutions Adopted by the 2006 Council Require ACEP Board Action prior to being instituted. (This is a selected list of some of the more relevant resolutions – it is not a complete list – visit the ACEP website for a complete listing).

Resolution 4 Fellow Emeritus (as amended)

RESOLVED, That the ACEP Bylaws, Article V – Fellowship be amended by the addition of a new Section 3 – Fellow Emeritus to read: ARTICLE V – FELLOWSHIP, Section 3 – Fellow Emeritus Members in good standing who are either [emphasis added] fellows or former fellows who are ineligible for another class of fellowship may be elected by the Board of Directors to Fellow Emeritus status. A Fellow Emeritus shall be authorized to use "FACEP (Emeritus)" in conjunction with professional activities. Fees, procedures for election, and reasons for termination of Fellow Emeritus status shall be determined by the Board of Directors.

Resolution 5 Eligibility Criteria for Fellow Emeritus

RESOLVED, That the ACEP College Manual be amended by adding the following section:

Eligibility for Fellow Emeritus. To be eligible for election, a member must:

1. Be nominated by a member, chapter or section, or be self-nominated.
2. Have made a significant contribution to and enhanced the profile of the College or the specialty of emergency medicine through their professional and personal endeavors.

Resolution 7 LLSA "Readings" Member Benefit (as amended)

RESOLVED, That ACEP actively pursue procurement of the American Board of Emergency Medicine "Life-Long Learning and Self Assessment" annual "readings" as a member benefit; and be it further RESOLVED, That ACEP, using its vast member expertise, explore the feasibility of developing American Board of Emergency Medicine "Life-Long Learning and Self Assessment" annual "readings" summaries as a member benefit; and be it further RESOLVED, That ACEP actively seek ways to provide more "value added services" to members.

Resolution 16 Universal Basic Health Care (as amended)

RESOLVED, That ACEP adopt as policy and provide financial, personnel, and political support for selected federal legislation or state legislation or initiatives that supports the vision to maximize the health of the population by creating a sustainable system which reallocates the public resources spent on health care in a way that ensures universal access; and be it further RESOLVED, That ACEP establish a liaison with the Archimedes Movement.

Resolution 17 Restoration of Emergency Department On-Call Services (as amended)

RESOLVED, That ACEP develop a comprehensive national plan to restore emergency department on-call services that addresses all pertinent elements of the on-call crisis, including but not limited to hospital, medical staff and payer accountability, appropriate compensation, liability reform, and workforce requirements, under the principle that emergency care is an essential public service.

Resolution 20 Psychiatric and Substance Abuse Patients in the Emergency Department (as amended)

RESOLVED, That ACEP provide guidance to states and chapters to respond to issues related to psychiatric patients and patients seeking treatment for substance abuse who present to the Emergency Department including adequately providing community resources for care, support for emergency physicians treating these patients, and the development of talking points to facilitate efforts to respond to the needs of this patient population.

Resolution 21 Selective Triage for Victims of Sexual Assault to Designated Exam Facilities (as amended)

RESOLVED, That ACEP supports the collection of forensic evidence (performance of evidentiary examinations) by specially educated and clinically trained personnel when available and appropriate; and be it further RESOLVED, That ACEP supports the development and funding of additional Sexual Assault Nurse Examiner (SANE)/ Sexual Assault Response Team (SART) programs.

Resolution 22 Egregious Testimony (as amended)

RESOLVED, That the ACEP Board of Directors publicize the names of members receiving public censure, suspension, or expulsion as a result of having given clearly egregious expert witness testimony; and be it further RESOLVED, That the ACEP Board of Directors develop a process for notifying the appropriate specialty society or licensing board when an episode of alleged egregious testimony by any individual testifying as an expert in emergency medicine is identified.

Resolution 23 Advocating for Certified Emergency Nurses (CENs) in Departments of Emergency Medicine (as amended)

RESOLVED, That the American College of Emergency Physicians support the efforts of the Emergency Nurses Association (ENA) and the Board of Certification for Emergency Nursing (BCEN) regarding defining standards of emergency nursing care and the provision of resources, support, and incentives for emergency nurses to be able to readily attain Certified Emergency Nurses (CEN) certification.

Resolution 24 Emergency Department Leadership (as amended)

RESOLVED, That ACEP develop a policy statement which states the ED medical director or chair should have oversight over all aspects of the practice of emergency medicine in an ED.

Resolution 25 Redefining the Front End Process to Optimize Emergency Department & Hospital Flow (as amended)

RESOLVED, That the American College of Emergency Physicians (ACEP) develop a position paper which defines optimal emergency care related to the "Front End" processing of patients presenting to an ED.

Resolution 26 Deferral of Care for Emergency Department Patients (by substitution)

RESOLVED, That the ACEP Board revise the policy "Medical Screening of Emergency Department Patients" to state that ACEP strongly opposes deferral of care for patients presenting to the ED; and that in situations in which it is required that patients be deferred, very specific and concrete standards must be adopted by the hospital to ensure patient access to an alternative setting and timely, appropriate treatment. [Not official College policy. Implementation postponed by the Board until January 2007.]

(Continued on page 7)

Advocacy in the Fast Lane Part Two

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

Last EPIC, I gave you a brief overview of issues that are currently being hotly debated at the national advocacy level. These issues included the Access to Emergency Medical Services Act, Medicare Reform and the Sustainable Growth Rate, ER One, and the Institute of Medicine emergency medicine reports.

I hope I scared you a little, realizing that these are big problems, as well as big opportunities to change things for our future. Here is my list of five ways to become a political advocate for emergency medicine while not getting in trouble with the military and still maintaining some semblance of a life outside medicine.

Write to your Congressman

The ACEP website at http://www.acep.org/webportal/Advocacy/ has links you can click on to write a letter to your legislators. All you have to do is go to the website, pick your topic (i.e. Access to EMS Act, Medicare reform, liability reform), and the website will take you to a preformed letter to your legislator. You type in your name, address, and with the click of a mouse you've sent either an e-mail or a paper letter to your elected official, expressing your concerns and urging them to do the right stinkin' thing. It's quick, painless, and to my experience has not resulted in any more junk emails in my inbox.

Actually speak to your Congressman

Our stories, our experiences are very powerful to our elected officials. While I was at the Leadership and Advocacy Conference, I was able to schedule appointments to talk to my Representative and Senators from my home state of Oregon. The ACEP website has talking point papers, so all you add is some personal anecdotes and you sound like a superstar. You may end up talking to a legislative advisor, but these people have immense power to influence decisions for their lawmakers, so take advantage of the opportunity to talk to them.

You can also make appointments to see your members of Congress while they are in their home states, as well as invite them to tour your emergency department. One hour on a busy evening shift would open a lot of legislative eyes to the problems we have in our emergency departments.

Letter to the Editor

Dash off a quick letter to the editor of your local newspaper or favorite magazine, urging them to become involved in the push to improve emergency care. You can get a lot of legs out of this effort, as the same letter can be used several times. Again, just tell your story, and why you think people should care if their loved ones stay in the waiting room 11 hours prior to being seen.

Too lazy to write a letter to the editor? Check out www.emra.org and join their Letter to the Editor campaign. The legislative advisor, Yogin Patel, has created several very well written letters that you can sign your name to and email to the publication of your choice.

Donate to NEMPAC

The National Emergency Medicine Political Action Committee is a fundraising organization with the sole purpose of supporting ACEP's legislative agenda. Why should I have to pay politicians to do the right thing, you ask? NEMPAC doesn't do that. What NEMPAC does is support candidates who support emergency medical care, and provide monetary support to ensure that our issues are being heard on a national level.

Physicians are historically horrible at giving to political organizations. The average physician is somewhere along the lines of $35 per year. Trial lawyers, on the other hand, contribute an average of $1000 per year to political causes. Is it any wonder that the lawyers have the politicians' ears?

ACEP on the national level has instituted the "Give a Shift" program, urging each member to give one shift's worth of compensation in contribution to NEMPAC. However, as residents, I did the math and I think that one shift worked out to approximately $0.37. Rather than that, consider this: if you gave up 1 cup of mocha latte caramel frappuchino a week, you could contribute $100 per year. That pesky recurrent SVT might go away as well. To contribute, go to http://www.acep.org/webportal/Advocacy/nempac/.

Serve on a Task Force

Do you read this column every few months and snicker, thinking I'm a sucker to take on this extra work? No way you'd sign away a year of your life to toil for health care reform and the greater human good. Never fear, there are short term, low pain solutions.

EMRA's website lists multiple different task forces and committees you can become involved with, as well as those offered by ACEP. These task forces have a few meetings via conference calls and assign small items that can usually be completed in a few hours time. These committees, however, tackle big issues like the Institute of Medicine report, technology in the ED, and critical care credentialing. Find one in an area that interests you, and they will be thrilled to have extra hands on the project.

Very few people have the patience and drive to pursue political advocacy on a full time basis. However, if each of us would take just one of the above ideas per year and contribute a few minutes of time, our power to create change would be enormous. Just a few minutes, that's all it takes.

GSACEP Welcomes

The following people have joined the chapter since the last issue of EPIC. If you are new to GSACEP, we urge you to *please sign up on our website*, www.gsacep.org so that you may start receiving our member e-mails. It only takes a minute, and we do not sell the list to anyone.

Michael A.B. Akerley	Candidate
Richard Amesquita	Candidate Member
Juan Aviles	Candidate
Grace N. Ayafor	Candidate
Todd Baker, MD	Active Member
Sarah M Battistich	Candidate
Rebecca Bavolek	Candidate
Stephen Beckwith, MD	Candidate
John Bisges	Candidate
Ryschelle Bolton	Candidate
Andy Brainard	Candidate
Eric Brown	Candidate
Julie Buchner	Candidate
Daniel Chang	Candidate
Wayne D Charters, MD	Active
Meghan Checkley, MD	Active
William Chickering, MD, MPH	Active
Johnathan Clark, MD	Active
Lisa O. Clark	Candidate
Enesha Cobb	Candidate
Ian Cole	Candidate
Laura Cook	Candidate
James M. Dahle, MD	Active
Halcycane Dardaine	Candidate
Neil B. Davids	Candidate
David Durkovich, DO	Candidate
Lara De Nonno, Md	Candidate
Michael Thomas Dorrity, MD	Candidate
Stacy Einerson	Candidate
Eric Farabuagh, MD	Candidate
Robinson Ferre, MD	Active
Katina Fosen, MD	Candidate
Veronica Franklin	Candidate
Sanda Gelle, MD	Active
Marcy Gillespie, MD	Active
Mark Goldstein	Candidate
Megan Guest	Candidate
Michael Hampton, MD	Candidate
Camilio Gutierrez, MD	Candidate
Erin Heritage	Candidate
Christine Herr	Candidate
Evann Max Herrell, DO	Candidate
Nadim Islam, MD	Active
Richard Kowalczyk	Candidate
Niko Keys, MD	Active
Buddy Kozen, MD	Candidate
Lambert Laperouse,Jr.	Candidate
Jarone Lee	Candidate
Kayla Long	Candidate
Lanny Littlejohn, MD	Candidate
Jyh I J Lu	Candidate
Vip Mangalick	Candidate
Brandon Mahurin	Candidate
Christy McKenna	Candidate
Ryan Mihata, MD	Candidate
David Narunatvanich, MD	Active
Erik Oberg, MD	Candidate
Cynthia Obi	Candidate
Joseph Pendon, MD	Active
John Perona, Jr	Candidate
Elizabeth Plummer	Candidate
John T. Powell, MD	Candidate
HJulie Query	Candidate
Teresa Saultes	Candidate
Robert Spence	Active
Jeremy Spencer	Candidate
Joseph Spinell	Candidate
Sarah Sommerkamp	Candidate
Christian Stob, DO	Candidate
Ginger Swiderski	Candidate
Carly Tarr	Candidate
Eric Tomich	Candidate
Michael Tupper	Candidate
Scott Vandehoef, MD	Candidate
Michael Tupper	Candidate
Nikki Vasconcellos	Candidate
Jessica Walsh	Candidate
Robb Wiegand, MD	Candidate
Michael J White	Candidate
Holly Wilson, MD	Candidate
Patrick Wolfe, DO	Active
Rothsovann Yong	Candidate
Elif Yucebay	Candidate
Joseph Zaremba	Candidate

Research Point of Contacts

United States Army Medical Research Institute for Infectious Diseases (USAMRIDD)
MAJ Kermit Huebner
kermit.huebner@us.army.mil

Uniformed Services University of the Health Sciences
MAJ Chetan Kharod
ckharod@usuhs.mil

US Army Institute of Surgical Research (USAISR)
LTC John McManus
John.mcmanus@amedd.army.mil

Department of Combat Medic Training (DCMT)
MAJ Peter Cuenca MD
Peter.Cuenca@CEN.AMEDD.ARMY.MIL

Navy
Naval Medical Center Portsmouth
Department of Emergency Medicine
Research Director: Mark A. Kostic, MD FAAEM
ACMT
MAKostic@mar.med.navy.mil

Naval Medical Center San Diego
Department of Emergency Medicine
Research Director: LCDR Michael J. Matteucci MD
mjmatteucci@nmcsd.med.navy.mil

Air Force
Wright State University (affiliated with Wright Patterson Medical Center)
Research Director: John Wightman, MD

Army
Carl R. Darnall Army Medical Center
Research Director: MAJ Alex Rosin
Alex.Rosin2@CEN.AMEDD.ARMY.MIL

Army and Air Force
San Antonio Uniformed Services Health Education Consortium (SAUSHEC)
Emergency Medicine Residency Program
Research Director: LTC Robert Gerhardt MD, PhD
Robert.Gerhardt@CEN.AMEDD.ARMY.MIL

Council Actions *(continued from page 5)*

Resolution 27 Responsibility for Admitted Patients (as amended)
RESOLVED, That ACEP create a policy that regardless of the location of a patient within the hospital, the ultimate responsibility for a patient's care rests with the admitting physician once the patient has been admitted. [Not official College policy. Implementation postponed by the Board until January 2007.]

Resolution 28 Psychiatric Bed Availability (by substitution)
RESOLVED, That ACEP work with appropriate organizations to study the impact of psychiatric bed availability on emergency departments and EMS and seek solutions to problems identified; and be it further RESOLVED, That the ACEP Section Council to the American Medical Association (AMA) bring this issue to the AMA House of Delegates at the 2007 annual meeting.

Resolution 29 Procedural Sedation (as amended)
RESOLVED, That ACEP modify its existing policy regarding Procedural Sedation and Analgesia in the ED to state that emergency nurses are trained qualified personnel to administer all agents for procedural sedation under the direct supervision of emergency physicians; and be it further
RESOLVED, That ACEP oppose efforts by other professional organizations or nursing boards to restrict the supervised administration of sedating agents by emergency nurses.

Note: The information in this article was abstracted by LTC(P) Robert A. De Lorenzo, Immediate Past-President, GSACEP, from an October 16, 2006 ACEP memo from Todd Taylor, MD, FACEP, Council Speaker and Bruce MacLeod, MD, FACEP, Vice Speaker regarding the 2006 Council actions. Many thanks to the Council leadership for communicating the Council's successes to the chapters.

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

WWW.GSACEP.ORG

Fall 2006

A Chapter of the American College of Emergency Physicians

Government Services EPIC

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

President's Message

LTC John McManus, MC, USA

WELCOME NEW RESIDENTS!

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

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

Some of the resources that GSACEP offers include:

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

What's Going On?

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

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

Final Thoughts

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

In This Issue

GSACEP Welcomes

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

Memorial Day in Baghdad

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

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

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

Congrats

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

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

Dear Fellow Councillors:

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

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

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

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

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

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

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

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

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

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

Sincerely,

LTC John McManus MD, MCR, FACEP

President GSACEP

Important GSACEP Dates 2006-2007

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

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

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

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

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

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

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

Abstract Submission Requirements:

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

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

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

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

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

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

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

GSACEP Activities

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

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

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

GSACEP Reception (open to all GSACEP members)

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

GSACEP members speaking at SA:

MAJ Robert Blankenship, MD, FACEP,

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

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

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

LTC David A. Della-Giustina, MD, FACEP

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

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

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

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

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

Advocacy in the Fast Lane

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

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

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

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

Access to Emergency Medical Services Act

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

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

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

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

Medicare and the Sustainable Growth Rate

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

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

ER One

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

Institute of Medicine Report

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

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

GSACEP – A New Journal for a New Direction?

by LTC John McManus MD, MCR, FACEP

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

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

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

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

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

Emergency Medical Services Fellowship

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

GSACEP Member Takes Command

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

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

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

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

New Army Consultant-Elect to the Surgeon General

by LTC (P) Ian Wedmore, MC, USA

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

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

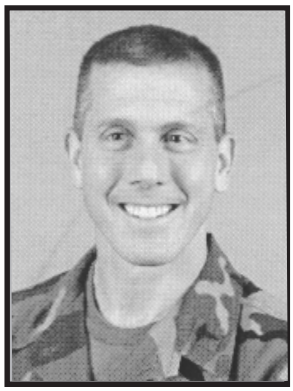
Army Emergency Medicine has and will continue to have many challenges over the next several years. Op-tempo will remain high. Emergency physicians can expect to be deployed, and graduating emergency physicians can expect to go to operational assignments. We continue to evaluate what type of electronic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

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

LTC(P) Ian Wedmore, MC, USA

Should Residents Deploy?

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



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

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

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

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

> *"Military emergency medicine residents are essentially training for the wartime mission. So, it makes sinse to provide a relevant educational opportunity."*

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

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

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

ACEP Board of Directors Update

by Col Linda Lawrence, Vice President ACEP

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

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

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

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

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

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

GSACEP Members on ACEP Committees 2006

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EDUCATIONAL MEETINGS COMMITTEE
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EMS COMMITTEE
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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.

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A Chapter of the American College of Emergency Physicians

Government Services EPIC

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.

Contents

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!

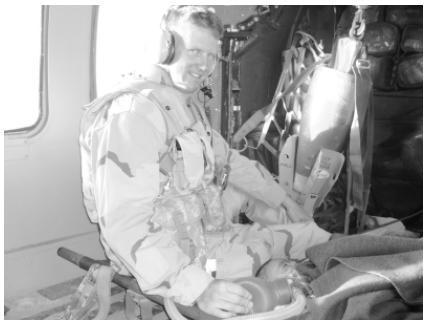
It takes a long time to develop leaders. Emergency medicine is still a relatively young specialty but we have been in existence long enough and have achieved a level of notoriety and respect as a specialty so that we are beginning to see career emergency physicians branching out and leading on the national 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

continued on page 6

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.

continued on page 6

Mission in Afghanistan

continued from page 5

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

continued from page 4

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 UniversityÕs 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 organizationÕs 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 ÒBest Practices to Reduce Boarding of Patients in the EDÓwhere 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 Òextended ED observation unitÓthat 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 Òprotected Óor 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 - (conÕt)

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!

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

WWW.GSACEP.ORG

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

Spring 2009

A Chapter of the American College of Emergency Physicians

Government Services EPIC

President's Message

Greetings to all,

It is my privilege to be able to speak to you through this first issue of the 2009 Epic. The 2009 year has begun with a bang as this year's Joint Services Symposium on the River Walk was an incredible success. We were able to bring together a very talented group of speakers to help further everyone's education. The curriculum was one of the best that I have seen to date. This is in great part to the incredible work of LTC Torres. Thanks also to MAJ Brad Younggren who developed the Ultrasound Courses. The attendance was the highest in many years. I want to personally thank all of the speakers and attendees that made this venture such a wonderful success. But our work is not done; preparations have started for the 2010 Joint Services Symposium. Next year we will be travelling to Lake Tahoe for the first time. The conference committee is beginning the preparatory work to plan for this event.. Everyone should mark their calendars as we hope that everyone will join us on the slopes of Lake Tahoe between 11 and 15 April 2010 for another incredible conference.

The month of April will bring new opportunities for growth for our up and coming leaders within the chapter. We are very pleased to announce that GSACEP will be sponsoring the attendance of three residents to the annual Leadership and Advocacy conference in Washington, DC. The selection was performed by members of the Board of Directors, and I must say it was very difficult choosing our winners as we had such an incredible pool of applicants.

For all who are deployed or will be deploying a new benefit has been made available to you. Thanks to the Sullivan Group free CME is now available to those deployed. For more information, please see our website.

During the next year we look forward to working for all our members ensuring that your voices are heard within National ACEP. I also want to thank all of our members as you are the true core of the chapter, but at the same time I would like to challenge EVERYONE to get involved in helping improve our profession. The sky is the limit with the talent that our chapter hosts, if you have any ideas of areas to improve our chapter, please contact myself at jrlairet@pol.net or our Executive Director Bernadette Carr at GSACEP@aol.com.

Regards,

Julio Lairet, Maj, USAF, MC

In This Issue

The President-Elect's Column
Maj Melissa Givens, MC, USA

I am still riding the energy high that infected me at JSS in San Antonio. What a phenomenal conference! I want to extend a special thank you to LTC Ron Torres for producing such a well-orchestrated meeting. JSS will move to Lake Tahoe in 2010 (April 11-15) so I already put it on my calendar and I encourage you to do the same. While you are coordinating your schedule for the conference, ask the others in your department if they are GSACEP members. A trip to Lake Tahoe and an outstanding conference is a great way to introduce someone to the GSACEP chapter.

I'm honored to serve as President-Elect, especially for a group of physicians who are boundless in terms of contributions to the government services and the practice of medicine. Thank you for entrusting me with this opportunity. For those I have not had the opportunity to meet . . . yet . . . here is a little background. I am a native of North Dakota, did my undergraduate degree at The United States Military Academy (ring knocker) and medical school at USUHS (proud Rugby team alumni). I came to EM via a Family Medicine internship at Ft Belvoir, VA and a two-year GMO tour with the 1st Cavalry Division at Ft Hoot with a side trip to Bosnia for the better part of one of those years. I did residency at SAUSHEC and then decided I needed more Army commitment so I did a toxicology fellowship at University of Texas Southwestern Medical Center. After fellowship, I had the pleasure of working as the assistant Residency Director at Madigan Army Medical Center and that opportunity provided the springboard to my current job as Residency Director at Carl R. Darnall Army Medical Center, Fort Hood, TX.

I am writing this brief column three days before I take my Army-sponsored vacation in Baghdad. I am excited to deploy again and see the advances in medicine that are occurring in theater. JSS highlighted the strides Emergency Medicine is making in terms of practice enhancement in the combat environment. There has never been a better time to collaborate and take advantage of the wealth of operational experience within our field. This is also a unique opportunity to build relationships between our DoD hospitals and the VA as the patients we care for transition between these organizations.

We have a lot to look forward to in the next year. I challenge all GSACEP members to get involved in chapter activities. For those that are already actively involved, mentor a new member and identify his or her area of expertise that contributes to the chapter. Cruise the GSACEP website and see all the services the chapter has to offer. Each of these products can be attributed to the hard work of GSACEP members who saw a need and worked to resource that need.

I look forward to my tenure as President-Elect. Please feel free to contact me anytime with questions or concerns. My email is melissa.givens@us.army.mil.

The opinions and assertations 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.

The 2009 Resident Leadership Award Winners

The GSACEP Board of Directors reviewed submissions of all three services and selected the following residents as recipients of the 2009 Leadership Award:

LCDR Amy Hubert, MD - NMC Portsmouth, VA

LCDR Lanny F. Littlejohn, MD - NMC Portsmouth, VA

CPT Cameron Olderog, MD - SAUSHEC, San Antonio, TX

Congratulations to the recipients who will attend the ACEP Advocacy & Leadership Conference in Washington, DC, April 19-22. GSACEP pays transportation, hotel and per diem for these future leaders.

The 2009 Research Forum Winners

Best Resident Poster Presentation: Becky Abell, MD, SAUSHEC EM - Rapid, Field Deployable Diagnostics to Fight the War on Dengue

Best Attending Poster Presentation: Brandon K. Wills, MAJ, MC, Sean Bryant, MD, Peter Buckley, LTC, MC, Benjamin Seo, MD - Prevalence of Metformin-associated Lactic Acidosis in Acute Overdose - Madigan Army Medical Center

Best Resident Oral Presentation: Jeffrey Lightfoot, MD, Michael Juliano, MD - Resident Performance in the Setting of Indeterminate First Trimester Ultrasounds - Naval Medical Center Portsmouth, Portsmouth, VA

Best Attending Oral Presentation: Vikhyat Bebarta, MD, Julio Lairet, DO, Patricia Dixon, MS, Anneke Bush, PhD, Rebecca Pitotti, RN, BSN, David Tanen, MD - Hydroxocobalamin And Sodium Thiosulfate Versus Sodium Nitrite And Sodium Thiosulfate In The Treatment Of Acute Cyanide Toxicity In A Swine (Sus Scrofa) Model - SAUSHEC EM

Reflections on my Deployment
by Maj Nora Gerson, USAF, MC

Dr. Gerson recently completed her deployment in Iraq. She is now at Wright-Patterson. She was stationed at Joint Base Balad in Iraq with the 332 AEW/EMDG.

Dr. Annette Williams and Dr. Gerson

Hardest:

1) Several times we received a critically injured patient and discovered that they had non-survivable brain injuries. Unless we were busy with incoming traumas, these patients were usually kept in the trauma bay for comfort care measures until they passed. Although I certainly understood that I would face moments such as these, it never got any easier to sit back and allow them to pass when every bit of me wanted to try and jump in to resuscitate them. It is easy to stay focused on being the "doctor" when there is something we are actively doing to save their lives but I slip into "mommy/sister/daughter" role when the decision has been made to provide comfort care only. I have stood by the gurneys of several patients, holding their hand, stroking their hair, cleaning their faces off, saying a silent prayer for peace for the patient and their family members for several minutes or even hours as they passed.

2) Losing any patient or learning that they only made it to the states to have care withdrawn. It does, however, provide some comfort to realize that the patient made it home to be surrounded by their families and allow the families a chance to say "goodbye."

3) Compartmentalizing grief over the patient we could not save was especially difficult when providing routine, non-emergent care for a detainee caught doing something detrimental to our troops. I believe I successfully did that and provided care to each of these patients to the best of my ability but, sometimes, after a shift like that, I have to remind myself that our young men and women are here fighting and dying to provide the freedom to the people in this country--regardless of people's feeling towards us--and to protect our families at home.

4) Missing my family and friends. Watching my children grow through the webcam. Not being able to be there when my children are not feeling well or sad to comfort them. I guess I found it a bit comical to realize that I was actually feeling bad that I couldn't be there to get puked on when all three of the girls had N/V/D around Thanksgiving. (smile)

"Suck it up and carry on" moments: (these are accurate descriptions but only shared for comic value)

1) Running sick call out of the ED. Actually, this was pretty easy for me to deal with. I just decided from day one that I would be here to support our troops--in any way I could. If that could be done simply by prescribing some Sudafed for their common cold or Motrin for their menstrual cramps, I would do it as cheerfully as possible.

2) Standing on the flight line in 100+ degree heat with full IBA and 40 lb back pack over winter-weight ABUs with no dry spot on my body or clothes trying to get on board a C-130 to fly to Balad and the line stopping while I am halfway up the ramp of the arse-end of the plane with a friend holding on to my uniform to keep me from falling over backwards on the ramp.

3) Coming out of the shower cadillacs in a dust storm and feeling like a powdered donut by the time you reach your hooch since the dust clings to damp skin.

4) Being "groped" by a shower curtain when you tried to avoid that contact at all cost.

5) Salisbury steak or grilled chicken again???

6) Wading through ponds and mud during the rainstorm to get to the gym or work.

7) Dressing up like an insurgent to make it back to your hooch without an eye or lung injury from swirling dust.

8) Discovering that sometimes our patients are much more creative in their attempts to get intoxicated than I initially gave them credit for.

9) Sand flies biting me and leaving welts.

10) Getting two entirely different patient histories by two different interpreters---on the same patient.

11) Having a military working dog as a patient.

12) Getting your "whites" back from the laundry to find that they are now a lovely shade of brown/green. Finding out that your underwear is missing but now you have those that belong to someone else in your bag. Hmmmm.....

Favorable memories/moments:

1) Making a difference, no matter how small, to make someone better. There is simply never a greater reward here than realizing that you were part of a team that brought a patient home alive to their family.

2) Making friends and enjoying the camaraderie of my colleagues.

3) Fulfilling my obligations to our profession, our service, and our country.

4) Realizing how blessed I am, especially to have having the friends and family that I do.

5) The comedy routine of Major Aaron Quinn, Lt Brad Clower, and SrA Emilio Martinez. You just have to experience this yourself to appreciate it.

6) Realizing that I am not only a good emergency medicine doctor but a good military doc as well and it is my future to stay in for the long haul.

7) The present my girls made and sent me for Christmas. It was a white shirt box that was decorated with lots of finger paint and glitter by my daughters. Although the box may seem empty, it was stuffed full of love that I could keep and hold close whenever I needed it.

8) Getting my mission home assignment on Christmas day and then booking the trip to Disneyworld that I am surprising my girls with when I get home!

Your Resident Representative
By Capt Joseph D. Novak, USAF, MC

I am excited to begin my two-year tenure as the new Resident Representative to GSACEP, and I would like to start by briefly introducing myself. My military career began in 1994, when I joined the ROTC program at Cornell University. It was a great unit with a very strong Tri-service legacy and sense of community. Four years later, after earning degrees in engineering I found myself at a joint-NATO pilot training program. I then went on to fly the F-15C and flew sorties throughout the world including in Iraq with Army, Navy, and coalition forces. Later, I attended medical school at the University of Chicago, and I am currently an intern at the joint Army-USAF SAMMC EM program in San Antonio.

I feel that the Resident Representative has several roles. My first job is to represent the views of the resident members of GSACEP to the Board. This involves two way communications between the Board and the resident members of GSAEP. I plan on utilizing the web to disseminate high-yield information and to solicit feedback on initiatives and policy. Second, I will ensure that I advocate for policies that concern us all. Regardless of our long term career plans, policies being put into place now will affect us on the line and beyond. This is why it is critically important that the Resident Representative position exists, and through advocacy for residents, I plan on protecting our interests.

My focus for this first year is to increase chapter membership, communication, and coordination. Regarding membership, I plan on first focusing on ACEP members who are not GSACEP chapter members, then on those residents who are not ACEP members. In this day of sweeping healthcare policy change, I believe that ACEP membership sells itself and I hope to convey this to non-members. Increasing communication among chapter residents is also very important. There is a tactical significance to this. Deploying often requires working with a multitude of different agencies in very trying circumstances. Whenever I deployed and saw familiar faces from pilot training, Red Flag, or elsewhere, this immediately made things easier. A common background and language was called upon to increase mission effectiveness and make life easier. This is what GSACEP provides for us and this role cannot be understated. With the ops tempo at a shocking rate and the consolidation of DOD healthcare resources moving forward it is up to organizations like GSACEP to do what they can to make things easier. Finally, I would like to increase coordination within the chapter. The annual convention has been a great vehicle for communication and coordination for years. Another opportunity for increased coordination that we cannot lose sight of is the opportunity to conduct research among our different programs. The data that exists from the recent conflicts and that is being created within our individual programs is a gold mine of knowledge that cannot be lost between the cracks. Working together as a chapter, I believe we can facilitate harnessing more of this data for the good of our patients.

I look forward to the coming years and would love to hear from you. Please e-mail me with any questions or concerns at joseph.novak@lackland.af.mil. It is a privilege to be a part of GSACEP, thank you for voting me in as your Resident Representative.

Sincerely,

Capt Joseph Novak

Col Lee E. Payne
2009 Recipient
of GSACEP Excellence Award

Col Lee Payne, USAF MC, Commander of the David Grant Medical Center, Travis AFB, CA, was voted the recipient of the GSACEP Excellence in Military Emergency Medicine Award. Col Payne was presented with the award at the GSACEP Chapter Lunch on February 10 in San Antonio.

After completion of his medical training at Vanderbilt University, Col Payne completed his residency at The University of Colorado Health Science Center. He entered Active Duty in 1987. His first assignment as an Air Force emergency physician was at Madigan Army Medical Center Dept. of Emergency Medicine. After five years at MAMC, he went to Wilford Hall as a staff EM physician and later became the Chief, Acute Care Division. In the eight years when his career was focused on emergency medicine, he participated in grant funded research, presented at multiple conferences and published. He was an active leader in GSACEP serving on the Board as Alternate Councilor to ACEP.

In 1995 Col Payne's military career took him down the Command track causing him to leave the full-time practice of EM. This aspect of his career would include three tours as MTF Commander including his current assignment as Commander David Grant Medical Center, the second largest MTF in the Air Force Medical System. He has also served as USCENTAF Command Surgeon where his EM background helped him be a strong advocate promoting military medical operations with the proper focus on trauma and critical care management.

In his current assignment he has found time to remain clinically active as an EM physician, re-engaged with GSACEP, serving as an alternate and then regular Councillor since 2006 and member of the GSACEP Board of Directors. He has maintained his ABEM certification throughout his career. He is also nationally active as a member of the ACEP Quality & Performance Committee since 2007.

Col Lee Payne is a respected role model for emergency medicine doctors, especially in the Air Force. He has demonstrated that is possible to ascend to leadership positions et remain true to one's roots as an emergency physician. His commitment to emergency medicine is demonstrated by his continuous ABEM certification and return to leadership and clinical EM when his career brought him back to a hospital setting. His participation in organized EM while executing the highly demanding job as MTF Commander is impressive.

There are few who find the ability to balance the demands of military leadership and, yet, in the later years of their career still volunteer to be a leader within their own specialty. Col Payne's career impact has been felt beyond the Air Force which is why he was chosen for the Triservice recognition.

Academic Announcements Grants

COL Robert A. De Lorenzo, MD, MSM, FACEP has received over one million dollars in combined grants for the study of combat casualty care. He recently received $450,000 in grants from US Special Operations Command for a demonstration of bedside ultrasound to detect pneumothorax and an engineering design of a blast wave sensor. These are in addition to $600,000 in active grants from the Telemedicine and Advanced Technology Research Center to study intraosseous infusion physiology, ultrasound estimation of fluid status, and diagnostic screening and biosurvelillence of respiratory pathogens. Dr. De Lorenzo is a senior research fellow at Brooke Army Medical Center, Fort Sam Houston, Texas, and a Professor of Military and Emergency Medicine at the Uniformed Services University of the Health Sciences.

Abstracts Presented at The Joint Services Symposium 2009

Title: **Comparison of four hemostatic agents, CELOX-A™ , ChitoFlex®, WoundStat™ and Combat Gauze™, versus standard gauze dressing in control of extremity hemorrhage in a limited access swine model of penetrating combat trauma.**

Naval Medical Center, Portsmouth, VA IRB/IACUC protocol (CIP # P08-045).

Primary Investigator and POC: Lanny F. Littlejohn, MD Emergency Medicine Resident (PGY-4) lanny.littlejohn@med.navy.mil **Assistant Investigators**: John J. Devlin, MD, Sara S. Kircher, BS, RLAT, Robert Lueken, MD, Michael R. Melia, MD, Andrew S. Johnson, MD, Department of Emergency Medicine, Naval Medical Center, Portsmouth

Study Objectives: Exsanguination from extremity wounds remains the leading etiology of preventable combat death. We conducted a randomized, prospective, unblinded trial to investigate the efficacy of the most commonly used hemostatic agents in a model of severe vascular injury with mixed high pressure arterial and venous bleeding in a small, linear tract wound that was designed to replicate a penetrating injury from a projectile such as a rifle round or shrapnel where the bleeding site cannot be directly visualized.

Methods: A complex groin injury with transection of the femoral vessels through a 3 cm entrance wound and 45 seconds of uncontrolled hemorrhage was created in 40 swine prior to randomization to 5 groups. Group 1 included standard gauze (SD); Group 2 Celox (CX); Group 3 Chitoflex (CF); Group 4 Combat Gauze (CG); and Group 5 WoundStat (WS). Each agent was applied with 5 minutes of manual pressure prior to resuscitation.Hemodynamic parameters were recorded over 180 minutes. Primary endpoints included incidence (failure of initial hemostasis) and amount of rebleeding.

RESULTS: Rebleeding was seen in 3 of 8 (38%) CX, 3 of 8 (38%) CF, 1 of 8 (13%) CG, 3 of 8 (38%) WS, and 2 of 8 (25%) SD subjects. Post-treatment hemorrhage (rebleeding) volume was 6.088 ml/kg for CX, 7.009 ml/kg for CF, 5.266 ml/kg for CG, 11.148 ml/kg for WS, and 5.576 ml/kg for SD subjects. Sequential sampling indicated a trend toward significance between CG subjects and WS subjects (p=0.133).

Conclusions: Our study demonstrated no statistically significant differences among the five treatment arms in the primary outcomes measured. To determine if the observed trend continues, and thus a difference exists, sampling will be extended to enlarge the current sample size. Keywords: hemostatic agent; trauma; combat; hemorrhage; swine

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Prospective Randomized Trial of Antibiotic Treatment for Uncomplicated Skin Abscesses in Patients at Risk for Community Acquired Methicillin-Resistant Staphylococcus Aureus Infection.

Timothy Livengood, MD, CPT, USA[1]; Gillian Schmitz, MD[2]; Cameron Olderog, MD, CPT, USA[1]; Justin Williams, MD[3]; Michael Barakat, MD, Capt, USAF[2].

[1]SAUSHEC Emergency Medicine Residency, San Antonio, Texas. [2]Wilford Hall Medical Center, San Antonio, Texas. [3]Brooke Army Medical Center, San Antonio, Texas.

Study Objective: Community-acquired methicillin-resistant Staphylococcus aureus (cMRSA) abscesses have been increasing in prevalence in the emergency room. Retrospective studies have had mixed results in determining whether or not antibiotics improve outcome or decrease recurrence rates. One randomized prospective study using keflex failed to show antibiotics to be of benefit beyond incision and drainage (I&D) alone in treatment of uncomplicated abscesses, however keflex does not have activity against MRSA. Our study seeks to determine whether incision and drainage followed by the administration of trimethoprim-sulfamethoxazole, which has activity against cMRSA, may prevent recurrence of abscesses better than I&D alone.

Methods: Immunocompetent patients ages 18-55 with uncomplicated cutaneous abscesses were randomized either to receive I&D followed by one week of trimethoprim-sulfamethoxazole or to receive I&D alone. At the end of 30 days the patients were contacted by investigators who were blinded to the study groups and asked whether or not they had formed a new abscess. Recurrence was defined as a new abscess in the same or different location requiring additional incision and drainage or treatment. Results: 28 of the 31 patients initially enrolled were able to be reached on follow up at 30 days. 8.3% (1/12) of those who received I&D alone had a recurrence, while 0/16 of those who received antibiotics had a recurrent abscess. The prevalence of MRSA in this study group was 55% (17/31) and the only patient who had a recurrence was MRSA positive.

Conclusions: Our preliminary data suggests that antibiotics may have some benefit in the prevention of recurrence of cMRSA abscesses, but the sample size is too small yet to draw any conclusions as there was only one recurrence. A larger prospective trial using medications with activity against cMRSA is necessary to fully answer the question.

MRSA+	17			
Non-MRSA	14			
Abx	16			
	MRSA	9	Recurrence	0
	No MRSA	4	.Recurrence	0
	Unknown	3	Recurrence	0
No Abx	13			
	MRSA	7	Recurrence	1
	No MRSA	4	Recurrence	0

Title: Hydroxocobalamin and Sodium Thiosulfate Versus Sodium Nitrite And Sodium Thiosulfate In The Treatment Of Acute Cyanide Toxicity In A Swine (Sus Scrofa) Model

Authors: Bebarta, Vikhyat MD 2: Lairet, Julio DO 3: Dixon, Patricia MS 4: Bush, Anneke PhD 5:Pitotti, Rebecca 6: Tanen, David MD

Background: Hydroxocobalamin (HOCOB) is considered a more practical antidote for cyanide (CN) toxicity because of fewer serious adverse effects. No study has directly compared HOCOB and sodium nitrite (SN) with sodium thiosulfate (ST) in an acute CN toxicity model.

Objective: To compare the return to baseline of mean arterial blood pressure (MAP) between 2 groups of swine suffering from acute CN toxicity and treated with HOCOB+ST or SN+ST

Methods: 24 swine (38-42 kg) were intubated, anesthetized and instrumented (continuous arterial and cardiac output (CO) monitoring) and then poisoned with a continuous CN infusion (0.20 mg/kg/min), until severe hypotension (50% of baseline MAP). Animals were then randomly assigned to HOCOB (150 mg/kg) + ST (25 mg/kg) or SN (10 mg/kg) + ST (25 mg/kg) infused over 10 minutes and monitored for 40 minutes after start of antidotal infusion. Twenty animals were needed for 80% power (alpha 0.05). RMANOVA and post hoc t-test were used for determining significance.

Results: Baseline mean weights, time to hypotension (31 min 3 sec vs. 28 min 6 sec), and CN dose at hypotension (5.57 vs 5.91 mg/kg) were similar. One animal in the HOCOB and 2 animals in the SN group died during the study and were excluded from analysis.HOCOB resulted in a faster return to baseline MAP with statistically significant improvement beginning at 5 minutes and lasting through the conclusion of the study ($p < 0.05$). No statistically significant difference was detected between groups for CO, HR, SVR, or mortality. Mean CN blood levels (4.03 vs. 4.05) and lactate levels (peak 7.9 vs. 8.1 mmol/L) at hypotension were similar. Lactate levels (5.1 vs 4.48 mmol/L), pH (7.40 vs. 7.37) and base excess (-0.75 vs. 1.27) at 40 minutes were also similar.

Conclusion: HOCOB+ST led to a faster return to baseline MAP compared to SN+ST in this acute CN toxicity hypotensive swine model. Given HOCOBs lack of serious adverse effects, it may be the best choice in the treatment of acute CN toxicity.

Title: Bedside Emergency Ultrasound Training In The Dominican Republic

Type: Process Improvement, Poster – IRB oversight not applicable

Institution: Department of Emergency Medicine, Naval Medical Center, Portsmouth, 620 John Paul Jones Circle, Portsmouth, VA 23708

Primary Investigator: LCDR Jonathan E. Clarke, M.D., PGY-4 EM Resident, Jonathan.Clarke@med.navy.mil,(757)953-1365, DSN 388

Secondary Investigators: LCDR Michael Juliano, M.D., NMCP Attending Emergency Physician, Michael Owens, M.D., NMCP Attending Emergency Physician

Background: Use of bedside ultrasound as an aid for diagnostic and procedural purposes in emergency departments is quickly becoming standard of care in the United States. However, this modality remains underused in developing countries. Improved access to equipment and training in these settings may improve quality of healthcare.

Objective: Our aim was to provide formal training in bedside emergency ultrasound to residents of a newly founded emergency medicine program in a developing country. Prior to this course, there was limited instruction in bedside ultrasound and little practical experience among trainees.

Methods: We delivered a three day ultrasound course to 29 emergency medicine and general surgery residents at Hospital General Plaza de la Salud, Santo Domingo, Dominican Republic. This is an urban emergency department with approximate annual census of 35,000 patients. The course was proctored by two attending staff and five residents from our program, and consisted of lectures and hands on practical sessions with volunteer patients and procedural simulators. Topics included ultrasound physics, FAST, cardiac and critical care ultrasound, diagnosis of deep vein thrombosis, aorta, gallbladder, and renal disease, first trimester pregnancy, and ultrasound guided procedures.

Results: Informal surveys were completed by trainees to assess their knowledge and proficiency with emergency ultrasound before and after the course. Course feedback was very positive and all participants reported significant gains in their knowledge and practical skill in emergency ultrasound.

Conclusions: With improved access to equipment and ongoing formal training, the use of bedside emergency ultrasound in developing countries has the potential to positively impact the quality of healthcare.

Experience with Thrombolytic Use for ST Elevation Myocardial Infarction Among Emergency Medicine Residents in the United States

Authors: MAJ Melissa Givens MD, MPH, Carl R. Darnall Army Medical Center, Fort

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(continued from page 5)
Hood, TX, Melissa.givens@us.army.mil • MAJ David Masneri DO, Womack Army Medical Center, Fort Bragg, NC • CPT Michael Thomas PA, Carl R. Darnall Army Medical Center, Fort Hood, TX

Objective: The purpose of this study is to describe patterns of thrombolytic use for ST elevation myocardial infarction (STEMI) in Emergency Medicine Residencies in the United States

Methods: This is an IRB approved observational study in which investigators emailed a survey to all Emergency Medicine Residency Program Directors in the United States. Follow up emails were sent to non-responders one week following the initial mailing and then follow-up phone calls were made to those not responding electronically. The relationship between setting, on-site access to cardiac catheterization laboratory, emergency medicine (EM) rotations at community medicine sites and experience with the use of thrombolytics for STEMI was determined using logistic regression analysis.

Results: Sixty-five programs of 142 responded. For the 64 who described their residency setting 49 (78%) were urban, 8 (13%) suburban, and 7(11%) community hospitals. Sixty-one (95%) of the respondents reported on-site access to a cardiac catheterization lab. Twenty-five (39%) of the respondent programs have away EM rotations at facilities with no catheterization lab on site. Nineteen programs (30% 95CI 18%-40%) reported thrombolytic use as "none" in both parent and away sites. There was a significant relationshipin use of thrombolytics between practice settings in the parent EM facility ($p<0.001$) but not at away rotations ($p<0.05$). There was a significant relationship between the availability of on-site catheterization and the use of thrombolytics at the parent EM facility ($p<0.001$) and also between rotations that have no access to cardiac catheterization laboratory and the use of thrombolytics ($p<0.001$).

Conclusions: Many Emergency Medicine training programs rely on cardiac catheterization labs for the treatment of STEMI. Residents may graduate from training without the opportunity to manage a patient with STEMI with thrombolytic therapy. EM rotations away from the parent facility may provide the opportunity for thombolytic use but this is dependent on the availability of a cardiac catheterization lab. Residents entering the workforce may be unprepared to manage STEMI patients in hospital settings without access to cardiac catheterization. Residency programs should take this into consideration when designing the curriculum.

Ultrasound Detection of Pneumothorax with Minimally Trained Sonographers: A Preliminary Study

CPT Jonathan D. Monti PA-C, MAJ Bradley Younggren MD, Robert Blankenship MD, Department of Emergency Medicice, Madigan Army Medical Center, Ft Lewis, WA

Primary Investigator is a physician assistant currently enrolled in the joint US Army/ Baylor University DSc Emergency Medicine Physician Assistant Program at Madigan Army Medical Center

This study was accepted for presentation at the December 2008 Special Operations Medical Association Conference in Tampa, FL and is currently pending review for publication in AMSUS Journal of Military Medicine. This study was approved by the Madigan Army Medical Center Institute for Animal Care and Use Committee.

BACKGROUND: Prompt recognition and treatment of a tension pneumothorax is critical to reducing mortality in both military and civilian settings. Non-physician providers are often the first medical providers to care for combat trauma patients with penetrating chest trauma and frequently have limited diagnostic capabilities available to them. This study demonstrates that with minimal training non-physician providers can accurately determine the a bsence or presence of a pneumothorax with a portable ultrasound machine.

METHODS: Physician Assistants, SOF and conventional force medics, veterinary technicians, and food service inspectors, all naïve to ultrasound, were recruited for this study. Participants underwent a brief presentation on detection of a pneumothorax by ultrasound and were then asked to perform a thoracic ultrasound examination on euthanized, ventilated swine. Some of the swine were induced with a pneumothorax prior to these examinations, and all participants were blinded to the absence or presence of a pneumothorax.

RESULTS: Twenty-two participants examined a total of 44 hemithoraces. A total of 21 out of 22 pneumothoraces were correctly identified with one false-negative. 22 of 22 normal hemithoraces were correctly identified for a sensitivity of 95.4% (95 % CI 0.75-0.99), and a specificity of 100% (95% CI 0.81-1.00), with PPV of 100%, NPV of 95.6%.

CONCLUSIONS: Non-physician healthcare providers can accurately detect a pneumothorax with portable ultrasound after receiving minimal focused training. Consideration should be made for the incorporation of concise ermergency ultrasound training into the training of non-physician providers such as physician assistants, SOF, and conventional force medics.

Impact of operational conditions on medication concentration: A Pilot Study

Authors: MAJ Melissa Givens MD, MPH, Carl R. Darnall Army Medical Center, Fort Hood, TX, Melissa.givens@us.army.mil • CPT Cynthia McPherson MPAS, PA-C, Carl R. Darnall Army Medical Center, Fort Hood, TX • CPT Andrew Kagel MD, 1ST BCT, 4ID • COL Bruce Adams MD, William Beaumont Army Medical Center, Fort Bliss, TX

Objective: Military providers need to be able to deliver the right medication, to the right patient, with the right dose, at the right time. Stability of medications in austere environments has not been fully elucidated. EMS literature describes degradation of resuscitation medication in pre-hospital conditions inside ambulances. Other studies have shown a degradation of succinylcholine at a rate of up to 30% per month at room temperature. The purpose of this study is to conduct a pilot study of remaining drug concentration in medications routinely carried in a deployed environment to determine if significant degradation occurs.

Methods: Four medications (naloxone 0.4mg/mL, succinylcholine 20mg/mL, epinephrine 0.3mg (Epipen®), and etomidate 20mg/10mL) were obtained from the operational theater, specifically those carried in an aid bag of a brigade surgeon on missions with exposure to typical conditions outside a temperature regulated environment with extremes of heat for a period of 9 months. The medication concentration was measured using standard protocol for reverse-phase HPLC and results reported as percent purity as compared to standard sample.

Results: Four medications were tested for remaining drug concentration.Naloxone and etomidate maintained 100% purity. Epinephrine remained 99% pure and succinylcholine retained 97% purity. All medications had reached their expiration date at the time of testing.

Conclusions: Stability of drugs in operational environments is crucial to quality care of the soldier in forward operations. Despite previous reports in literature of medication degradation in non-standardized storage conditions, our pilot study did not show significant degradation of medication purity despite exposure to extremes of temperature and medication reaching the end of its shelf life. Further studies need to be undertaken that explore the effects of operational conditions on medication stability.

Resident Performance in the Setting of Indeterminate First Trimester Ultrasounds

Authors: Jeffrey Lightfoot MD, Michael Juliano MD

Institution: Naval Medical Center Portsmouth, Portsmouth, VA

IRB approval: Yes

POC: Dr. Jeffrey Lightfoot 240-460-9023, jeffrey.d.lightfoot@med.navy.mil, Jeffrey Lightfoot, PGY-4, 3rd year resident, Michael Juliano, Staff Attending

Objective: In early pregnancy the essential element of the Emergency Department (ED) ultrasound (US) is its ability to diagnose an intrauterine pregnancy (IUP). The ED US can be indeterminate, finding an empty uterus or empty gestational sac. This study assessed how well ED residents performed in the setting of indeterminate US in first trimester pregnancies as compared to US performed in the radiology department.

Methods: Naval Medical Center Portsmouth is a military teaching hospital with an average of 80,000 ED visits per year. First trimester symptomatic pregnancy complaints account for approximately 150 patient encounters per month. We performed a retrospective chart review of all patients diagnosed with: pregnancy, abortion (threatened, spontaneous, complete, incomplete or missed), embryonic demise or ectopic pregnancy who presented to the ED between the dates of December 2005 and September 2006. Those charts were then evaluated for the following inclusion criteria: 1) positive pregnancy test in the first trimester, as determined by last menstrual period; 2) US evaluation by the emergency physician that is deemed to be indeterminate; 3) subsequent formal US prior to ED discharge. The results of the ED US were then compared to the formal US findings.

Results: 209 women met inclusion criteria. Of those, 158[m1] (75.6%; 95% CI 69.8-81.2%) had similar findings on both formal and ED US; 35 (16.7%; 95% CI 11.6-21.8%) had an IUP on formal US (fetal pole or yolk sac) and 16 (7.7%; 95% CI 4.1-11.3%) had signs suggestive of ectopic pregnancy (adnexal mass or free fluid) that weren't seen on ED US. 38 total formal US had signs of ectopic pregnancy of which 22 were also documented on the ED US.

Conclusion: ED US performed by residents have a high level of accuracy when compared to formal US. However, 7.7% of formal ultrasounds had findings suggestive of ectopic pregnancy that weren't seen in the ED.

Intern Training: Educational Innovations

LCDR A. Hubert (Res.), LCDR W. Dennis (Attending)

Objective: Implementation of a new procedure-based teaching curriculum to enhance the educational experience of rotating interns in the emergency medicine department of a military teaching hospital.

Background: Prior emergency medicine intern training was an unstructured combination of bedside teaching and lecture-based didactics.Interns would occasionally complete their rotation without experiencing procedures essential to emergency medicine practice.Moreover, informal sampling demonstrated that many interns begin their residency training with minimal procedural experience.The intern curriculum was therefore restructured.

(continued on page 7)

(continued from page 6)

Methods: A curriculum utilizing weekly, 4 hour, hands-on training precepted by Naval Medical Center Portsmouth senior emergency medicine residents and staff was developed. Emphasis was placed on airway skills, central lines, lumbar puncture, slit lamp exams, ultrasound, "tricks of the trade," and utilization of the command simulation center.

Results: Formalized feedback from rotating interns has uniformly positive. We now routinely entertain requests from matriculated interns, medical students, physician assistants and Navy general medical officers to enroll in this training program. Due to the positive feedback, we have taken these training exercises to the military's tri-service medical school to teach students basic procedural skills.

Conclusion: Patient care has changed and young trainees are unable to complete an adequate number of procedures. Qualifications must be done, sign-off's need to be finished, verified, and senior residents/staff get priority. Interns and medical students are not obtaining the procedural experience necessary to become competent physicians. Our educational sessions provide a unique opportunity for interns and medical students to practice and to master basic qualifications essential in every field of medicine.

An Army Aviator with Buldging Neck Veins

Benjamin L. Baker, DO (house staff) • Chris Strode, MD (attending staff), Department of Emergency Medicine, Madigan Army Medical Center, Fort Lewis, WA.

Study Objective: To discuss the common presenting signs and symptoms, classic and evolving etiologies and emergency department (ED) adjuncts and definitive treatments of Superior Vena Cava (SVC) Syndrome.

Method: Case report and clinical images of an Army OH-58D pilot presenting with buldging neck veins, two months of dry cough and recent counseling by his unit for increasing run time on his Physical Fitness Test.

Results: Not applicable for case report with clinical images.

Conclusion: SVC Syndrome is caused by intraluminal thrombosis or external compression. ED adjuncts can temporize effects of this syndrome while definitive treatment depends on the etiology-which is currently evolving. A wide differential diagnosis must be considered when patients present to the ED.

Consent: The author has the patient's signed photo consent available upon request.

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Correlation of a portable, non-invasive hemoglobin monitor with venous blood levels

Eric Tomich, DO • Tristan Knutson, MD • David Della-Giustina, MD • Brandon Wills, DO, MS • Emily Merchant, MD, Department of Emergency Medicine, Madigan Army Medical Center, Tacoma, WA

Study Objective: In most medical settings throughout the world, the only way a medical practitioner can determine hemoglobin concentration is through a percutaneous blood draw, a process that can take over an hour to yield results. The Masimo Rainbow SET® is a recently FDA approved device which performs non-invasive oximetry and estimates venous hemoglobin measurements. Within one minute of placing the probe on a patient's finger, an estimated hemoglobin level is determined. This technology has the potential to positively impact the care of our sickest patients in the Emergency Department (ED) and patients in austere environments without modern laboratory capabilities. Our study evaluates the accuracy of this technology by comparing non-invasive hemoglobin measurements with venous levels in ED patients. This is the first study using this technology in an ED population.

Methods: This is a prospective, observational, cross-sectional study of adult patients presenting to a high-volume, military Emergency Department. A convenience sample of patients requiring a complete blood count is being enrolled. We are evaluating the performance of non-invasive hemoglobin determinations over both normal and abnormal hemoglobin concentrations. Venous hemoglobin values are categorized into four groups. Group one represents the normal reference range for venous hemoglobin which is 11.5-17. Group two represents values less than 11.5. Group three represents values greater than 17. Group four represents all measurements. Data is summarized for each hemoglobin group with the mean absolute difference between venous and probe values with a 95% confidence interval.

Results: Pilot data collected from 37 patients is presented. The mean probe and venous hemoglobin were 12.4 and 12.8 g/dL respectively. The probe averaged 0.4 g/dL less than the actual venous sample. The mean absolute difference between probe and venous hemoglobin concentration was 1.3 g/dL (95%CI 0.9-1.7) with a correlation coefficient of 0.7.

Conclusion: Within relatively normal hemoglobin ranges, estimates of venous hemoglobin were generally within 1.3 g/dL of actual measurements. Further study will need to correlate estimates in abnormal hemoglobin ranges.

Prevalence of Metformin-associated Lactic Acidosis in Acute Overdose

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Introduction: Metformin associated lactic acidosis (MALA) is well described in patients taking therapeutic metformin who develop renal failure or other serious co-morbid conditions. MALA from acute overdose has also been described in case reports but is debated by some clinicians, arguing that metformin overdose does not cause lactic acidosis. Our aim was to perform a multi-center poison control database review to determine the prevalence of MALA in mono-overdose in patients with no co-morbid conditions.

Methods: This was a retrospective chart review of the Illinois and Washington Poison Centers between the 2001-2006 and 1999-2006 respectively. Metformin overdoses that were referred to healthcare facilities were categorized into mono-overdose with or with out MALA, and polypharmacy overdose with or without MALA.

Results: The overall prevalence of MALA was 14 out of 412 (3.4%) cases referred to a healthcare facility. MALA prevalence in mono-overdose and polypharmacy overdose were 9.1% and 0.7% respectively. There was one death out of 132 mono-overdoses referred to healthcare facilities. There was no evidence of hypotension in 57% of the mono-overdose MALA cases.

Conclusions: Metformin associated lactic acidosis can occur from a mono-overdose even with preserved hemodynamics and no co-morbidities. Dosages which place patients at risk for MALA will require additional study.

Success of Endotracheal Intubation by Novice Users: A Comparison of Glidescope, Airtraq and Macintosh Laryngoscopes

Authors: Ryan G. K. Mihata MD; James E. Brown MD; Thomas Masters MD; Gregory Kennebeck MD

Objectives: We compared the Airtraq (King System Corporation), Glidescope Ranger (Verathon, Inc.), and direct laryngoscopy (Macintosh) in time required for successful intubation and perceived ease of use in novice intubators.

Methods: After institutional IRB approval, a prospective crossover trial with 48 medical students with no prior intubation experience was accomplished. We used a convenience sample of volunteer medical students. Students were randomized to one of six groups using the devices in different orders. Each student intubated a manikin with each of the three devices in four scenarios: normal airway, difficult airway (cervical spine immobility), difficult airway (pharyngeal swelling), and repeat normal airway.

Results: After each attempt subjects rated the ease of use of the device using a Likert scale. Airtraq and Glidescope were consistently rated easier to use than the Macintosh. In most scenarios, Airtraq was rated easier to use than Glidescope. In the initial scenario, Airtraq (mean=15.8) was faster ($p=0.026$) than Glidescope (mean= 21.5), which was faster than Macintosh (mean=26.0) ($p<0.01$). No significant differences in time to intubation between the devices in the cervical spine immobilization scenario were seen. With pharngeal swellling, Airtraw (mean=10.3) yielded faster times than Glidescope (mean=13.9) and Macintosh (mean=16.8) ($p<0.05$). There was a significant decrease in time to intubation and a significant increase in ease-of-use with all devices between the first and last scenarios.

Conclusions: For novice users, Airtraq and Glidescope show significant advantages in time to intubation as well as perceived ease-of-use when compared to direct laryngoscopy. Airtraq outperfromed Glidescope in most scenarios. We saw improvement in time to intubation as well as ease-of-use over a short training period.

Prospective Randomized Trial of Septra for Uncomplicated Skin Abscesses in Patients at Risk for Community Acquired Methicillin-Resistant Staphylococcus Aureus Infection.

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Study Objective: Communtiy-acquired methicillin resistant staphylococcus aureus (CA-MRSA) is emerging as a common etiology of skin and soft tissue infections. The treatment of abscess caused by CA-MRSA is controversial and the role of antibiotics in the treatment is debatable. This study sought to determine whether antibiotics in addition to incision and drainage improved outcome at 7 days of therapy.

Military Relevance: MRSA is particularly common among athletes and military personnel. Identifying an optimal treatment strategy will have a significant impact on treatment on basic military trainees and other military personnel who are at risk of skin and soft tissue infections.

Methods: Patients age 18-55 presenting to the ED with uncomplicated skin abscess who meet study criteria were prospectively enrolled at two military academic emergency departments in San Antonio, Texas. Patients were randomized on enrollment to either re

(continued on page 8)

(continued from page 7)
ceive incision and drainage alone or incision and drainage plus a 7 day course of sulfamethoxazole/trimethoprim. Physicians were blinded on patient re-evaluation at days 3 and 7. The presence of erythema, warmth, purulent drainage, fever, or persistent abscess requiring additional incision and drainage was documentation of treatment failure. Inclusion and exclusion criteria?

Results: Twenty one patients (67%) presented for wound recheck at 7 days. 55% of patients (17) were MRSA positive. 1 patient did not have wound cultures sent. At Day 3, there were 3 treatment failures, one requiring admission for IV antibiotics. All three patients had been randomized to antibiotics. Two of the three patients were MRSA positive. By day 7, there were 7 total treatment failures and 5 were MRSA positive. Of the seven total treatment failures, 4 had been on antibiotics and 3 had I&D only. Of those who were MRSA positive, 9 received antibiotics and 8 did not receive antibiotics. In the MRSA + subset, 33% of patients on antibiotics failed treatment. 25% of those not on antibiotics failed treatment.

Conclusions: In the small amount of data collected, antibiotics did not appear to improve outcome at 7 days, though it is inadequately powered. A prospective, double-blinded, randomized trial is needed to definitively answer the question of the utility of antibiotics in the treatment of CA-MRSA skin abcesses.

Ultrasound in the diagnosis of knee pain in a young adult male

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A 27 year old male presented to the emergency department complaining of left knee pain. He states he injured it while playing basketball just prior to arrival. While attempting a jump shot he felt his knee give out from under him, noted a deformity, and was unable to walk. He admits to mild numbness to the medial aspect of his foot. On physical exam he is unable to ambulate or perform a straight leg raise; the knee is edematous, tender to palpation and has limited range of motion. There is a high riding patella. Sensation is intact distal to the injury, dorsalis pedis pulse is strong and equal.

A plain film radiograph was taken (Figure 1) followed by a bedside ultrasound with a high frequency linear probe of both the affected (Figure 2) and uninjured knee (Figure 3).

Patella tendon rupture is the third most common injury to the knee extensor mechanism behind quadriceps tendon rupture and patella fracture. It is seen primarily in active males <40 years of age. Rupture usually results during eccentric contraction of the quadriceps when the foot is planted and the knee flexed.[1] A force >17 times body weight will often result in rupture, however most patients who tear have pre-existing degenerative changes to the tendon and therefore require less force for injury to occur.[2] Patellar tendon rupture is prevalent in athletes, especially those with patellar tendinopathy, also called jumper's knee, a clinical diagnosis that involves aching pain at the inferior pole of the patella with activity and point tenderness to palpation. Patellar tendinopathy is often a precursor to tendon rupture and has characteristic histopathologic and radiographic appearance. Studies comparing ultrasound (US) and magnetic resonance imaging (MRI) found that US has a better diagnostic accuracy when compared head to head for confirming clinical suspicion.[3] Patients with tendon rupture often complain of sudden pain, a popping or tearing sensation, high riding patella, edema, inability to bear weight or straighten leg against resistance.[2]

While history and physical is often sufficient for diagnosis there is a role for plain film radiographs and bedside US in the emergency department. Plain films may show avulsion fractures or patella alta when the patella resides in a more superior position than normal. Soft tissue swelling and joint effusion may also be seen.[2] US in the diagnosis of patellar tendon rupture is considered by many to be the imaging modality of choice. Its single greatest advantage over MRI is the ability to perform dynamic scanning.[4] Differentiating between partial and complete tears is important in terms of disposition, where complete tears require early operative repair, partial tears can be treated conservatively. This can be difficult at times to determine, as one study showed that up to 1/3 of patients are misdiagnosed initially.[2] Small studies looking at accuracy20of US in diagnosing quadriceps tendon rupture confirmed by surgical findings showed a high degree of correlation.The only misdiagnosis resulted from a patient with delayed presentation, which is a known pitfall of US due to scar tissue formation.[5] Emergency physicians can make rapid and accurate diagnosis using US in civilian and austere environments with little training where MRI is not available or practical.

US of the patellar tendon is best performed with a high frequency linear probe. Optimal visualization of the tendon occurs when the knee is flexed to 30-45 degrees. In a longitudinal plane the tendon is scanned, but it is important that the probe be kept parallel to the fibers so as to prevent anisotropy, a phenomenon that will create the appearance of hypoechoic bands, which can mimic tears or fluid. The normal appearance of the tendon is a series of parallel hyperechoic bands except at places of insertion. Peritendinous fluid or hypoechoic spaces between fibrils may represent patellar tendinosis.[6] Tendon ruptures will show a discontinuity of the hyperechoic fibrils with hematoma filling the void.Dynamic scanning is accomplished by observing the presence or lack of tendon translation across the area of abnormality when the thigh is squeezed, patella is manipulated or patient attempts to extend the knee.[7] Patients with any type of patellar tendon rupture should be referred to an orthopedist. Delays in repair result in worse outcomes from muscle atropy and contracture. Scar tissue and adhesions also complicate repair. Patients should be kept non-weight bearing, placed in a knee immobilizer and given analgesics.[2]

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Rapid, Field Deployable Diagnostics to Fight the War on Dengue

Author: Becky Abell, MD, SAUSHEC

Dengue is a vector-borne disease without an available vaccination or cure that affects populations in tropical and subtropical regions worldwide and poses a significant threat to military operations. Dengue is recognized as an emerging infectious disease globally to include the US. Traditionally virus culturing and identification would take weeks in a laboratory.The development of a rapid field-deployable diagnostic method would allow for a population transmission risk assessment, environmental control, and symptom control avoiding unnecessary medical tests, expenses, and improper treatments that have potentially harmful side effects.The JBAIDS and RAPID are DoD approved analytic platforms that have been previously used to identify biological warfare agents and infectious diseases. A dengue virus RT-PCR freeze dried assay that can detect all four serotypes of the dengue virus in adult mosquitos has previously been documented. Sample preparation and analyses requires less than two hours. This assay was combined with the vector surveillance technique ovitrapping while under austere conditions in Thailand during the rainy season. Of the 4,180 larvae, 202 pupae, and 2,370 eggs collected the RT-PCR performed with the RAPID showed that transovarial transmission of the Dengue Virus does not occur during the rainy season, and has a prevalence of 0.01% during the dry season. The importance of this data combined with previous studies allows for a better understanding of dengue virus transmission and therefore prevention and eradication to decrease patient morbidity and mortality while protecting the fighting force.

Feasibility of nurses and paramedics to establish intraosseous access using the EZ-IO® device in the distal femur of pediatric patients

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Objective: To establish the feasibility of nurses and paramedics to establish intraosseous access using the EZ-IO® device in the distal femur of pediatric patients.

Methods: We performed an observational study in which 2 paramedics and 3 nurses inserted the EZ-IO® device into the distal femur of pediatric cadavers. The site of insertion was established as 2 cm proximal to the patella on the anterior aspect of the femur. The participants were consented and trained in the placement of the EZ-IO® device. Three (3)complete embalmed pediatric cadavers (average weight 3.3 kg) were selected by availability for the study. Each participant placed an EZ-IO® needle set 9 times between the 6 cadaver legs. Morticians wax was used following each insertion, to cover and fill any external signs of previous insertion attempts. Time of insertion was recorded. A digital x-ray AP and lateral, using a GE C-arm, was taken to determine the precise placement and the presence of complications. Successful placement was defined as placing the EZ-IO® catheter tip securely within the medullary cavity of the anterior distal femur. All data was manually recorded on standardized data collection forms.

Results: A total of 45 insertion attempts were performed. The EZ-IO® was placed correctly on the first attempt in 44 of 45 insertions, (97.8%) success. The catheter was securely seated in 44 of 45 insertions (97.8%). One placement error occurred, defined as improper placement of the needle set. The needle set was placed in the soft tissue medial to the distal femur. There were no cases of placing the needle tip adjacent to the opposite cortex or growth plate, or penetrating the opposite cortex or joint capsule. Average time of insertion was recorded at 3.45 seconds (range 1.2- 6.2seconds).

Conclusion: Our results support the feasibility of nurses and paramedics ability to successfully place the EZ-IO® device in the distal femur of pediatric patients. Limitations include using cadavers for anatomical IO placement analysis and the small number of cadavers used. Further studies should be performed to further evaluate the placement and flow capabilities of the EZ-IO® device in the distal femur of pediatric patients.

Combat Fluid Resuscitation 2009: An Update

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After reading, you can receive a CME credit for this article by visiting gsacep.org, going to the membership section, taking the quiz, and providing the information required. You must be registered at gsacep.org to participate in the quiz, so please do so.

Hemorrhage control and resuscitation are the top priorities in trauma care. Advancement has been made in combat casualty care over the past decade, bringing the killed in action (KIA) rate down for the first time since the Crimean War. Changing strategies in fluid resuscitation are no small part of this, but due to a lack of definitive randomized controlled trials, the optimal resuscitation strategy remains to be elucidated. The ideal combat resuscitative fluid should be durable under a variety of environmental conditions, have the ability to expand plasma volume, be capable of delivering adequate oxygen to the periphery, have a good duration of effect, prevent or reverse coagulopathies, and have no risk of disease transmission or need of crossmatching. These characteristics should be kept in mind when reviewing the following case examples:

Case 1: Baghdad – A 29 year old Marine was on foot patrol when a nearby IED detonated. Open left radius/ulna fractures and open left tib/fib fractures were splinted in the field and proximal tourniquets were applied. Intravenous access was unable to be obtained in the field or enroute. He arrives 40 minutes after his injuries, combative and in shock despite tourniquet use: blood pressure 81/49 mmHg, heart rate 125 .

Case 2: In the mountains of Afghanistan, 10,000 feet above sea level, a 26 year old member of a Ranger Quick Reaction Force is shot in the lower right flank. Hostile fire is suppressed but the only landing zone is still "hot" – Tactical evacuation (TACEVAC) will not be able to arrive until nightfall. His mental status slowly deteriorates over hours.

The Combat Environment

As practitioners of military medicine, a familiarity with the entire spectrum of combat casualty care is essential. If this familiarity does not exist, inappropriate direction and feedback may be given both to the front line medic and to commanders in the tactical operations center. In addition, units such as the Army Forward Surgical Team (FST), the Air Force Mobile Forward Air Surgical Team, and the Navy Shock Trauma Platoon (STP) may encounter combat conditions by the very nature of their missions.[1] Further, the placement of far-forward Emergency Physicians has been shown to bring the case fatality rate (CFR) from 10.45% to 7.14%[2]. Tactical Combat Casualty Care (TCCC) dates back to 1996 when the principles were first published in Military Medicine[3] and has now become the standard for medic/corpsman training throughout the U.S. Armed Services[4]. Because of this, physicians must be aware that current concepts call for little or no resuscitation in the field. TCCC calls for an initial 500 ml bolus of colloid (Hextend) only if there is a poor radial pulse (SBP<80) oraltered mental status (a sign of poor perfusion). This is repeated in 30 minutes only if signs of shock remain. No casualty should receive more than 1L of Hextend in the field. TACEVAC (formerly CASEVAC) is the final phase of TCCC and begins when a vehicle of opportunity engages to transport casualties to the next higher echelon of care. TCCC ends when the casualty has arrived at a higher level of care, usually the Combat Support Hospital.

Resuscitative Fluids

The ideal resuscitative fluid is yet to be found. The debate of crystalloids versus colloids in the treatment of shock has continued unabated for the past five decades. Blood components, while necessary to transport hemoglobin, bring with them increased morbidity and mortality.[5] Artificial hemoglobin carriers have significant side effects that continue to restrict their use in humans. No resuscitative fluid is totally benign and all may potentiate the cellular injury associated with hemorrhagic shock if not used judiciously. These agents should be viewed as medications with specific indications and dosing parameters.

Crystalloids:

Crystalloids designed for resuscitation can be divided into solutions that are either isotonic or hypertonic relative to plasma. Isotonic crystalloids include normal saline (NS) and lactated Ringer's solution (LR). Since the Vietnam War, these have been the primary resuscitative fluids. Aggressive crystalloid resuscitation became the standard of care during this time and volume replacement was recommended at three times the amount of blood loss.[6] This approach was later found to not improve outcomes – contributing to the development of abdominal compartment syndrome and ARDS (known as Da Nang Lung from the era in which it was first characterized).[7],[8] A change in approach to fluid resuscitation did not occur until the mid-1990's when a landmark paper was published demonstrating that delayed fluid resuscitation until the time of definitive hemorrhage control demonstrated at least no difference in mortality, and at best a survival advantage.[9] This is not a new concept – Cannon having written in 1918 that "inaccessible or uncontrolled sources of blood loss should not be treated with intravenous fluids until the time of surgical control."[10] Fluid resuscitation in uncontrolled hemorrhage is now known to dilute clotting factors and exacerbate coagulopathy, worsen acidosis (NS and LR have pH's of 5.0 and 6.5, respectively), and disrupt early thrombus.[11] Although important theoretical differences do favor the use of LR over NS, most studies do not show a difference in outcomes except in severe hemorrhagic shock where NS is associated with greater mortality.[12]

Modification of LR began after the 1999 Institute of Medicine's report on fluid resuscitation indicated that the D-isomer of lactate found in LR was responsible for most of its unfavorable properties.[13] These included increased neutrophil oxidative burst,[14] exacerbation of acute lung injury, and an increase in apoptosis in multiple organ systems.[15] LR in the pure L-isomer form is commercially available and should be favored over the racemic form. Experimental versions of this crystalloid, with lactate replaced by beta-hydroxybutyrate or pyruvate, are now being studied and show a more favorable profile over the racemic form.[16] Since the third phase of TCCC calls for continued resuscitation with LR after colloid has been utilized, the adverse effects of racemic LR must be considered, and all measures taken to ensure supplies are stocked with the pure L-isomer until better versions become available.

Hypertonic Saline (HTS) was first studied as early as 1919 (Weed, McKibben) but its use in hemorrhagic shock was not popularized until 1980 when it was described separately by Velasco[17] and DeFelippe.[18] The concentration in various studies have ranged from 2.5% to as high as 30%.[19] It rapidly expands blood volume after major blood loss with little adverse effects. HTS (7.5%), at a dose of 250 ml, compares with a resuscitative volume of 2 to 3 L of NS. HTS is also a potent attenuator of immune mediated cellular injury which is a major component of the late effects of hemorrhagic shock. The IOM report of 1999 recommended that combat casualties be resuscitated first with 250 ml of HTS.[12] HTS 7.5% is yet to be FDA-approved in the United States so this recommendation has not been implemented in the U.S. Military, although other NATO countries currently use this or HTS-Dextran as their initial resuscitative fluid of choice. HTS-Dextran may be used at one-tenth the volume of isotonic crystalloids.[20] Because of its smaller volume and weight, HTS has a significant logistical advantage and seems to be the most ideal resuscitative fluid for combat operations. At this time there are two multicenter trials ongoing in the U.S. on HTS in the trauma population and we may yet see 7.5% concentration as an FDA-approved resuscitative fluid in the near future.[21]

Special mention must be made for the casualty with multi-trauma who also sustains traumatic brain injury (TBI). In TBI, secondary injury is avoidable and is usually related to some degree of hypotension or hypoxia. Mortality doubles in the hypotensive patient with TBI when compared to normotensive TBI casualties.[22] HTS or HTS-Dextran may be the optimal resuscitative fluids for these patients when hypotension must be treated and cerebral edema avoided.[18] HTS in a 3% concentration is currently available for use in Combat Support Hospitals. The osmotic actions have been well categorized, but the discovery of extra-osmotic actions such as immune modulation and augmentation of cerebral blood flow are intriguing and invite further study. A meta-analysis of six trials

and 604 subjects showed that HTS-Dextran provided a discharge survival rate of 38% versus 27% for the NS control in the subgroup of patients who had sustained multi-trauma with concomitant TBI.[23] Once started, HTS should be titrated to keep serum Na concentrations at 145-155 mEq/L and cessation should be gradual secondary to concerns of rebound cerebral edema and herniation

Artificial Colloids:

Colloids are large molecular weight substances that are effective in exerting an osmotic force across the walls of capillaries, thereby maintaining intravascular volume. A recent Cochrane review indicates that when fluid resuscitation is required, there is no appreciable difference in outcomes after resuscitation with colloids versus crystalloids.[24] Crystalloids are less expensive which lends support for their primary use in civilian trauma resuscitation. Due to the far different environment in which combat casualties take place, however, colloids offer the distinct advantage of less volume and weight. The hydroxyethyl starches (HES), Hespan and Hextend, are colloids composed of 6% hetastarch, a synthetic colloid derived from a starch composed almost entirely of amylopectin. Hespan is hetastarch in NS. Hextend consists of high-molecular-weight 6% hetastarch in a balanced lactated solution containing calcium, magnesium, glucose, and potassium in addition to NaCl, thus resembling the composition of normal plasma. Resuscitation with Hextend results in one third the volume requirement of LR.[25] This artificial colloid has replaced LR as the fluid of choice carried by medics in the field for reasons discussed previously.[26]
It has a favorable acid-base profile and has been shown to decrease overall fluid requirements.[27] The degree of substitution of the various hydroxylethyl starches determines their duration of effects as well the effects on coagulation. Hespan is more highly substituted than Hextend, leading to Hextend's recommendation as the initial colloid of choice for resuscitation. A newer HES, Voluven, has just been FDA approved and appears to have the least pronounced effect on coagulation than any of the other HES formulations.[28]
Dextran is a complex, branched chain polysaccharide made of many glucose molecules. Although osmotically active, it does have a significant antiplatelet effect and some formulations are used by microsurgeons to decrease thrombosis – properties not favorable in traumatic injury.[29]
Both artificial colloids activate neutrophils. When Dextran is given in conjunction with HTS, however, the latter blunts this immune system response, while the colloid prolongs the duration of effect of the HTS.[17] What effect this combination has on the anticoagulant effect of dextran remains to be seen.

Artificial Oxygen Carriers:

In combat theaters, donor blood is a precious resource that is not always available near the point of injury. Current Hemoglobin Based Oxygen Carriers (HBOCs) provide volume, O2 transport and unloading, are universally compatible, easy to administer, and can survive a variety of conditions. All are characterized by a sigmoidal oxygen dissociation curve that allows O2 transport and unloading similar to blood.[30] Diaspirin Cross linked Hemoglobin (DCLHb) was the first generation HBOC. Phase III clinical trials in the late 1990's were halted prematurely after a higher mortality rate was seen when compared to NS.[31] DCLHb contained 100% tetrameric Hb which contributed heavily to the HBOC-associated vasoconstriction and hypoperfusion of end organs which remains the primary concern today.
Second generation HBOCs were developed with the goal of decreasing this vasoconstrictive effect by polymerization into larger molecules. Two of these have shown great promise to date. Human trials with human polymerized hemoglobin (Polyheme, Northfield laboratories) have shown decreased mortality in trauma patients. Phase III trials have been completed showing polyheme to provide a survival benefit to patients without access to blood products.[32] HBOC-201 is a bovine, polymerized Hb that has been studied in phase III trials as a blood substitute in surgical patients, decreasing transfusion requirements.[33] It is now approved for human use in South Africa for acute anemia in surgery patients. Side effects of HBOC-201 include mild liver transaminase elevations, methemoglobinemia, and elevated blood pressure (primarily with the first and second dose). Recent studies indicate that this increase in vascular resistance may not be as high as once thought.[34]
Several other products capable of carrying oxygen are also in development. MP4 is a modified hemoglobin molecule designed to overcome the vasoconstrictive effects found with the other HBOCs. It has a high oncotic pressure which also makes it promising as a plasma expander. PFC emulsions (Oxygent) carry oxygen as dissolved gas. They have a linear relationship between O2 partial pressure and O2 transport capacity, thus they work well only when Fi02 is high, restricting its utility in a prehospital setting.
Overall, there has been tremendous progress in the area of artificial O2 carriers, although none have achieved approval for use in the U.S., Canada, or Europe. Colloids and crystalloids will continue to be used to replace plasma volume. Further research on combined HBOC/hypertonic solutions may prove to offer greater survival for the injured combatant, particularly when evacuation times are prolonged.[35]

Blood Products:

Blood transfusion is not without major complications and is an independent predictor of mortality in civilian trauma.[36] However, nothing replaces blood loss like fresh whole blood (FWB). Only in the military is FWB, available via the "walking blood bank", utilized. Thawed plasma at a 1:1 ratio with PRBC's is the current resuscitation strategy for hypovolemic shock due to blood loss at combat support hospitals. Simultaneously, a whole blood donor drive is initiated. In OIF III, 13% of all transfused patients have received FWB[37] with one unit having the hemostatic power of 10 units of platelets.[38]
Plasma alone is an effective volume expander, does not activate the pathways of cellular injury, and provides physiologic quantities and ratios of clotting factors. However, it does have all the drawbacks of blood product transfusion, storage, and transport. Investigations funded by the DoD are \ underway on autologous freeze-dried plasma which can be reconstituted when needed, lessening its logistic impact.

Case Reviews

The cases presented here are not hypothetical, they are actual cases from OIF and OEF. This first case represents a common scenario in a mature operating theatre where blood loss can still be significant before hemostatic control can be achieved, but the evacuation times are relatively short. Because the casualty is showing altered mental status he should have received at least one 500ml bolus of hextend enroute. As IV access is difficult in the field, one should not hesitate to recommend a sternal IO for fluid resuscitation. Blood loss is significant in this case and blood products, either FWB or RBC's and plasma in a 1:1 ratio, should be given early. As resuscitation progresses, keep in mind that wounds with tourniquets and hemostatic agents may start to rebleed as blood pressure overcomes the smaller force that was required to stop blood flow to once underperfused extremities. The second case is from the battle at Takur Gahr during Operation Anaconda and describes the USAF PJ that died from a bleeding groin/pelvic wound 6 hours after injury and 2 hours prior to planned evacuation.[39],[40] In this case there are two complex points of interest that may have resulted in preserving his life. First, he had brought PRBC's with him \on the mission and these were apparently administered. If he had access to a HBOC, could he have held on longer? Particularly at 10,000 feet when alveolar pO2 is 60 mmHg (103 at sea level) and SaO2 is at best 87%[41]. Second, he did continue to bleed internally and externally. His trauma, acidosis, hypothermia, and cold PRBC's would have exacerbated his hemorrhage. Prevention of hypothermia, in conjunction with some form of IV hemostatic agent may have improved his outcome as well.
The past decade has shown a tremendous amount of research in solving the hemostasis and resuscitation dilemma. As this science advances into the clinical realm we will assuredly continue to see significant changes in the way combat casualties are treated in the prehospital and hospital settings. As resuscitative physicians this will require continuous vigilance in assessing the literature, thereby providing combat casualties with the best chance for survival.

Combat Fluid Resuscitation continued.

Questions:

_____ 1. The initial resuscitative fluid for U.S. combat casualties in the prehospital phase is:
A) Lactated Ringer's
B) Hextend
C) Normal Saline
D) Hypertonic Saline

_____ 2. All of the following are true with respect to the use of blood products in combat casualties EXCEPT:
A) PRBC's and thawed plasma should be given in a 1:1 ratio.
B) Transfusion of PRBC's is an independent risk factor for mortality in trauma.
C) Fresh Whole Blood represents the majority of blood transfusions during OIF
D) One unit of Fresh Whole Blood has the hemostatic properties of 10 units of platelets.

_____ 3. Which is true with regards to hypertonic saline (HTS)?
A) Does not appear to be ideal in the initial phases of hemorrhagic shock resuscitation.
B) Exacerbates the immune activation seen in shock.
C) Is not as effective as a volume expander when compared to isotonic fluids
D) May be the optimal fluid of choice in TBI when hypotension and cerebral edema must be avoided

_____ 4. All of the following are properties of Hemoglobin-based Oxygen Carriers EXCEPT:
A) Have a sigmoidal shaped oxygen dissociation curve.
B) Have few side effects and have proven safe in animal and human studies.
C) Are universally compatible with no need for cross-matching.
D) Can survive a variety conditons making them more ideal with respect to this than blood for far-forward resuscitation.

_____ 5. Which artificial colloid has the highest molecular weight, giving it the least favorable profile with respect to preventing coagulopathy?
A) Hextend
B) Albumin
C) Voluven
D) Hespan

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Summer 2009

A Chapter of the American College of Emergency Physicians

Government Services EPIC

President's Message

By Maj Julio Lairet, USAF, MC

The summer has arrived and with it the new set of rotations going out the door in support of OIF/OEF. Emergency Medicine continues to lead the way throughout the continuum of care. We have members playing key roles from the front lines extending through level II and level III facilities to the CCATT mission of bringing our injured troops home and the mission of our VA partners at the poly-trauma centers. Military Emergency Medicine has become synonymous with mission success.

But our success is not limited to the operational setting. As a specialty, we continue to shine in the areas of GME and research. All of our emergency medicine residencies continue to be successful in preparing our future military emergency physicians. Recently, at the 2009 Society of Academic Emergency Medicine annual meeting, Maj Vikhyat Bebarta from Wilford Hall Medical Center received the Best Basic Science Research Award for his project titled "Hydroxocobalamin And Sodium Thiosulfate Versus Sodium Nitrite And Sodium Thiosulfate In The Treatment Of Acute Cyanide Toxicity In A Swine (Sus Scrofa) Model" [see our interview with Dr. Bebarta]. Accomplishments like this one highlight the caliber of our membership.

Looking into the future, the 2009 Scientific Assembly in Boston is only a few months away. We look forward to working hard for the chapter representing your interests at the Council meeting. While not everyone will be able to attend, we hope many of you will join us at our Board Meeting, to which you are always invited, and at our chapter reception. As soon as we have the exact locations of these two meetings, we will post them on our website. Meanwhile, I hope you are taking advantage of the CME GSACEP is offering in the current, and in the Spring issue, of EPIC, as well as the excellent CME program online offered to us by The Sullivan Group.

While our chapter is full of very talented and bright individuals, our mission is to foster them and emergency medicine throughout the federal healthcare system. Once again, I invite you to contact me with all of your suggestions. In closing , I want to welcome back President-Elect LTC Melissa Givens, MC, USA, who just returned from Ibn Sina. And, to all of you who are currently deployed, or will soon deploy, thank you and your families for your sacrifice and dedication. It is truly an honor to serve with you.

Regards,

Julio

In This Issue

Be a Player
Maj Melissa Givens, MC, USA

You must get involved to have an impact. No one is impressed with the won-lost record of the referee." Napolean Hill

How easy it is to observe the game and blow the whistle when you perceive the rules are broken. But are you willing to get in there and put in all the practice hours, break a sweat, feel the pain, learn to work with your team, and lay it all on the line on game day for everyone to see?

There are athletes willing to do this for the sake of a game. Are you willing to do it for the sake of your career…for the sake of emergency medicine…for the sake of your patients?

During my brief time covering for COL Wedmore as Army EM consultant I started to get the vibe that many of the EM physicians working out in small MEDDACs, and those sent out to the operational jobs, felt disconnected and maybe even ostracized by those practicing in the "ivory tower" academic centers. Recognizing the differences in resources, personnel, and practice environment; there is no reason why physicians in the military/government services EM community need to feel disconnected no matter what their practice environment or in what small corner of the world they may be living.

GSACEP has endless opportunities to get involved and I would highly encourage those who are feeling disconnected from EM to use GSACEP as the means to re-engage. The organization cannot grow and evolve if the same 10 people just trade seats at the board room table each year. Give the "grey hairs" a chance to let their legacy live by allowing them to be mentors and teach the next generation to take the reigns. How many of you have actually attended a GSACEP Board Meeting, held during our annual conference, or at ACEP's Scientific Assembly? I can tell you that there are only a few members present, although our meetings are open to all GSACEP members. What about contributing to the EPIC, or to our CME program in the EPIC? If you have an idea that you think would be helpful to GSACEP members, why aren't you working on that idea with us?

If you are in a practice environment where you feel remote from the heartbeat of EM, then it is imperative that you find a way to keep one hand on the pulse of your chosen specialty. GSACEP is full of people who have done your job, or are working in the job you want, or know someone who can help get you to where you want to go. Don't let that kind of opportunity go to waste. Just by showing up to find those connections, you will discover how valuable your time and talents can be to the organization and the specialty of EM.

Don't be an armchair quarterback. You can't play the game of EM without getting on the field. I lookforward to hearing from anyone who has questions and I hope to see you in October at our Board Meeting and reception during national ACEP's SA, and in the spring at Lake Tahoe at JSS 2010.

The opinions and assertations 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.

Interview with a SAEM Award Winner

Maj. Vikhyat Bebarta, chief of medical toxicology and a staff emergency physician at Wilford Hall Medical Center Emergency Department, Lackland Air Force Base, TX, is the 2009 recipient of the Society of Academic Emergency Physicians BestBasic Science Research Award. We spoke with Maj. Bebarta concerning this outstanding honor.

Please tell us about your topic We studied antidotal treatment for acute cyanide induced toxicity in a pig model, essentially a comparison of two antidotes to determine the most effective treatment for cases of cyanide poisoning that result in acute cyanide toxicity and hypotension. In the project, we induced shock by cyanide infusion. Two antidote kits—an older version and a newer one—were used and evaluated in the treatment. It's the first time the two antidotes have been compared in a complex model and it was also the first time cyanide induced shock has been studied. The findings showed the newer antidote caused a faster and higher rise in blood pressure in subjects critically ill with low blood pressure due to the cyanide toxicity. It also removed all cyanide from the blood, while the older antidote didn't.

Why did you become interested in cyanide? As an emergency physician, and toxicologist, I see patients with cyanide toxicity resulting from structural fires, or overdoses. There is a real threat that terrorists may use cyanide as a weapon too. As a military emergency physician, I wanted to know how to treat it better.

When did you become interested? I became interested when I was on a toxicology fellow back in 2002-2004, at The Rocky Mountain Poison and Drug Center in Denver. In 2004, I created the model to study low blood pressure and cardiac arrest. I worked with my mentor, Dr. Kennon Heard, a toxicologist in Colorado, and Associate Professor at The University of Colorado-Denver. We received a grant from The American College of Medical Toxicology. I deployed twice during the period 2005 -2007. The second time I was deployed, I had a conference call from Iraq to have the research protocol, evaluating cyanide-induced cardiac arrest, approved. We then competed for a grant from the Surgeon General's office. The grant was approved for approximately $80,000 for supplies, drugs, etc. For this project submitted to SAEM, we compared the two antidotes for cyanide-induced hypotension. I worked with CAPT Dave Tanen, an experienced researcher and senior medical toxicologist, and Program Director for Emergency Medicine, at NMC San Diego. Dr. Tanen also had an interest in cyanide research. We worked together by phone and by e-mail, and I did the study at Wilford Hall. We have been funded for another year to continue to study the treatment of cyanide-induced shock.

What made toxicology irresistible to you? I was impressed by the caliber of researchers, the gifted clinicians, and the basic science. I also enjoyed its connection to emergency medicine, particularly military medicine.

Do you think it's more difficult for doctors in military emergency medicine to obtain this kind of recognition? Yes, because the military often doesn't have the same resources as civilian research facilities. In addition, other demands of being a military officer compete for your time. Deployments may interrupt the development of an academic path with performing research. Nonetheless, several senior military physicians have done very well academically and continued their success as civilian physicians.

What would you tell other young physicians who are interested in research? Just a few years out of fellowship, I am still one of those 'young physicians' learning the ropes and receiving mentorship. I have learned that military opportunities exist. You have to find the right mentors and the right resources for your work. Those resources may not always be in emergency medicine.

About the medical situations in this war: What are the areas that you saw emerge as critical? Of course, I was very much interested in how we treat blast injury, traumatic brain injury, and the injuries of non-combat patients.

If you had unlimited funding, what would you spend it on? I would continue emergency care, and toxicology research with preclinical and clinical studies. We would set up a program with staff to help study chemical weapons, drug toxicity, focused points for emergency care related to the war. Research is not a lonely road. It involves many people including collaborators, other medical researchers, bench scientists, technicians, statisticians, nurses, and senior leadership. Supportive leadership is fundamental. We have been fortunate to have all of these individuals supporting myself and other physicians who conduct military research.

How do you relax, get away from all this? You must do that, even if you love your work. I have a wonderful wife, Corey, and three children, ages six, five and two (Emma, Grace, and Owen). My family life is very important. We enjoy heading to the beach and traveling together. They keep me grounded and focused. They are my first passion.

An Update on the VA Emergency Department

By Mark D. Olszyk, MD, MBA, FACEP
Deputy Chief of Staff, VA Marylnad Health Care System, Chairman,
VHA Advisory Committee for Emergency Medicine

Scope

The Veterans Health Administration (VHA) includes about 140 emergency departments and urgent care clinics with a combined total of 1253 beds. As of 2007 (our last comprehensive survey), 542 fulltime and 860 part-time physicians staffed the emergency departments and urgent care clinics. Of that total, about 200 were board-certified by ABEM. Over half of those so certified were also residency-trained. The ranks of board-certified emergency physicians continue to grow in VA emergency departments. In 1993, a study reported a mere 19% of VA EDs employed emergency medicine–trained physicians; today, the percentage of VA emergency departments that employ board-certified emergency medicine physicians is up to 54% (C.S. Kessler, MD, unpublished data, 2008)

Over the past 20 years, the VA has attempted to improve the state of its emergency departments. Until recently, for instance, characterization of EDs varied widely between the many VA medical centers. Terminology was inconsistent, with most hospitals using either "Emergency Room (ER)" or "ED" but others using "Evaluations and Admissions" or "Admitting Office." Aside from producing confusion on a basic level, the absence of a standard terminology indicated a lack of consensus on the roles and responsibilities of the emergency department. To address this problem, the VA issued a 2006 directive that sought to establish uniform definitions for its emergency departments and set minimal standards on the responsibilities of and level of care provided by these departments.

Publications

Research, education, and publications also continue to increase in number and depth reflecting the maturity and expansion of our academic ranks. In the past year, VHA emergency medicine physicians have published papers in Federal Practitioner, the American Journal of Managed Care, Maryland Medicine, and various federal newsletters.

EDIS

The VA uses Emergency Department Integration Software (EDIS), a patient-tracking tool that helps monitor, record and manage the flow of patients through emergency care to help reduce wait times and increase patient access to services.
This electronic version of the tried and true grease board gives real-time graphic visualization of patient location, acuity and status. It grew from a Class III patient tracking tool developed in Syracuse, New York, as part of our efforts to make local innovations into national solutions.
EDIS records key activity events during emergency care and produces accurate reporting on the performance of patient care services. This includes elapsed time and department workload reports that identify bottlenecks, support planning and enable performance improvements. Such detailed visibility allows EDIS to be a powerful patient flow management solution for standardization of emergency department processes and the adoption of best practices. The result - increased efficiency, reduced wait times, better decision support and ultimately better care for our veteran patients.

Stroke

VHA emergency medicine is taking a leading role in upgrading our response to veterans who present with stroke. According to the VHA Quality Enhancement Research Initiative (QUERI), 15,000 veterans are hospitalized for stroke each year, with new strokes costing an estimated $111 million for acute inpatient care, $75 million for post-acute inpatient care, and$88 million for follow-up care over six months post-stroke. Forty percent of these stroke survivors are left with moderate functional impairments and 15-to-30% with severe disability. Even among those veterans with "mild stroke," significant residual deficits may limit mobility, increase risk for falls, and limit community reintegration and quality of life. To this end, we have surveyed all facilities in VHA and are coordinating efforts to increase patient education, speed response times, make imaging modalities responsive and available, and to maximize the appropriate use of thrombolytics.

Continued on page 11

Hemostatic Agents: Where are we now?

By LCDR John Devlin, MC, USN

At the conclusion of this article, the reader will be able to:

1. Review the history of hemostatic agents used in the combat setting.
2. Review the current literature related to the use of various hemostatic agents.
3. Compare available hemostatic agents in terms of advantages and disadvantages.
4. Link the combat use of hemostatic agents to civilian applications.

Case Report

A young adult Iraqi national struck by shrapnel during a mortar attack presented with a profusely hemorrhaging zone two neck wound to the 24th Marine Expeditionary Unit battalion aid station. Awake and alert, initial evaluation revealed no airway compromise. The brisk bleeding from the anterior neck wound could not be controlled with direct pressure and was not amenable to a tourniquet. A pressure dressing could not be devised that would not occlude arterial flow or compromise his airway. Definitive surgical management was a twenty minute helicopter flight away and several other critically injured patients needed to be attended to. To achieve hemostasis, a piece of a HemCon® bandage (HemCon Medical Technologies Inc., Portland OR) was placed deep within the wound and pressure was applied for approximately 5-10 minutes. After application of the hemostatic agent, no active bleeding was noted. The patient remained alert, stable, and with an intact airway throughout his medical evacuation to surgical care.[1]

Introduction

Hemostatic agents were originally developed for use by military personnel on the battlefield. Hemorrhage control in combat casualties has challenged medical professionals since antiquity. Despite technological progress, exsanguinating extremity wounds remain the primary source of preventable battlefield mortality.[2] Analysis of the injuries to US Army soldiers during the Battle of Mogadishu accelerated clinical investigation into the efficacy of topical chemicals used for hemorrhage control.[3] Ridley Scott's film adaptation of Mark Bowden's 1997 novel Black Hawk Down, the documentary of these casualties, catapulted investigation of these hemostatic agents into the public eye. Today several hemostatic agents are available, representing the product of several decades of research.

A brief history of battlefield hemostatic agents

US Forces have utilized several hemostatic agents on the modern battlefield. Dry fibrin sealant dressing (DFSD, American Red Cross, Holland Laboratories, Rockville, MD) was the first hemostatic agent employed by US Armed Forces. The topical mesh impregnated with lyophilized fibrinogen proved to be extremely efficacious in animal models[4] and was approved for use under the FDA's Investigational New Drug protocol. However, its lack of durability in a combat environment and cost prompted the US military to abandon it after the introduction of two more cost effective and FDA-approved agents. The HemCon® bandage, discussed in the case study above, was approved for use in 2002 and was rapidly adopted by the US Army. Investigations by the US Army Institute of Surgical Research demonstrated the agent's efficacy, durability, and safety.[5-7] The chitin-based active agent in HemCon® promotes clot formation by adhering to bleeding tissue, activating platelets, activating the intrinsic coagulation cascade, and accelerating fibrin polymerization.8 However, lot variability in product batches opened the door for a competitor. QuikClot® (Z-Medica Corp., Wallingford, CT), a granular, zeolite-based hemostatic application, was also approved in 2002. QuikClot®, which achieves hemostasis by adsorbing free water and concentrating the body's natural clotting factors, was distributed to US Marine Corps units in both Operation Enduring Freedom and Operation Iraqi Freedom. An unfortunate side effect of the original QuikClot® formulation was its exothermic properties during activation, resulting in unnecessary thermal injury.[9, 10] In the past five years, both companies have corrected these initial design flaws. Investigations involving the HemCon® bandage have yielded more consistent results than early trials, and Z-Medica has released a low-heat QuikClot® ACS+™ product. To date, numerous after action reports are available to document the effectiveness of both the HemCon® bandage and the QuikClot® granular formulation when utilized by proficient personnel on the appropriate wounds.

Recently published and ongoing investigations

Over the past eighteen months, several new hemostatic agents have been introduced by both industry veterans and fledgling companies. CELOX®, WoundStat™, ChitoFlex®, and QuikClot eX™ represent promising new agents. Each product has shown potential in initial or pre-clinical trials, as manufacturers struggle to produce the ideal agent.

CELOX®, was approved by the United States Food and Drug Administration in June 2006, and has already been deployed to the warfront. This granular dressing is composed of marine biopolymer (primarily chitosan), and works by interacting directly with red blood cells and platelets to form a cross-linked barrier, thus facilitating blood clot formation. CELOX®, developed by SAM Medical Products, was recently tested for efficacy in an animal model of severe extremity hemorrhage.[11] This model, designed by Alam et al, simulates a blast injury with considerable tissue loss.12 Using Alam's model, Kozen et al demonstrated that CELOX® is a viable alternative to hemostatic dressings currently being employed on the battlefield.[11] SAM Medical Products plans to introduce an array of new hemostatic products for both military and civilian use within the next year (personal communication). One of these devices, CELOX-A™, consists of a hand-held applicator that injects the product directly into limited access injuries, such knife or bullet wounds. These products have yet to be tested in controlled trials.

Another topical agent that received FDA approval in 2007 is WoundStat™, a mineral-based granular material developed by Virginia Commonwealth University. WoundStat™ was tested in a collaborative study with the Army's Institute of Surgical Research, and was reportedly effective at controlling hemorrhage, non-exothermic, and easily removed from the wound after use.[13] WoundStat™ achieved 100% survival in a high pressure arterial bleed model compared to 20% in the HemCon® group and no survival in the QuikClot® group.[13] These data appear promising, however, CELOX® was not tested and these findings have not yet been reproduced.

Z-Medica Corporation, the manufacturer of QuikClot®, has created the novel mineral-based hemostatic agent QuikClot eX™. No published studies of efficacy or safety are currently available. QuikClot eX™ has allegedly shown marked potential in proprietary trials and may represent another suitable alternative to existing agents.

Model development

Initial animal studies utilized Alam's pioneering swine model of uncontrolled extremity bleeding. The model consisted of making a generous incision in the groin of the Yorkshire swine. Blunt dissection was used to identify, isolate, and completely expose the femoral neurovascular bundle. In various studies, the bundle was completely transected to initiate an uncontrolled hemorrhage. To simulate the response time of a first responder, the animal was allowed to bleed freely for 5 minutes before an intervention was made. The animal was then randomized to receive either no dressing, standard gauze or one of three hemostatic agents in addition to standard gauze. Employing Alam's model, several agents were developed. However, conflicting clinical results and documented battlefield failures of various hemostatic agents has generated criticism regarding the model's applicability in all battlefield.[10, 14, 15] One trend in hemostatic agent research over the past three years has been the reduction of post-injury bleeding times from 5 minutes to 3 minutes, and now, to 30-45 seconds. The rationale for this evolution is as follows: first, although response times to a wounded warrior will generally exceed 45 seconds, the warrior will perform maneuvers to limit exsanguination that cannot be reproduce in an anesthetized animal; second, an anesthetized animal's catecholamine-induced hemodynamic response to injury is blunted and does not accurately approximate that of a wounded soldier.

Although currently fielded hemostatic agents have without question saved many lives, multiple application failures have been documented. Retrospective analysis has identified the culprits as operator errors, such as misplacement of the agent, and use of the dressings in wounds not conducive to hemostatic agents, such as torso injuries. Hemorrhage from small, linear-tract injuries created by projectiles have proven to be particularly refractory to existing agents. To investigate hemostatic agent performance in these injuries, a limited-access model was developed to simulate penetrating injuries.[16] Unlike Alam's model where the bleeding vessel can be directly visualized, ensuring correct placement of the agent on the site of hemorrhage, Gustafson's model precludes direct visualization. His novel model represents a subpopulation of injuries for which currently employed hemostatic agents are not ideally suited. To date, Gustafson's study has been the only published trial with this new model.[16]

HemCon Medical Technologies, Inc., responding to this military need, has introduced ChitoFlex®, a rolled bandage incorporating the same chitosan-impregnated materials as the original HemCon® wafer. Unlike its predecessor, this pliable dressing was designed to be packed directly into wounds of irregular sizes. ChitoFlex™ was recently employed in the limited-access model by the Department of the Navy.[17] Publication of these results is pending.

Like HemCon, Z-Medica Corporation has recently created a new dressing that reportedly incorporates the same clotting properties of their original product, with the advantages of being non-exothermic, highly pliable, and impregnated into a similar material as standard gauze (personal communication). These properties make the new agent ideally suited for small entrance wound injuries. Z-Medica is currently collaborating with the US Navy on a controlled trial in a limited-access model scheduled to begin in February 2008.

What makes a hemostatic agent ideal has been debated. However, expert consensus in the field agrees that the optimal product must be simple to apply by our troops, durable under harsh environmental conditions, inexpensive, safe, and effective.[14] The Committee on Tactical Combat

Casualty Care currently recommends the use of traditional hemostatic techniques, direct manual pressure, pressure dressings, and tourniquets, as a first-line method of hemostasis. If traditional techniques fail to arrest hemorrhage, then the HemCon® bandage is recommended prior to application of QuikClot®.[18] However, this recommendation predates the introduction of Z-Medica's low-heat formulation as well as novel agents from SAM Medical and TraumaCare. The investigation of topical adjuncts for hemorrhage control is a fledgling field and all of the recently released products are untested. Only further research will identify the ideal hemostatic agent.

A shift from the military to the civilian world

Although created for military use, hemostatic agents show promise in civilian prehospital systems. Where delays to definitive surgical care exist, these cutting-edge technologies may be as effective in civilian trauma patients as they have been with our troops. All of the aforementioned agents were designed with ease of use in mind. Application by paramedics, prior to transfer of patients to the emergency room, may be an efficient and efficacious method of controlling hemorrhage in the field. Additionally, expansion of product use to non-extremity hemorrhage is a viable alternative. The authors have personal experience in the effectiveness of these agents to stop epistaxis, dental bleeding, and post-operative circumcision bleeding in a military emergency department. Hemorrhage control in sports injuries, post-op oozing, and warfarin-associated bleeding represents another potential target. The shift from the warfront to everyday emergency medicine conditions is already occurring.

Conclusion

Future research is crucial in the development of hemostatic agents. Despite the many advances that have surfaced in recent years, an ideal means of hemorrhage control has yet to emerge (Table 1). As we increase our knowledge and fine-tune the science behind these products, we set the stage for enhanced efficacy and safety. The applicability and public acceptability of hemostatic agents, both on battlefield and in the civilian world, can only move forward.

Links for Further Information on Hemostatic Agents

Information on the QuikClot® family of products: http://www.z-medica.com/index.asp

Information on HemCon® and ChitoFlex®: http://www.hemcon.com

Information on the CELOX® family of products: http://www.celoxmedical.com

Information on WoundStat™: http://www.traumacure.com

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Table 1. What Makes A Good Field Hemostatic Agent?

Ideal Quality	Standard Dressing	CELOX	HemCon	QuikClot	WoundStat	ChitoFlex
Able to stop bleeding in accessible wounds	-	x	+/-	x	x	?
Able to stop bleeding in limited access wounds	+/-	+/-	+/-	+/-	?	+/-
No adverse effects	x	x	x	**	?	x
Easily stored	x	x	x	x	x	x
Long shelf life	x	x	x	x	?	x
Ready to use; no pre-mixing	x	x	x	x	x	x
Built in re-usability	-	x	-	-	?	-
Minimal training	x	x	-	-	x	-
Amenable to field staff use	x	x	x	x	x	x
Lightweight and easily transported	x	x	x	x	x	x
Biodegradable and fully absorbable	-	x	x	-	?	x
Expense	$	$$	$$$	$$	not yet available to the public	$$$

(+/-) varying results; (**) Reported evidence of tissue damage; (?) theorized based upon observations, but not studied; ($) $0 - $25; ($$) $25 - $100; ($$$) >$100

Adapted by authors from - Acheson EM, et al. Comparison of hemorrhage control agents applied to lethal extremity arterial hemorrhages in swine. *J Trauma*. 2005;59:865-875

Table 2. Tactical Combat Casualty Care Recommendations for Providing Hemostasis

STEPS OF CARE	INDICATIONS
STEP 1: Traditional Hemostatic Techniques	Apply direct firm pressure to wound for two to four minutes using sterile gauze dressing.
	If bleeding is stopped or nearly stopped after pressure, wrap and tie bandage to maintain pressure on the wound and transport.
	Apply tourniquet to extremity if possible.
STEP 2: HemCon® application	If moderate to severe bleeding continues, open HemCon® packet. Remove previously applied bandages and wipe away as much excess blood and liquid in wound area as possible.
	Apply dressing directly over actively bleeding wound with tan backing away from wound.
	Apply pressure to the backing for two minutes, or longer if required for dressing to adhere and bleeding to stop, then wrap and protect area with compression bandage.
	Transport as soon as possible. Remove dressing within 48 hours with saline or sterile water.
	Precautions: For external use only. Contains chitosan from shellfish. Medical attention should be sought for suspected allergic reaction.
STEP 3: QuikClot® application	If traditional methods and HemCon® fail to provide hemostasis, open QuikClot® packet. Remove previously applied bandages and wipe away as much excess blood and liquid in the wound area as possible.
	Pour QuikClot® directly into wound, or apply self-contained QuikClot® ACS+ sponge into wound.
	Immediately reapply direct pressure for three minutes or until bleeding stops, then wrap and protect area with compression bandage.
	Transport as soon as possible. Be certain QuikClot® package accompanies patient to the ED so the physician or medical staff can follow directions to remove QuikClot® with irrigation and/or suction.
	Precautions: For external use only. Head and scalp wounds produce profuse volumes of blood that can cause discomfort from exothermic reaction during application.

CME Questions

1. The dry fibrin sealant dressing was replaced by the US military with the currently employed hemostatic agents because

    a. it lacked durability in a combat environment.

    b. it was not cost effective for universal employment.

    c. FDA-approved agents became available

    d. all of the above are correct.

2. All of the following agents have been approved by the FDA for combat use. Which agent(s) is not commercially available at this time?

    a. CELOX®

    b. HemCon® and ChitoFlex®

    c. QuikClot®

    d. WoundStat™

3. Hasan Alam's original model differs from Scott Gustafson's model in what way?

    a. different animal

    b. different free bleeding times

    c. different ability to directly visualize the bleeding vessel

    d. different use of resuscitation fluids

4. The rationale for the trend in reducing free bleeding times in the swine model is that shorter times

    a. reflect the improved first responder time in OIF and OEF after several years of experience.

    b. better approximate the hemodynamic state of the wounded soldier at the time of hemostatic agent application.

    c. reflect the move away from hypotensive resuscitation in damage control surgery for combat trauma.

    d. are more likely to receive approval from Institutional Animal Care and Use Committees, facilitating the conduct of battlefield resuscitation research.

5. After failure of direct pressure, a pressure dressing, and tourniquets to control extremity hemorrhage, the Tactical Combat Casualty Care Committee currently recommends

    a. applying a HemCon® bandage prior to QuikClot® due to concern over thermal injury associated with the later.

    b. utilizing CELOX® or WoundStat™ because multiple preclinical trials have demonstrated their improved efficacy when compared to HemCon® and QuikClot®.

    c. mixing CELOX® with QuikClot® prior to application , negating the exothermic effects and utilizing the synergistic efficacy of the two.

    d. not employing hemostatic agents because no human, double-blinded, randomized clinical controlled trials exist.

This Year's Leadership conference

By CPT Cameron Olderog, MC, USA; LCDR Lanny littlejohn, MC, USN;
LCDR Amy Hubert, MC, USN and Capt Joseph Novak, USAF, MC

We, the 2009 GSACEP Leadership Award winners, and the GSACEP Resident Representative, Joe Novak, attended the ACEP Leadership and Advocacy Conference in April in Washington DC. as guests of the GSACEP chapter. The two-fold aim of the conference is to increase awareness and advocacy among emergency physicians and to develop leaders. Certainly, the latter goal was strongly enforced by the presence of residents who made up nearly 25% of attendees. The conference consisted of a day of information on current issues, including the Access to Emergency Medical Services Act 2009, and leadership development in emergency medicine, a day devoted to meeting with senators and congressmen on Capitol Hill to discuss issues, and, on the last day, a Town Hall meeting focused on emergency medicine issues. Here are what we believe to be the highlights from the meeting.

The Importance of Advocacy

Many lecturers stressed that advocacy is a core competency, and that we all need to become more involved. We must recognize the importance of being advocates in our professional lives.

As emergency physicians, we all advocate in many ways, and for many reasons. We do it for our patients, particularly those with little means, by calling in a consultant, or pushing for a certain diagnostic test. We may—and should-- take an active role in advocating for our profession in the form of local commitments, such as participating in our own hospital board and medical staff meetings, by working on overcrowding solutions, or helping to guide state laws and policy with respect to emergency medical care.

On a national level, advocacy involves working to strengthen our voice in the shaping of the health system that will deliver care for future generations. While emergency care forms a small part of the overall costs of the healthcare system, it is a critical link that we cannot allow to be overlooked. If you think we've done a good job of making our concerns heard, consider the fact that, at President Obama's recent health reform summit, there were no emergency physicians at the table. In fact, there were very few physicians present at all. Clearly, we must be advocates, not just for our patients, but to help shape the future healthcare system itself which, to a great extent, will determine how we will be able to treat our patients.

Access to Emergency Medical Services Act 2009

Certainly, The Access to Emergency Medical Services Act is a very important tool in this fight. It calls for the creation of a national bipartisan commission on access to emergency medical services to examine factors that affect the delivery of healthcare in U.S. emergency departments. This legislation also requests that the Centers for Medicare & Medicaid Services develop standards, guidelines and measures to address boarding and ambulance diversion.

Many of our nation's emergency departments are overcrowded and under-funded. Healthcare costs are soaring and hospitals are operating on reduced budgets. An increasing number of patients are seeking emergency department care and they wait hours- even days- to be transferred to an inpatient hospital bed. The Access to Emergency Medical Services Act would increase physician payments by10% for EMTALA-related services provided to Medicare beneficiaries in hospital emergency departments or critical access hospitals. This increase will help offset the financial burden placed on emergency physicians who provide an average of $140,000 per year in uncompensated EMTALA-related care.

This bill will also set aside additional funding for on-call specialists who provide emergency medical care. Fewer specialist physicians are taking call from the emergency department because they are not compensated for their work, but are liable for unanticipated patient outcomes.

Leadership

Learning how to advocate effectively is a leadership trait. There is no point in understanding the issues unless we know how to be effective leaders. ACEP offered a number of workshops to help us, supplying strategies and tactics to bring attention to our agenda, showing how to develop effective relationships with public policy makers, and how to work with volunteers and supporters. Overall, we learned that the language we choose, and the way we behave as we express our message, can make all the difference. This training will be useful throughout our careers, and certainly will help us to advance them.

At the end, we had a Town Hall meeting which focused on the workforce issues related to emergency medicine.

At times, all this seemed overwhelming, but the meeting definitely helped us realize how incredibly active ACEP is, and how much it wants each of us to be.

An Update on the VA Emergency Department (con't)

Traumatic Brain Injury(TBI)

In peacetime, more than 7,000 Americans diagnosed with TBI are admitted to military and veterans' hospitals yearly. During times of combat, TBI admissions increase significantly. Historically, 14- 20% of the wounded in armed conflicts are left with TBI. A recent article in The New England Journal of Medicine (Okie, NEJM, 2005;352(20):2043-2047) noted that 59 % of blast-exposed patients from Operation Iraqi Freedom and Operation Enduring Freedom admitted to Walter Reed Army Medical Center had brain injury. As members of the Armed Forces return from engagements in Afghanistan and Iraq, it is anticipated that some will exhibit symptoms of TBI that may not have been diagnosed prior to demobilization. Given the high rate of exposure to conditions that may cause TBI, it is important that VA clinicians maintain a low threshold to suspect TBI and to initiate its management.

While few combat TBI cases are seen initially in VHA EDs, the emergency departments do see a number of non-combat related TBI. Each year in the United States, at least 1.4 million people sustain a TBI. Of these, about 50,000 die, 235,000 are hospitalized, and 1.1 million are treated and released from an ED. Approximately 475,000 TBIs occur among children ages 0 to 14 years. ED visits account for more than 90% of the TBIs in this age group. Falls are the leading cause of TBI; rates are highest for children ages 0 to 4 years and for adults age 75 years or older.

While the nature and outcomes of brain injuries resulting from blast exposure are not yet fully understood, it is important to recognize that brain trauma causes both acute and delayed symptoms. Each requires prompt identification and multidisciplinary evaluation and treatment. Providing specialized health care for military personnel and veterans sustaining a brain injury continues to be a high VA priority. For more details about the diagnosis and treatment of TBI, see Veterans Health Initiative, Traumatic Brain Injury: A CME Program which can be found at:http://www1.va.gov/environagents/docs/USHInfoLetterIL10-2006-004.pdf. Regarding combat-related TBI: VHA emergency department physicians screen all patients to determine if there is any undocumented TBI or a need for more services.

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Summer 2010

A Chapter of the American College of Emergency Physicians

Government Services EPIC

President's Message

By LTC Melissa Givens, MC, USA

There are a lot of exciting things going on within GSACEP. JSS attendees should have received a thumb drive with copies of all the excellent lectures from the conference. Were you there? If not, you really missed something. The conference took on a different flavor in Squaw Valley, CA. From the feedback we received, it was a great venue. We also "combined" the administrative program under the umbrella of JSS, welcomed the participation of emergency physicians and nurses from the VA (who developed some parallel lectures), and even offered a Wilderness Course with COL Wedmore and COL Della-Giustina as faculty.

During the conference, at the GSACEP Board meeting, a logo was approved. I would like to thank Andrew Morgan for his artistic efforts and his patience as we kept sending him back to the drawing board. Take some time to read the meaning behind the logo and give us your feedback on how we can put this logo to use. Are our members interested in hats, t-shirts, etc with GSACEP logo? We look forward to hearing from you on this matter.

Please take some time to read the article in this issue by Nadia Pearson and Tina Sauter. The two Leadership and Advocacy Scholarship recipients do a great job of summarizing their experience in Washington D.C. and instructing us on the rules of the road on getting involved in the advocacy arena.

Scientific Assembly is right around the corner. Make sure to reserve your room in Las Vegas early. We look forward to seeing some new faces in our planning committees at the Scientific Assembly. A description of GSACEP committees and opportunities to get involved can be found in this edition of the EPIC and on the website - www.gsacep.org. We will have a BOD Meeting at SA, as always, and we would love to have you come to it.We know you are going to want to attend our reception. Both are on Wednesday, Sept. 29. Please see our announcements and save the times.

If you have not been to the GSACEP website lately, take a moment to check it out. Don't forget to take advantage of the FREE CME offerred by the Sullivan group. I want to thank Torree McGowan for tirelessly working to improve our website. Torree just returned from deployment. All the time she was away, she maintained the website, and stayed on top of things.

As always, if you can think of ways to improve the site or have other contributions to make, please get involved to make GSACEP work for you.

Important Announcements

The GSACEP Board of Directors Meeting will take place from 1000 to 1200 on Wed., Sept. 29, at The Mandalay Bay in Las Vegas, NV. Room number to come (watch website). All GSACEP members are invited.

The GSACEP reception will take place from 1800-1930 at The Mandalay Bay in Las Vegas, NV, on Wed., Sept. 29. Room TBA. GSACEP members invited.

The Government Services Symposium 2011 will take place March 6-March 9 at The Crowne Plaza Riverwalk, San Antonio, TX. Please watch our website in the fall for details. GSACEP is introducing a Simulation Lab this year.

In This Issue

Bylaws Changes

The following changes to the GSACEP Bylaws (boldface) were approved by the ACEP Bylaws Committee. They will be voted on at the GSACEP BOD meeting in Las Vegas on Sept. 29. GSACEP members present are asked to vote on these changes at the meeting.

Article 6, Section 2: **The Board of Directors is composed of the Officers of the Chapter, those Councillors who are not chapter officers, and a resident representative.**

Section 3: **Each Director shall be elected by ballot, with the ballot made available to voting members online, or by regular mail if the member has no e-mail address** (60) days before the annual meeting with said election no closer than (30) days preceding the annual meeting. The candidate receiving the most votes shall be declared the winner. In the case of a tie, a run-off election will occur prior to the annual meeting to close no later than two days prior to the annual meeting.

The Resident Director shall serve until the annual meeting in his/her final year of residency and shall be elected by ballot of the resident members.

Any current ACEP Board or Council Officer shall be an ex-officio, non-voting Board member.

If You Received a Flashdrive from JSS....

Apparently, some of the flashdrives mailed from the GSACEP office to JSS attendees that were supposed to contain data were blank. The manufacturer erroneously submitted blank drives along with the data-filled shipment. This was completely the manufacturer's error, and they have acknowledged it. They have re-shipped the correct data-filled drives to the office. So far, we have heard from 4 attendees and sent them new drives. If your drive is blank, please notify the office at gsacep@aol.com. The value of the blank drive is approximately $8-$9. The manufacturer wants you to consider it a gift. Thank you.

2010 Recipient of GSACEP Military Excellence Award

CAPT James V. Ritchie, MC, USN, was selected as GSACEP's recipient of the 2010 Excellence in Military Emergency Medicine Award. Because of his outstanding leadership in the chapter (he served as President Elect, President, and Immediate Past President from 2006-08), mentorship of emergency medicine residents as Residency Director at Naval Medical Center Portsmouth, pursuit of teaching excellence, and strong academic standards, Dr. Ritchie is more than worthy of this award. But there is so much more.

He presented justification for development of the Simulation Center at NMC Portsmouth, arranged for multidisciplinary training there, and provided individual instructor and student training. During its first year of operation (2005), the Simulation Center served over 20 separate departments or entities, trained hundreds of physicians, nurses, and corpsmen, and has since become a military center of excellence for the region.

Dr. Ritchie's outstanding efforts in the field were demonstrated while deployed to Kandahar, Afghanistan, in support of 26th Marine Expeditionary Unit in Operation Enduring Freedom. There, he directed the Shock/Trauma area, including casualty receiving. He treated combat and trauma casualties and directed detainee medical care, involving the setup of a medical system to care for up to 400 detainees, including intake screening, surgical care, daily medical treatment, and medication administration.

Because he was deployed to Iraq at the time the award is usually presented, Dr. Ritchie will receive the award at the GSACEP reception at Scientific Assembly in Las Vegas.

The opinions and assertations 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.

Be a Military Leader and Advocate for the Best Specialty in Medicine

By CPT(P) Nadia Pearson, MC, USA, Carl R Darnall Army Medical Center, Ft Hood, TX
LCDR Bettina Sauter, MC, USN, Naval Medical Center, Portsmouth, VA

Emergency Medicine is in the forefront of healthcare for many people in our country. The needs of the community are therefore obvious to emergency physicians, and it should be natural that we employ our education and savvy to convey current healthcare issues and concerns to the public and to policymakers who may not truly comprehend their intricacy. In order to improve healthcare as a whole, physician leaders should advocate for their patients. Leadership skills are essential in order to convey not only the importance and urgency of the issues, but also to gain the support and allegiance of others. However, leadership is a skill that must be developed and practiced. The military, as do other prosperous institutions, relies on its leaders to achieve their objectives and mission. As military emergency medicine specialists, it is imperative that leadership skills are fostered and practiced, not only for the benefit of our patients in the emergency department, but for the success of our service men and women. As military officers, we serve many roles for our service members, in which the success of the service members' missions and objectives relies on our success as leaders. Seeking training in leadership and advocacy, we had the pleasure and privilege to be selected for a scholarship offered by GSACEP to attend the ACEP Leadership and Advocacy Conference, April 2010, in Washington, DC.

In retrospect, prior to our attendance at this meeting, our knowledge of topics relating to leadership and advocacy was quite limited. We had little insight into how these important topics affect us as members of the US Armed Forces. As another aside, residents often get lost in learning the clinical aspect of the part of the specialty, forgetting that health law and policy will ultimately drive our practice environment. Do we really want Medicare or Tricare, for that matter, governing what we order in the ED because of reimbursement costs? Unanimously , we would hope that our policymakers would be able to understand how that could potentially be problematic. After being in Washington, DC, we have come to realize that the only way policymakers can come up with valid solutions to our issues, is education on what the issues really are in the Emergency Department. Who better to educate them, than emergency medicine physicians, and even more so, military EM docs because of their inherent strong leadership skills.

Knowing why and for what issues to advocate may be more obvious than the actual "how to" go about making a difference. As a member of the US Armed Forces, it is hard to know what is acceptable and what is not. For example, going on your local news in uniform to discuss ED boarding, or wait times, may not be the smartest idea. There is a right way to lobby while in the military and here are a few points to consider:

LCDR Sauter and CPT(P) Pearson

• As long as you are advocating as a private citizen (i.e. not in uniform or representative of the government), who is a leader and representative of the Emergency Medicine specialty, you can meet and discuss, any issue with a political leader, be he/she local, state or national. As a matter of fact, the more personal you can make the issue, the more likely they will understand the issue you are trying to discuss. Personal accounts and patient stories often help.

• Do not use military references, to include rank, grade, or hospital references

• Organizations such as ACEP have common agendas and goals based on the current political actions up for discussion or vote. It is very useful to be in contact and sign up and receive the newsletters containing this information. It may sway your local representatives to know how their constituents will vote on certain bills

• GSACEP may not contribute to political campaigns as this may be interpreted as military endorsement. Individuals however, may participate in NEMPAC, through contributions or time.

It is easy to get started on advocacy. Healthcare reform is a major topic in today's legislative push, especially considering the new (2010) health care bill. There is a myriad of information that is on the internet which can help us to understand the issues. Also, there are many resources which we found extremely helpful.

GSACEP scholarship winners, and leadership, at LAC dinner together

Be a Military Leader (cont on page 4)

Be a Military Leader (cont from page 3)

1. The EMRA Emergency Medicine Advocacy Handbook- provides an excellent first look and will give you an outline of major issues in health policy. It also explains the advocacy process – Do's and Do Nots. The EMRA (Emergency Medicine Residents Association) website also list may helpful resources.

2. ACEP- many resources can be found on the website www.acep.org ACEP 911 network is an email list serve that is extremely helpful to join to get the most up to date newsletters.

3. Local medical societies and state medical boards will provide local information regarding ongoing issues.

4. Local political offices may have health advisor representatives that may be helpful to obtain relevant information.

5. Join NEMPAC: this may be the most helpful thing that you can do. This is the National Emergency Medicine Political Action Committee. You can make donations to this organization monetarily or by "giving a shift", which will, in turn, support federal candidates for the House of Representatives or the Senate who will then vote for policy that is beneficial to our specialty. Information on NEMPAC can be found on the ACEP website on the Advocacy tab.

Vice-Speaker Marco Coppola, DO, FACEP, with Congressman Michael Burgess, MD, and CPT(P) Pearson

As we look forward to a long career in Emergency Medicine, and perhaps a military career as well, we would URGE you to develop, nurture and practice leadership skills. Emergency medicine advocacy is essential to help mold the future of how we will be practicing medicine. Nobody understands leadership better than military officers, and nobody knows the issues we face on a day to day basis more than ourselves. Be proactive and do something….because if you rely on others, the outcome may not be what you were hoping.

We would like to thank GSACEP for this awesome opportunity and encourage junior residents to take the opportunity to apply for this scholarship next year.

Research Forum Winners

This year's Research Forum at the Joint Services Symposium produced a record number of poster submissions and oral presentations. We are happy to present the winners:

Winner, Best Faculty Poster:

Maj Vik Bebarta, USAF, MC

Best Resident Poster:

CPT Jason Heiner, MC, USA

Runner-Up Best Oral Presentation:

Maj George Dockendorf, USAF, MC

Winner, Best Oral Presentation:

Capt Chris Pitotti, USAF, MC

Job Openings: GSACEP Committees

Government Services needs your skills, and a little bit of your time. Please consider joining one of our committees. They are a great training ground for leaders, and an opportunity for you to shape the organization. Just about every GSACEP president has served on one of these committees. For the most part, each committee requires only a few hours of your time each month. Contact the office at gsacep@aol.com or 877-531-3044.

Conference Committee

Our mission is to provide the latest advances in diagnosis, treatment, and skills necessary for emergency medicine practice to military emergency physicians and to emergency physicians practicing within the federal healthcare system.

Objectives:
• Design, evaluate, and implement the curriculum in a timely manner.
• Oversee ACEP Category 1 process, meeting ACCME and AMA standards.
• Meet budget requirements.
• Identify potential "supporters" of the conference.
• Provide onsite monitoring of, and assistance to, the faculty

Communications Committee

Our mission is to provide information of interest and value to our members and to provide the vehicles of communication.

• Identify topics and writers, assign articles, and meet deadlines for quarterly newsletter.
• Design website to reach the greatest number of members by keeping its content current, lively, and, if applicable, interactive.
• Develop new communication tools to reach membership.

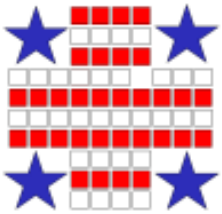
Membership Committee

Our mission is to retain and increase membership, and create membership development tools.

• Recruitment and retention of residents to Active membership.
• Outreach to delinquent members.
• Outreach to potential members.

A Logo for GSACEP

By MAJ Andrew Morgan, MC, USA



SYMBOLOGY:

The logo design that I have created for GSACEP is explicable in the following way:

The four blue stars represent emergency physicians serving in each of the three armed services and in service of any federal, state or local government.

The cross-shaped figure reminds us of our commitment to serve the ill, injured and vulnerable.

The tiles are reminiscent of our parent organization logo with the "missing link" denoting the critical role of our specialty in modern healthcare.

The stripe pattern and overall red, white and blue color scheme insinuate our national flag and affirm our allegiance to the simultaneous service of our patients and our Nation.

BIOGRAPHY: MAJ Andrew Morgan, MC, USA is the Battalion Surgeon for 1st Battalion, 3rd Special Forces Group (Airborne) in Fort Bragg, NC. Prior to his assignment to 3rd SFG(A) he served in joint overseas assignments with various SOF units while practicing as a staff emergency physician at Womack Army Medical Center, Fort Bragg, NC. He is a 1998 graduate of the United States Military Academy at West Point, NY, a 2002 graduate of the Uniformed Services University of the Health Sciences, and a 2005 graduate of the Madigan AMC-University of Washington Emergency Medicine Residency.

RESIDENT COLUMN: Do the New ACGME Proposed Standards Affect Me?

By Capt. Joseph David Novak, USAF, MC

Resident work hours have been a hot button topic in medical education since the tragedy of Libby Zion's death in 1984. More recently, multiple studies have analyzed the affects of the 2003 ACGME work hour guidelines. In a review of the new rules directed by Congress, the IOM determined that the 2003 guidelines resulted in residents trying to do the same work in less time, hence increasing their workload pressure. Based on their findings, the IOM made further recommendations to reduce resident work hours. This past June, the ACGME issued new draft standards for public scrutiny and comment for a period of 45 days. In September, the Board of Directors of the ACGME will vote on the new standards with implementation occurring July, 2011.

So what are the changes in the latest iteration? Most changes involve intern duty hours and supervision required. The maximum total weekly hours averaged over 4 weeks is still 80, with 4 total days out of 28 required to be off. However, time spent moonlighting is now to be added into the 80 hours, and PGY-1's will no longer be permitted to moonlight. Further, PGY-1s are only allowed to work 16 consecutive hours. No more 24 or 30 hour shifts for interns. PGY-2s and above can work a shift with direct patient contact for a maximum of 24 hours, with an additional 4 hours for "effective transitions in care". So a maximum of 28 hours vs. the current 30. The guidelines recommend alertness management strategies and napping after 16 consecutive hours. There are also caveats for "unusual circumstances" when residents "on their own initiative" can stay beyond these restrictions for continuity of care for a severely unstable patient, the academic importance of transpiring events, or humanistic attention to the patient or family. Time off between shifts is encouraged to be 10 hours, but mandated at 8 for interns and intermediate-level residents, and can be less than 8 for residents in their final years of residency.

Regarding resident supervision, the new guidelines specify four different levels of supervision from direct presence and oversight to supervision and availability from home. The physician providing the supervision can be a senior resident or staff. PGY-1s must have direct supervision immediately available at all times.

The new guidelines also put the focus of residency more on learning and teaching and less on busywork and events with no educational merit. Also, the report makes residents more accountable for time management and states that "Residents and faculty members must demonstrate ... management of their time before, during, and after clinical assignments."

These changes are important for EM residents, especially during off-service rotations. Anecdotally, EM residents are maximally utilized during off-service rotations. However, if you exceed your ACGME duty hours even while outside of your ED, you will put your EM program at jeopardy, something that definitely won't make your PD happy. In the ED, however, most of the new guidelines should already be followed. Supervision is provided by the staff on shift. And moonlighting is not allowed as DoD medical residents. Also, although not specified in the ACGME guidelines, shifts in the ED are not to exceed 12 hours. Where EM programs can get in trouble, however, is the time off between a preceding shift and other events such as cadaver labs, grand rounds, etc.

So, what should you do if you are violating ACGME guidelines? This is a tricky situation because you don't want your program to lose accreditation, and yet you are obligated to do something about the violations. Not saying something is the wrong answer. Picture this, you are at hour 31 of a call shift, or you are at 90 hours for the month, you write a simple order for a basic drug that your patient is allergic to, and the patient dies. Who is going to defend you? What is your recourse? Remember that after Libby Zion's death, the intern and resident involved were charged with 38 counts of gross negligence and/or gross incompetence. Also, thus far, as a profession, we are still governing ourselves. However, in researching this topic, I've found more than one call for direct governmental oversight of resident training, i.e. a Washington-run ACGME. Is this what we want? So, to deal with the ACGME offense, first off, I would highly recommend talking to your EM's Chief Resident, a trusted faculty member, or your Program Director. More than 99% of the issues will be resolved very quickly on this level. If this doesn't work, there is a hospital ACGME Designated Institutional Official (DIO) that you can turn to. If that still does not work, and the chain of command is also not working, you can submit a formal ACGME concern (which will not affect your program's accreditation status) or a formal ACGME complaint (which may affect your program's status). Information can be found on the ACGME website. The new guidelines are supposed to be accompanied by easier complaint/concern submissions and "whistleblower" protection, but those procedures have not yet been published. If your concern is not directly ACGME-related or you need other advice, try your chain of command, the base legal office, the base defense council, chaplains, the family advocacy office, the military equal opportunity office, the hospital or base inspector general, the hospital or base ombudsman, or the DoD Fraud Waste and Abuse hotline.

Will the new guidelines achieve the ACGME's stated goals of patient safety/quality and a safe and humanistic educational environment? I think this will be borne out in the literature in the decade to come. However, as a former pilot with very strict and clear flying hour regulations, I think that after an adjustment period and cultural acceptance by the House of Medicine, this will prove to be a change that will benefit patients and physicians alike.

GSACEP Conference
Squaw Valley, CA

For the first time in almost a decade, GSACEP held its annual CME conference outside of San Antonio, TX, at the beautiful Village at Squaw Valley, CA, April 12-15. It was a huge success with attendance breaking 150. The course schedule permitted down time to enjoy the slopes, and many did.

Kevin Klauer, DO, FACEP, guest lecturer at JSS

Drs. Christopher Martella, Mark Olsyk, Randy Case, and Frank Zwemer

Bernie Carr trying to fill Linda Lawrence's snow shoes

MAJ Kim Lairet, MD, guest lecturer

LTC Robert Gerhardt, MD, MPH, FACEP

Guests at the reception

LTC Givens introduces outgoing president Maj Julio Lairet

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Winter
2009-2010

A Chapter of the American College of Emergency Physicians

Government Services

EPIC

That Day at Ft. Hood

By LTC Melissa Givens, MC, USA

On November 5, 2009, the Emergency Department at Carl R. Darnall Army Medical Center, Fort Hood, Texas responded to a mass casualty crisis – a shooting in our Soldier Readiness Processing Center, located not far from the Emergency Department's doorstep. I cannot begin to describe the heroic efforts of those on scene, emergency responders, Army leadership on post, hospital leadership and personnel, and our amazing community. You will be hearing many of their stories. The following is a collection of thoughts from those involved in the tragedy. On that day, the contributions of each individual – staff physicians, administration, nurses, residents, clerks, housekeeping, medics, chaplains, social workers, and many more – resulted in an overwhelming team effort. In keeping with the spirit of cooperation that occurred that day, this collection of vignettes displays how it takes the whole team to tell a story.

continued on page 2

President's Message: Year-End/ New Beginnings

By Maj Julio Lairet, USAF, MC

As we reflect on 2009, just past, I would like to thank all of you for your involvement and efforts to make our chapter one of the most productive ones within ACEP. This was an exciting year for us with continued success by many of our members across the spectrum of Emergency Medicine. We are leaving our mark in everything we do, from academics to operational military medicine. Special congratulations to our very own Dr. Marco Coppola on winning the election as ACEP Council Vice-Speaker.

Moving forward into 2010, we have much to look forward to. I know that this will be another year of triumphs by our talented membership. JSS is just around the corner, and we are looking forward to an incredible educational program at Lake Tahoe. If you haven't yet, please mark your calendars - the dates are 12 to 15 April 2010. We are looking forward to seeing many of you with us on the slopes.

On the deployment front, our specialty continues to fill many operational and medical billets touching many lives as we do the mission that we were trained for. For those of you who have recently returned to the U.S. I would like to welcome you back home. For those of you who are still out there or have recently deployed, I wish you a safe and a rapid return. As a chapter we are here for you in anything you need. I would like to personally thank each of you and your families for all the sacrifices in what you do.

Also a reminder that The Sullivan Group generously provided all military emergency physicians with three courses of FREE CME. This program is all available to ALL military physicians not just the deployed ones. Please see our website for more information.

I wish you all a wonderful Holiday season and a Happy New Year!!!

In This Issue

"November 5, 2009 for me was a day of dichotomies. How could a bright, sunny, Texas fall day full of promise turn into such a dreary and gloomy expanse of time? How could the orderly life and job that I love so well suddenly be thrown into an entity that I didn't recognize?" – EM faculty.

"We got word of what was happening when a staff doc rushed through the admin area looking for the acting chief. They mentioned a GSW was on the way in a pick-up truck. I can't remember if at that time if they said it happened at the SRP site or what but when the driver got here, we realized it was the beginning of a nightmare." -EM administrator

"At approximately 1340 I was charting in the team area when I heard someone yell, 'We have gunshot victims in the ambulance bay.' As we walked out we were met immediately by two bleeding soldiers being carried in by their buddies." -EM faculty

"When I saw two rows of medics outside of ambulance bay ready to receive patients, I knew this was not a drill. When I saw Family Medicine and Internal Medicine staff members with bloody gloves around the ED, I knew this was not a drill. When I saw my attendings with bloody scrubs at patient's bedside, I knew this was not a drill." -EM resident

"You could feel the urgency in everyone--the docs, the nurses, the medics, the clerks--but everyone performed efficiently and without reserve. There were no doubts, no second guessing, just professionals doing what they were trained to do." -EM resident

"In that moment of crisis, when every doctor in the hospital descended on our ED, it was medicine as we all would hope for... no blocking, no turf wars, no ego contests, no different specialties; just doctors. Surgery, Medicine, Urology, Anesthesia, ENT, OB/GYN, Emergency, and more all working together in a seemingly natural efficiency for the greater good." -EM resident

"I had many doctors of all specialties arriving and asking me 'Where do you need me?' Not 'What's going on?', or 'This is what we are going to do'. Just simply, 'Where do you need me?'" -EM faculty

"As an intern, I've always assumed that there would always be more time to learn something. I had assumed that my first chest tube, central line, or trauma intubation would be some how in a controlled setting with a junior and senior resident and a attending supervising my work. On that day, there simply weren't enough people available. The time for hand-holding was over…" -EM intern

"All I can say about [the charge nurse] at the helm was I think at one point she had three phones up to her ears at once. Her calm and professionalism was inspirational to watch." -EM faculty

"Amidst the flurry of activity, there was a moment where all things seemed to move in slow motion...I saw interns witnessing with a slight awe all that was going on around them, 2nd years executing with hast those procedures they had been diligently taught, 3rd years practicing what they had preached, and calm staff managing it all. Each of us was, in that moment, living emergency medicine." -EM faculty

"For those of us who have yet to deploy, a little bit of down range was brought home." -EM resident

"Our docs are trained to do this in war zones so they had everything under control but I don't think anything could prepare the support staff for this assault in an urban, non-combat zone." -EM administrator

"I remember standing in the trauma bay getting supplies for a central line when [an attending] came in looking for a stylet for an ET tube. At that instant, I had absolutely no idea what a stylet was. [She] asked me where they were stored, which is something that I could tell [her] in my sleep. They're in the airway cart that I check before every shift. Right then, I couldn't even picture what the word meant. I remember being really frustrated because I knew it was a word that I knew, but I couldn't help [her]." -EM intern

"I walked by the airway cart three times, looking for a stylet, sitting right where it belonged." - EM faculty

"Without materials I was a glorified BLS provider." -EM faculty

"I remember clearly the efficiency at which patients were resuscitated and dispositioned. I would look around at beds where a patient was that was now empty and wonder if they were transferred or died; fortunately, the vast majority were the former." -EM resident

continued on page 4

The opinions and assertations 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.

Congratulations

During the annual meeting of the Association of Military Surgeons, Maj.Vikhyat Bebarta, emergency physician and medical toxicologist, received the Donald F. Hagen Young Physician award. The award is presented to recognize superior physicians whose leadership and outstanding execution of military and humanitarian operations has saved lives.

Maj. Gen. Tom Travis, 59th Medical Wing commander (center), congratulates 59th Emergency Medicine Squadron doctors Maj. Julio Lairet (left) and Maj. Vikhyat Bebarta who won awards during the Association of Military Surgeons of the United States annual meeting and awards dinner in St. Louis, Mo., Nov. 18.

Among Dr. Bebarta's many accomplishments are his work to improve combat casualty care, his support of Operation Iraqi Freedom and his achievements in medical research. He created Wilford Hall Medical Center's first toxicology consultative service which provides 24-hour coverage. While deployed, Dr. Bebarta served as an Emergency Department Flight commander where he developed a clinical policy on the treatment of white phosphorus burns and created the Department of Defense toxicology e-mail consult service for deployed providers.

Maj. (Dr.) Julio Lairet, director of the Enroute Care Research Center at the Joint Center of Excellence for Battle Field Health and Trauma Research, received the first ever AMSUS rising star award. The award recognizes individuals who demonstrate success in federal health care delivery or management and areclearly on an ascending path to an executive leadership role.

Dr. Lairet's numerous achievements included directing the operations of the busiest ambulance service in the Air Force, which transported more than 2,900 patients in 2008. As medical director for the critical care air transport team, or CCATT, pilot unit, he directed a process improvement program that assessed the care delivered on every critical care transport mission across the globe. His advice to the Air Mobility Command Surgeon shaped the training and equipping of all CCATTs deployed by the Air Force in support of global operations.

AMSUS is comprised of medical professionals serving in the full spectrum of healthcare disciplines, from the U.S. Army, Navy, and Air Force, to the U.S. Public Health Service and Department of Veterans Affairs. The organization provides up-to-date information and services to more than 9,000 members.

GSACEP Conference 2010 • Lake Tahoe, CA

Yes, it's true: The Joint Services Symposium 2010 will be held at The Village at Squaw in beautiful Lake Tahoe, CA. Dates are April 12 (Monday) through April 15 (Thursday).

We have an exciting program planned, including: a Wilderness Medicine Lab; Operational Medicine topics; Advanced Ultrasound Workshop; Risk Management - How to Avoid Getting Sued; Military Malpractice Process - Your Due Process rights; wide range of Pediatric Topics. So much more!

Resident fees are only $325 for all four days! GS or ACEP staff physicians pay $495 for all four days. There is also a Veterans Administration track this year. And, we've brought back a nursing track. Nurses can attend all four days for $395. So, save these dates!

Residents are also being offered the opportunity to sign up for two-bedroom suites at the cost of $199 nightly. These suites can accommodate four people. To take advantage of these suites, which are limited, you must register for the suites no later than March 1, 2010, and you must register through the chapter office. You can reach us online shortly, and certainly call us at 877-531-3044, Mon-Fri., 0900-1700 EST. Please have your credit card ready. Whatever suites are not used by residents will be released.

PLEASE VIST OUR WEBSITE at gsacep.org as details develop.

JOINT SERVICES SYMPOSIUM 2010

EMERGENCY MEDICINE AT LAKE TAHOE

CALL FOR ABSTRACTS

THE GSACEP RESEARCH COMMITTEE IS SEEKING SUBMISSIONS OF ORIGINAL RESEARCH FOR PRESENTATION AT THE JSS 2010 RESEARCH FORUM. THIS PROGRAM, WHICH HISTORICALLY HAS SHOWCASED BOTH CUTTING-EDGE INVESTIGATION AND UPCOMING MILITARY HEALTHCARE RESEARCHERS, WILL BE CONDUCTED ON WEDNESDAY APRIL 14, 2010 1500-1700hrs AT THE VILLAGE AT SQUAW, LAKE TAHOE, CA.

Abstract Submission Requirements:

Original research:

Abstracts should represent original basic science or clinical research. Trainees (Residents and students) may submit on-going projects or projects that have previously been presented within the last calendar year (Apr 2009 – Apr 2010). Attending faculty may submit only previously unpublished or material that has not been presented.

Abstracts must include the following subsections, consistent in style with those appearing in Annals of Emergency Medicine:1 title, study objectives, methods (design, setting, type of participants), results and conclusions. The abstract should fit on a single page of 8 x x 11inch paper, typed double-space with margins, with a minimum font size of 12 point, Times New Roman or Tahoma preferred. Tables and figures should not be submitted during the initial review.

Submission in electronic format is required. The file should contain names of all authors, appropriate institutions, main point of contact, title of abstract, text of abstract, and statement of IRB oversight if applicable. Primary investigators should also identify themselves as in-training (medical students and house staff) or attending staff.

Entries should be submitted to LTC Dave Barry at James.Barry@med.navy.mil with a firm deadline of 1700 hours (5:00 pm) EST on 20 Feb10. Abstracts will undergo screening by peer review. Those that are accepted will have been judged scientifically valid and as yielding important information which will ultimately affect patient care. Priority will be given to those abstracts that support the JSS 2010 themes of wilderness medicine, military and operational medicine, and cutting edge advancement in emergency medicine. Abstracts will be reviewed for oral presentation or poster exhibition. If accepted for oral presentation, one of the authors will have 15 minutes (10 minutes for presentation and 5 minutes for discussion) to present their work on 14Apr10. Final decisions will be made by e-mail to the principal investigator NLT. It is our understanding that all invited presenters will be provided central funding to cover travel costs.

GSACEP will present awards for best scientific presentation and best scientific poster (in-training and attending staff are judged separately). All submitted accepted abstracts will be published in the EPIC. Plans for publication in a peer-reviewed journal are ongoing.

For further information see the GSACEP Web site GSACEP.org. Or contact GSACEP: GSACEP@AOL.com / 877-531-3044 or James.Barry@amedd.army.mil

Reference: 1.http://journals.elsevierhealth.com/periodicals/ymem/content/instauth#abstract

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That Day . . . continued from page 2

"I was able to clear beds and get the delayeds out. Afterwards, [the triage officer] said to me, "Just when I thought we couldn't take another patient, you would come out and say 'Bed X is ready for the next casualty'". - EM faculty

"I returned to the ED and made contact with Scott & White Hospital to find an accepting physician. My report consisted simply of the patient's name and injuries and the patient was accepted, no-questions asked. In fact, concerned with the brevity of our conversation, I actually called him back a few minutes later to ensure that he was tracking the patient's need for an urgent exploratory laparotomy. He reassured me that S&W already had a surgical team standing by." - EM faculty

"One soldier asked to speak to his mom on the phone. He told her he did not regret enlisting in the Army." - EM resident

"In all my life I haven't see such a big human effort." -EM faculty

"Just when I thought I couldn't utter another word because of how dry my throat felt, the fast food chicken guy showed up with a bunch of large iced teas." -EM faculty

"I never thought before of the possibility of such massive carnage, to the point that we would run out of supplies-BVM's, stylets for ET tubes, saline, chest tubes…."- EM resident

"As quickly as the Mass Casualty Incident began, it ended. With rumors flying about another wave of patients, all other physicians had likewise fervently transferred their patients out of the ED. I was left to find my previous patients, among them was a 59- year-old hypertensive, hyperlipidemic, diabetic with chest pressure whom I had been evaluating in bed 11 just prior to the incident. In clearing out every other bed in the ED, someone had the foresight to leave her on a monitor and move her to bed three. Thank you, someone!" -EM faculty

"Told to me by a provider: 'I always learn patient's names.' That day, it was only GSW to body part and bed number. I never learned their names. I still don't know who they were..." -EM resident

"All I can say is: We raged against the tragedy not with violence or anger but violent passion, camaraderie, and tenacity to hold the tide of fear and destruction at bay. War had been something we got on an airplane to experience, but, on this day, we lived it in our backyard." -EM faculty

"Everyone here worked together and pulled some long hours yesterday. Yet, they all returned to work today. The ER is pretty much quiet now. It seems that everyone is trying to just carry on..... not much talk about yesterday's events. I mean: How do you really do that anyway, without replaying the day over and over in your mind(s)?" -EM administrator

GSACEP Reception at Scientific Assembly

Boston, 2009

Resident Column: Are Deployments as bad as they sound? Or worse?

By Capt. Joseph. D. Novak, USAF, MC

Talking with my fellow residents from EM and elsewhere, I've noted a few common sources of trepidation about our upcoming roles as physicians in the military. One theme that seems to come up again and again is that of deployments. As a prior service guy, I've had my fair share of deployments, prolonged TDYs, and other "time away from home" (including a "deployment" across the runway of my own home base for two weeks). I've seen the gambit of responses towards deployments, from loving that time to clinical depression. As EM physicians, like it or not, we WILL BE deployed multiple times during our military career (even if that career is only four years long). There are, of course, inter-service differences in deployments regarding lengths (sorry, Army), locations, units, and what you'll be doing, but the basic experience is the same. And really, the rest of this article can be summarized by saying, you're going, you're the Doc, make the best of it.

As a soldier on the line, I always liked interacting with "The Doc." I thought of The Doc as a cool guy/gal, with tons of education, really dedicated (they could easily be earning double or triple on the outside), and someone I could inherently trust. Like it or not, by virtue of their integral role in the mission, The Doc is a leader wherever he/she is. A cool Doc is a huge asset; a bad Doc, who isn't trusted by his unit, is a huge liability. Embrace the positive role.

Let's first talk about the bad aspects of deployments. Unpredictability was the major and most annoying theme during my time away. Unpredictability wears on you. You often don't know what you're doing tomorrow, next week, or even when you're going home. You're also most likely in a dangerous environment in which unpredictability is the norm. Just when you're getting "comfortable" in your new role, terror inevitably strikes. During all this, you're often working long, difficult hours in a new environment, with different rules, different players, and with dire consequences for any errors. And of course, you are away from your family. I've found this absence from loved ones to be one of the major reasons that people separate from the service. Understandably, being away from spouses and children takes an incredible toll on everyone.

Now, the "up" side: Deployment is also an incredible time. The memories and experiences last a lifetime. When deployed, you're part of a tight, mission-oriented team developing the camaraderie and cohesiveness for which the military is known. You also get to do what you've trained to do. And, typically, the paperwork and any other silliness of your home-station job is minimized. This means doing what you love, less impeded. Finally, in my opinion, deployments are where we earn the right to call it "the service." This is where we as individuals are specifically needed, and this is why we are in the military.

Here are some tips I've learned over the years in dealing with deployments:

1. Before the deployment, don't consider ANY dates as constants. As trite as it sounds, plan on being there until you're not there anymore.

2. Get your will, finances, bills, and other paperwork set as early as possible before deployment. I became a "Mission Ready" pilot (able to go to war) on September 10th, 2001. My biggest source of stress on September 11th was that I didn't have my will, life insurance, bills and finances in order. I knew I could employ my jet tactically and get the job done, but I didn't have the peace of mind that my family would be taken care of if anything happened to me. All of this simply means: You must prepare yourself, and your family, in case you don't return.

3. On a less somber note: Make goals for yourself in your job and for your free time while deployed. Studies have shown that the simple act of writing down your goals increases the likelihood of achieving them several-fold.

4. No matter how well-traveled or experienced you are, be ready for a culture shock. This is not just urban legend, but a well-documented reality for anyone traveling to a foreign land.

5. Take advantage of the lessons of those who've gone before. The internet has a lot of good resources for deployment preparation. Our own website, gsacep.org, has a deployment guide.

6. Keep in touch with family and friends at home. There are a myriad of ways to do this. It'll keep you grounded.

7. Finally, take advantage of this time! So many of life's distractions are gone. You can do incredibly productive and positive things if you have some downtime. During one deployment, I took Organic Chemistry via distance learning to satisfy my pre-med requirements. So, in short, embrace this time and embrace your role.

Nominations: Excellence in Military Emergency Medicine

It is time to nominate someone for GSACEP's highest honor. Please write to us about your nominee or e-mail a letter and CV to gsacep.org, but make sure you get it to us no later than Feb 20, 2010. In 1997, The Government Services Chapter developed a Chapter Award to recognize a member who had made outstanding contributions to military emergency medicine. In 1998, the first winner of this award was Col. Ray Ten Eyck, USAF MC. And, in 2009, the recipient was Col Lee Payne, USAF MC, Commander of the David Grant USAF Medical Center, Travis Air Force Base, CA.

Criteria for the award:

Eligibility

a. General. Any ACTIVE GSACEP member may be nominated.

b. Departing/former members. An individual nominated for the Award who transfers from or otherwise leaves GSACEP before the award selection process has been completed remains eligible for one calendar year from the date of nomination.

c. Resident, student, affiliate, honorary, or corporate members do not meet the normal eligibility requirements, but may be considered on an exception basis. Such an exception requires the consent of two thirds of the voting members present at a duly constituted meeting of the Board of Directors.

Criteria

Each nomination must document that the nominee has contributed to the advancement of Emergency Medicine in one or more of the following categories.

a. Sustained Chapter Leadership and Service. Individual leadership and service while a member of GSACEP that have brought growth to the Chapter, improved Chapter services to members, or enhanced the reputation of the Chapter within ACEP and/or organized medicine over a period of at least three years.

b. Advancement of Federal/Military Emergency Medicine. Service as an emergency physician that has advanced the specialty within the Federal/Military Medicine. This may include contributions specific to Emergency Medicine, or more general contributions to Federal/Military Medicine that have brought favorable recognition to an individual noted as a representative emergency physician. This could include high visibility service in non-Emergency Medicine positions.

c. Emergency Medicine Education/Research. Conspicuous contribution to the specialty through research, teaching, publications, or other significant academic endeavors while serving as a Federal/Emergency Physician.

d. Clinical Emergency Physician. Singular achievements related to direct patient care, such as responding to disaster or mass casualty situations; unusual clinical acumen resulting in life-saving diagnosis or intervention with one or more individual patients, or patient care involving personal heroism by Federal/Military emergency physicians.

Nominations

Each nomination must be submitted by an ACTIVE member of GSACEP, or be accompanied by an endorsement from an Active Member of GSACEP. Each nomination will consist of a cover letter, a narrative justification, and a curriculum vitae of the individual being nominated.

a. The cover will identify the nominee and the category or categories for which nominated, and a means to contact the nominator (telephone and e-mail, please).

b. The narrative will be no longer than two pages, double-spaced, in 12pt font.

Marco Coppola Elected Vice-Speaker of ACEP Council

Council Speaker Arlo Weltge, MD, MPH, FACEP, and Col Marco Coppola, DO, FACEP, following the election

At Scientific Assembly, Boston, 2009, COL Marco Coppola, DO, FACEP, a GSACEP Councillor and former President of this chapter, was elected Vice-Speaker of the ACEP Council. The election took place on the last day of the Council Meeting, Sunday, Oct. 4.

The ACEP Council consists of members representing ACEP's 53 chartered chapters, 30 sections of membership, and the Emergency Medicine Residents' Association. The Council is a deliberative body that meets once a year for two days in conjunction with the College's annual Scientific Assembly. The Council votes on resolutions which may be introduced by any member. The Council is also the body that votes on proposed changes to the Bylaws.

The vice speaker of the Council is the second highest-ranking officer of the College elected by representatives of the members. The vice speaker represents the interests of the College and the Council, and serves as the presiding officer of the Council in the absence of the speaker. The vice speaker co-chairs the annual Council meeting and participates in all Board of Directors meetings as the representative of the Council. The vice speaker serves as vice-chair of the Council Steering Committee, communicates, supports and defends policies and programs adopted by the Council and the Board of Directors.

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WWW.GSACEP.ORG

A Chapter of the American College of Emergency Physicians

Government Services

EPIC

Spring 2011

The President's Column

By Col Lee Payne, USAF, MC

"GSACEP is a great place to get engaged, have your opinions heard, impact the specialty of emergency medicine, and help develop your organizational leadership skills in the process."

It seems like yesterday that we were saying good-bye to 2010 and ringing in the New Year! It is absolutely amazing how much of 2011 has already roared past and with it a good portion of my year as President of GSACEP. In this edition of the EPIC, I want to outline some of my goals for the chapter and what we hope to accomplish this year.

Membership: We are the 12th largest chapter of ACEP with 835 members! This currently allows eight counselors to represent us at council meetings and offers great opportunities to influence our national organization. We hope to analyze that membership over the coming year to determine where we can continue to grow. Many Veterans Administration Emergency Physicians have joined our chapter, and we encourage many more to join our ranks. We believe GSACEP is the perfect organization to represent ALL federal emergency physicians. As our membership grows, so grows the chapter's influence!

Committee Membership/Leadership Development: Committee participation is a great way to get involved in GSACEP, begin to understand how the organization works and interacts with the national organization, and develop the future leaders for this chapter and for national ACEP. My top goal is to expand our membership involvement in the chapter and grow the next generation of committee chairs, future board members and chapter president. Even if you do not plan to stay in the military past your service commitment, GSACEP is a great place to get engaged, have your opinions heard, impact the specialty of emergency medicine, and help develop your organizational leadership skills in the process. Currently, we have four committees: Membership, Col Chris Scharenbrook, Chair; Conference, LTC Bonnie Hartstein, Chair; Communications , Co-Chairs, Maj Torree McGowan, and Cpt Rachel Villacorta-Lyew, and Awards, Chaired by our President Elect, LTC Dave Barry. Please let me know if you are interested at lee.payne@us.af.mil, or at GSACEP@aol.com, and we will get you in touch with the right person. Also, if you see other committees you feel we should add, please suggest them and we'll present it to the board. We can really use more of our 835 member's participation in the chapter!

We are continuing to look for ways to add membership benefit. For example, we are researching the possibility of offering low-cost group insurance policies that would be written with the military physician in mind. We are providing three scholarships each year to ACEP's Leadership and Advocacy Conference.

This year, we are also expanding our awards program to recognize young up-and-coming emergency physicians—more on that to come! Our goal is to make this chapter as valuable as possible to you!

I am extremely honored to serve as your President this year and with the rest of the board of directors of GSACEP we look forward to serving you as you serve this great nation of ours! We understand your sacrifice and the contribution that you and your families make every day and the demands of nearly a decade of war. With the operations tempo, it is difficult to think of adding anything else to your plate, but I hope you will consider getting involved in GSACEP. This is an incredibly exciting and challenging time for healthcare in the United States and for emergency medicine. The decisions made about our specialty in the next few years will affect how we practice and how we care for our patients. Get involved and help us shape emergency practice for the future!

In This Isssue

World Class Research Presented at the 2011 Government Services Symposium Conference

BY MAJ Eric Baden, MC, USA

GSACEP held its annual research forum at GSS 2011, its CME conference in San Antonio, TX, March 6-9. Once again, it was an overwhelming success. Col Shawn Varney, USAF, MC, Emergency Medicine Research Director at the San Antonio Uniformed Services Health Education Consortium (SAUSHEC) led a team of judges that included CAPT James Ritchie, MC, USN, Portsmouth, VA; MAJ Everett Fuller, MC, USA, Ft Hood, TX, and MAJ Eric Baden, MC, USA, from the 121st CSH in Seoul, Korea.

Overall, 20 healthcare providers (EM attending physicians, residents, PAs, and medical students) representing all three services presented at one of two moderated poster sessions; seven residents/staff gave oral presentations. Congratulations to the following researchers who were chosen as the winners within their respective categories.

CPT Daniel Conway, DO Receives his plaque from Col Shawn Varney, MD for the Best Resident Oral Presentation

Best (tied) Resident Poster Presentation: CPT Aaron Cronin, PA-C from Madigan Army Medical Center.
Supraclavicular approach to subclavian central venous catheterization:
Ultrasound guidance versus landmark approach with a simulation training model
Assistant Investigators include Cord Cunningham MD; Laselle Brooks, MD; Christopher Kang, MD; James Schmid, DScPA-C; Ken Hyde PA-C; Raywin Huang, PhD; Jason Heiner, MD

Best (tied) Resident Poster Presentation: CPT Bret Pearce, MD, from SAUSHEC.

Lack of effect of intravenous fat emulsion therapy on hypotension in a swine model (Sus scrofa) of diphenhydramine toxicity
Assistant Investigators: Shawn Varney, MD; Susan Boudreau, RN; Toni Vargas, PA-C; Vikhyat Bebarta, MD

Best Staff Poster Presentation: MAJ David A. Masneri, DO from Womack Army Medical Center
Impact of a Formal Ultrasound Program on a Non-Residency Emergency Department
Assistant Investigators: Charlene C. Colon; Frank Christopher, MD

Best Resident Oral Presentation: CPT Daniel Conway, DO, from SAUSHEC
Emergency Department patients evaluated by bedside biliary ultrasonography:
Does Radiology ultrasonography alter disposition?
Assistant Investigators: Eric Baden, MD; Kenton Anderson, MD; Shane Summers, MD

Best Staff Oral Presenatation: LTC Steven Gaydos, MD,
from the U.S. Army Aeromedical Research Laboratory, Fort Rucker, AL
Comparison of the effects of ketamine and morphine on the performance of representative military tasks
Assistant Investigators: AM Kelley, PhD; CM Webb, MS; JR Athy, MA; PL Walters MBChB

Thanks again to everyone who participated. The need for high quality military emergency medicine research has never been greater, and based on the quality of this year's presentations, the call is being answered. We encourage all members of the EM community to pursue the lofty ideals of finding the medical truths in the universe as we continue to advance the knowledge of emergency and combat care. We look forward to seeing more high quality research at next year's scientific meeting which will be 1-5 April 2012 at The Village at Squaw, CA (http://www.gsacep.org/upcoming-events/) .

LTC Steven Gaydos, MD receives his plaque from Col Shawn Varney, MD for the Best Staff Oral Presentation

GSS 2011

If you missed this year's GSACEP CME Conference in March in San Antonio, you missed one of the highest attended in recent years with almost 200 participants. This year, too, a Simulation Lab was developed under the direction of LtCol Robert Thaxton, and CAPT James V. Ritchie. It received extremely high marks from attendees, and will be repeated in 2013. There were other highly valued workshops, including Basic and Advanced Ultrasound, LLSA Review, and a Toxicology Lab.

Among the conference's more than 40 distinguished speakers were former ACEP presidents E. Jackson Allison, Jr., MD, MPH, FACEP; J. Brian Hancock, MD, FACEP; and Col Linda Lawrence MD, FACEP. Lt Gen J. Bruce Green, MD, Surgeon General of the Air Force (pictured with Col Payne and LTC Givens) was a guest speaker as was ACEP Board member, Jay Kaplan, MD, FACEP, and the Three Consultants to the Surgeons General Antonacci, Johnson, and Wedmore.

There was still time to party at our opening reception, and to honor our leaders at the Chapter Lunch. The 2010 recipient of the GSACEP Excellence in Military Emergency Medicine Award, CAPT James V. Ritchie, MD, FACEP, received his award there having been deployed last year. The 2011 recipient, COL John McManus, MD, FACEP, accepted in the company of his wife and twins.

Thanks to the leadership of LTC Melissa Givens, conference chair for the last two years, and her outstanding committee including VHA leadership, the conference has gotten better and better. It also got a little more high tech with a specially designed program from Maj Torree McGowan to access faculty evals on your smartphone with a chance to win an IPad2. Congrats to winner CPT Delbert Clark.

If you missed out this year, please don't next. Join us at Squaw Valley April 1-5.

Emergency Department Patients Evaluated by Bedside Biliary Ultrasonography: Does Radiology Ultrasonography Alter Disposition?

CPT Daniel Conway, MC, USA
MAJ Eric Baden, MC, USA
Capt Kenton Anderson, USAF, MC
CPT Shane Summers, CPT, MC, USA

Study Objective: The primary objective is to determine if radiology biliary (GB) ultrasonography changes the disposition of adult Emergency Department (ED) patients who already received emergency physician performed bedside GB ultrasonography. The secondary objective was to determine how much radiology GB ultrasonography increases the ED length of stay.

Methods: We conducted a prospective, observational study on a convenience sample of adult ED patients presenting with a chief complaint of abdominal pain suspicious for biliary disease. Bedside GB ultrasonography was performed by emergency medicine residents and attending physicians at an academic institution. The emergency physician assessed for gallstones, a sonographic Murphy's sign, gallbladder wall thickening, and pericholecystic fluid. The emergency physician then recorded the diagnosis, disposition, and the time on a structured data collection form prior to radiology GB ultrasonography. After the radiology GB ultrasonography, the emergency physician recorded the radiology findings, the final disposition of the patient, and the time the radiology report was received.

Results: Fifty-one patients were enrolled and received bedside and radiology GB ultrasonography. Eleven patients (21%) were diagnosed with acute cholecystitis. All eleven of these cases were detected on bedside GB ultrasonography. Twenty-two patients (43%) were diagnosed with cholelithiasis on bedside GB ultrasonography. Only 2 patients (4%, 95CI 1.1-13) had their diagnosis & disposition changed based on the radiology GB ultrasonography. These 2 patients were diagnosed with cholelithiasis on bedside GB ultrasonography, but the radiology GB ultrasonography was normal. Agreement between bedside GB ultrasonography and radiology GB ultrasonography was excellent (K= 0.92, 95CI 0.8-1.0). Length of stay was increased by an average of 101 minutes (SE 9.4 minutes) with a median of 93 minutes waiting for the radiology GB ultrasonography.

Conclusion: In this single center study, radiology GB ultrasonography increased the ED length of stay without significantly altering the disposition of ED patients with suspected biliary disease who already received bedside GB ultrasonography. With adequate training, bedside GB ultrasonography has the potential to be an acceptable, stand-alone study that may improve ED throughput.

Dr. McManus' wife and twins at the chapter lunch.

Opening reception GSS 2011 was held at Pat O'Brien's

Meet GSACEP's 2011 Excellence in Military Emergency Award Winner

COL John McManus, MC, USA, is the recipient of the GSACEP 2011 Excellence in Military Emergency Medicine Award.

COL McManus is the Director of U.S. Army EMS Programs Management Division, AMEDDC&S, Fort Sam Houston, TX. As such, he is responsible for the sustained training of over 39,000 Combat Medics on Army installations throughout the world. He also serves as an EMS Fellowship Program Director, SAUSHEC, and Adjunct Associate Professor of Emergency Medicine University of Texas Health Science Center, San Antonio, TX.

Prior to joining U.S. Army EMS, COL McManus served as Director of the Center of Pre-Deployment where he trained thousands of healthcare personnel preparing to deploy. His various assignments included Eisenhower Army Medical Center, Fort Gordon, Georgia; Supreme Headquarters Allied Powers Europe (NATO HQ), Belgium; 123rd MSB, Tuzla, Bosnia; Madigan Army Medical Center, Fort Lewis, Washington; Darnall Army Medical Center, FT. Hood; 11Sth FSB 1st Cavalry Division, Operation Desert Spring, Kuwait; U.S. Army lnstitute of Surgical Research, Brooke Army Medical Center; the 28th Combat Support Hospital, Mosul, lraq; Camp Diamondback and Camp Marez, lraq.

As a longtime member of GSACEP, Dr. McManus served for three years as Committee Chair of its annual CME conference. He was Secretary-Treasurer of the Chapter from 2003-2005, President in 2006-2007, and has been a Councillor or Alternate since 2003. With a chapter grant from ACEP, he developed a Combat Tactical DVD that was made available to all military emergency physicians deploying.

As an academic, COL McManus created the first military emergency medical fellowship, EMS, and served as the inaugural program director. He has published over 75 scholarly works in the field of trauma and emergency medicine. He serves as a reviewer and editor for multiple journals and textbooks. He is a nationally acclaimed speaker and has presented over 60 abstracts and over 200 academic presentations world-wide.

COL McManus has received numerous awards, decorations and honors. He also received the Surgeon General's Recognition Award as the outstanding LTC in the AMEDD in 2006.

Resident Scholarship Winners 2011

LCDR Miguel Gutierrez, MC, USN, and LCDR Ellie Ventura, MC, USN, both of Naval Medical Center Portsmouth, are the 2011 recipients of GSACEP's Resident Scholarship Award to ACEP's Leadership and Advocacy Conference in Washington, D.C. The residents submitted their CVs and letters of interest and were selected among candidates from several residencies.

LCDR Gutierrez is currently Chief Resident at Portsmouth. He also serves as the program representative to EMRA, and hopes to become more active in GSACEP through its conference committee as well as serve on ACEP committees. LCDR Ventura has over 20 years in the Navy where she began as a Seaman Recruit and rose through the ranks. In her first years in the Navy, she built and maintained underwater explosive mines as a mineman seaman. She received her Doctor of Medicine from Northwestern University in 2004, and received an MPH from Easter Virginia Medical School in 2008. She too is active in EMRA.

GSACEP pays transportation, per diem, and hotel costs for scholarship winners. GSACEP's Resident Representative, CPT Joshua Simmons, MC, USA, from Madigan, is also being financed by the chapter to attend. In a future issue of EPIC, the residents will highlight their experiences at the meeting and on Capitol Hill.

GSACEP believes in developing its future leaders, and introduced its Resident Scholarship Program to the ACEP L & A in 2007.

Residency Membership in GSACEP

By CPT Joshua Simmons, MC, USA

We cross state lines and bring together all three military medical branches. Joining the chapter and attending our annual conference is a great opportunity to meet some of the leaders in the field of emergency medicine.

Fellow soldiers, airmen and sailors, I am the Resident Representative for the Government Services Chapter. Most of you who are reading this are probably already members of GSACEP, but I know that there will be some people who will not be, and I wanted to talk to each group because I think you may not be aware of the benefits of being a member.

We are one of the larger chapters of ACEP with over 800 members. We cross state lines and bring together all three military medical branches. Joining the chapter and attending our annual conference is a great opportunity to meet some of the leaders in the field of emergency medicine with vast experience both here and in theater. In our current climate, we will most likely all be deploying soon after our residency ends. GSACEP is an amazing opportunity to help prepare yourself for that experience. We are also unique in that throughout our military service we will most likely not be staying in the same area, but instead be scattered across the nation, or the world. GSACEP is an excellent way to network, to meet people that have held positions or been stationed at positions that interest you, and perhaps even help you get there. In my short time as the resident representative, I have learned about many opportunities that I did not know existed. For example, did you know that you could be the White House physician? Several of our members have been. There are many other unique jobs out there that other members can let you know about.

At the last conference, GSS 2011, there were also several great lectures to help residents prepare for graduation and the new experiences they may face, such as moonlighting. Along with those lectures, there were many other excellent lectures on the issues facing emergency medicine that we don't get exposure to in a military setting, or during residency. At this CME conference, there are also opportunities to present research or give a presentation that will help bolster your CV. The chapter has committees that will give you an excellent grounding in communications, or conference planning, research, etc.

When the time comes, GSACEP can also be extremely helpful as you transition out of the military community. There is a strong presence of the VHA, CDC and other federal agencies, as well as many former military members who have remained part of GSACEP. They can be instrumental in helping you find the right job after you leave the military. Finally, GSACEP is a great opportunity to network and meet peers who will work with you in the future as well as reunite with people you have worked with in the past. For all of these reasons and more, I hope that you will consider joining our chapter. If you are already a member, glad you are. Get active! I hope to see you all April 1-5, 2012 in Squaw Valley, CA.

Make A Difference: Write That Council Resolution

ACEP is a living entity, which needs new ideas to keep it healthy and viable in the 21st century. Many College members introduce new ideas and current issues to ACEP through Council resolutions. This may sound daunting to our newer members, but the good news is that only takes two ACEP members to submit a resolution for Council consideration. In just a few months the ACEP Council will meet and consider numerous resolutions (deadline for submission is July 16).

ACEP's Council, the major governing body for the College, considers resolutions annually in conjunction with Scientific Assembly. During this annual meeting, the Council considers many resolutions, ranging from College regulations to major policy initiatives thus directing fund allocation. For 2011, the Council has 338 Councillors: ACEP members representing chapters, sections, EMRA, AACEM, and CORD.

This Council meeting is your opportunity to make a resounding impact by setting our agenda for the coming years. Topics such as the direct election of the president-elect, or working with the Emergency Nurses' Association on staffing models, grew directly from member resolutions submitted to the Council. If you have a hot topic that you believe the College should address, now is the time to start writing that resolution.

I'm ready to write my resolution

Resolutions consist of a descriptive Title, a Whereas section, and finally, the Resolved section. The Council only considers the Resolved when it votes, and the Resolved is what the Board of Directors reviews to direct College resources. The Whereas section is the background, and explains the logic of your Resolved. This should be short, focus on the facts, and include any available statistics. The Resolved section should be direct and include recommended action, such as a new policy or action by the College.

Continued on Page 7

Make A Difference...continued from page 6

There are two types of resolutions: general resolutions and Bylaws resolutions. General resolutions require a simple majority vote to pass, while Bylaws resolutions require a two-thirds majority. When writing Bylaws resolutions, list the Article number, and Section from the Bylaws you wish to alter. Then, in the resolution, you should show the current language, and bold your suggested new language while striking through the suggested edits. See the ACEP Web site article, "Guidelines for Writing Resolutions," which further details the process and offers tips on writing a resolution.

I want to submit my resolution

It takes at least two members to submit a resolution, or a Chapter, Section, AACEM, CORD, or EMRA may submit a resolution. If the resolution comes from a Chapter or Section, then a letter of support from the President of the Chapter or Chair of the Section is required. The Board of Directors or an ACEP committee can also submit a resolution. The Board of Directors must review any resolution from an ACEP committee, and usually reviews all drafts at their June meeting. Bylaws resolutions pass through the Bylaws committee for review and suggested changes. These changes and suggestions are referred back to the author of the resolution for consideration. One may submit a resolution by mail, fax, or email. Resolutions are due at least 90 days before the Council meeting. This year the deadline is July 16, 2011.

All resolutions should be submitted to:
Dean Wilkerson, JD, MBA, CAE
Executive Director & Council Secretary
American College of Emergency Physicians
PO Box 619911
Dallas, TX 75261-9911
E-mail: execdirector@acep.org
Phone: 800-798-1822 x3202
Fax: 972-580-2816

Debating the resolution

Councillors receive the resolutions prior to the annual meeting along with background information from ACEP staff. Discussion often occurs on the Council electronic list serve prior to the Council meeting. At the discretion of the Speaker, non-Councillor resolution authors may be added to the Council e-list serve upon request.

At the Council meeting, the Speaker and Vice-Speaker divide the resolutions into four reference committees. The reference committees meet and hear testimony on each resolution. You, as the author of your resolution, should attend the reference committee that discusses your resolution. Reference committees allow for open debate and unlimited testimony, and participants often have questions best answered by the author. Afterwards, the reference committee summarizes the debate and makes a recommendation to the Council.

The Council then meets to discuss all the resolutions. Each reference committee presents each resolution, providing a recommendation and summary of the debate to the Council in writing and on the podium, and then the Council debates each resolution. Any ACEP member may sit in the back and listen to the Council debate whether a Councillor or not. If you wish to speak directly to the Council, you may request to do so in writing to the Speaker before the debate. Include your name, organization affiliation, issue to address, and the rationale for speaking to the Council. Alternatively, you may ask your Chapter or Section for alternate Councillor status and permission for Council floor access during debate. Chapters and Sections often have alternate Councillor slots and encourage the extra participation.

The Council's options are: **Adopt** the resolution as written; **Adopt as Amended** by the Council; **Refer** to the Board, the Council Steering Committee, or the Bylaws Interpretation Committee; **Not Adopt** (defeat or reject) the resolution; or **Postpone**.

Hints from Successful Resolution Authors

- Present your resolution prior to submission to your Chapter or Section for sponsorship on the Council floor. This way, they can give advice and assistance.
- Consider the practical applications of your resolution. A well-written resolution that speaks to an important issue in a practical way passes through the Council much more easily.
- Do a little homework before submitting your resolution. The ACEP web site is a great place to start. Does ACEP already have a policy on this topic? Has the Council considered this before? What happened?
- Find and contact the other stakeholders for your topic. They have valuable insight and expertise. Those stakeholders may co-sponsor your resolution.
- Attend debate concerning your resolution in both reference committee and before the Council. If you cannot attend, prepare another ACEP member to represent you.

Continued on Page 8

Make A Difference...continued from page 7

I need more resources

Go to ACEP's Web site, www.acep.org. Click on "About Us," then "Leadership," and finally click on "Council." Scroll down and you will see a link to the "Guidelines for Writing Resolutions" article. All authors should review this article prior to writing their resolution. Additionally, there is information about the Council Standing Rules, Council committees, and Councillor/Alternate Councillor position descriptions. Of special note, there is a link to Actions on Council Resolutions. Under this link are PDF documents dating back to 1998 summarizing each resolution and what has occurred with each of them. You can review past actions, or keep track of what happens once your resolution passes.

Well, get to it

Writing and submitting Council resolutions keeps our College healthy and vital. A Council resolution is a great way for College members to speak to the leaders of the College and the Board of Directors. Even if your resolution does not pass, the College will debate the topic and consider its ramifications. Additionally, other members may have resources or suggestions to address your issue. I encourage you to take advantage of this opportunity and exercise your rights as part of our Emergency Medicine community. Dare to make a difference by submitting a resolution to the ACEP Council.

Our next issue of EPIC is planned for late summer. If you have any ideas or would like to contribute, please contact Dr. Villacorta.

A Chapter of the American College of Emergency Physicians

Government Services

EPIC

Fall 2011

The History of Military Emergency Medicine

By Col Lee Payne, USAF, MC

Perhaps it's my age, and the fact that I have to write everything down these days in order to preserve any possibility of remembering anything, but I have become very interested in history lately. In particular, my interest has been focused on the history of emergency medicine and the beginnings of military emergency medicine. All this reflection has given me ideas for our chapter which I would like to share with you, and enlist your support. But I am getting ahead of myself; let me go back a bit to how this all got started.

One of my goals as president this year was to re-establish our visits to all our residency programs to highlight ACEP, Government Services Chapter, and encourage resident and academic faculty membership and involvement in our organization. Texas ACEP was scheduled to visit the joint residency in San Antonio and graciously invited me to join them. I was asked to prepare a talk on the history of emergency medicine, and military emergency medicine. While doing the research for the presentation, I discovered this year was the 50th Anniversary of the beginnings of emergency medicine in Alexandria, Virginia. ACEP has done us a great favor by posting three videos on the Alexandrian Plan which gives a great historical perspective on the start of emergency medicine at Alexandria Hospital by Dr. James Mills and three other colleagues. In the videos, there are introductions by the CEO of Alexandria Hospital, including a very good presentation by Dr. Brian Zink, on why the Alexandria Plan got started and the environmental conditions present in medicine in 1961 that led to the development of the specialty. Dr. Zink is the chairman of Emergency Medicine at Brown University and the author of Anyone, Anything, Anytime: A History of Emergency Medicine. Published in late 2005, this is the only well-documented history of our specialty. It is unfortunately out of print, but I contacted Dr. Zink who told me he is trying to get it reprinted by another publisher.

The next step on my journey led me to some of our founding fathers in military emergency medicine. I spoke with Dr. Barry Wolcott, the founder of Army Emergency Medicine, the residency at Brooke Army Medical Center, and the specialty's first Consultant to the Surgeons General. I also spoke with Dr. Ray TenEyck, one of the early Air Force Consultants to the Surgeons General, and a fount of knowledge about Air Force Emergency Medicine. Ray served as our consultant for a total of 14 years! Dr. Cloyd Gatrell, a former department chair at Madigan, and a GSACEP past-president, was also helpful with a treasure trove of memories about our beginnings. My journey was lacking in the story of the birth of emergency medicine in the Navy which is one aspect I would like to correct as I refine the presentation for the future. I gave the presentation at the joint session with TCEP and it was well received by the residents—or at least they were politely attentive! I hope to give the next iteration of the presentation at another joint visit with TCEP to Darnell Army Emergency Medicine program on December 1st. The story is a very interesting one!

Dr. Wolcott suggested that it was important to try and capture as much of this history as possible while those that created it were still alive. He put me in contact with Dr. Dale Smith of the Uniformed Services University of Health Sciences (USUHS) to propose a project to use trained historians to obtain structured interviews of the many people involved with the development of military emergency medicine since its beginnings in the mid-seventies to the present. This will not be an inexpensive undertaking and I would like to propose that GSACEP take the lead in obtaining funding to complete this project. We will need others to contribute, but who better to sponsor this effort than our chapter!

I have been involved in military emergency medicine since I came on active duty in 1987 and I was very proud, if somewhat surprised, to learn about the whys and wherefores of the origins of our specialty in Virginia and at Brooke Army Medical Center. It is a great history that has done much for medicine, and even more for the patients we serve. I look forward to helping document that history more completely in the future.

In This Issue

Tidbits from the Editor

By MAJ Rachel Villacorta Lyew, MC, USA

Please check out the newly re-designed GSACEP website at www.gsacep.org. The layout of the resources has been improved, but any feedback you have is welcome. There is a section called "In The Field" for those who may be deploying or those who want to share their experiences. There will also be a link for the Member Services Survey. The idea is that our members indicate what professional needs the chapter can enhance or add to better serve members. GSACEP is also making a greater effort to recognize our members with various awards. Also, In this edition of EPIC we are going to have a "Clinical Corner" to showcase the clinical highlights of a medical case seen by a GSACEP member. Please also check out the information about the awards available to our members and the nomination process.

Medicine has always been a profession of service to our patients and it has never been more true in the military and GSACEP. It is truly exciting time to be part of the military and Government Services as we transition to a model of joint service medical treatment facilities. The National Capital Area now has two joint MTF's in Walter Reed National Naval Medical Center in Bethesda, MD, and the brand new Fort Belvoir Community Hospital built in the concept evidence-based health care. While there will always be rivalries amongst the sister services, the patients will benefit greatly in the collaboration of knowledge and experience the different branches of the military are able to provide. There will be "growing pains," but ample opportunity to impact the future of military emergency medicine.

This edition of EPIC is publishing very close to the ACEP Scientific Assembly in San Francisco. I hope to see many of you there to exchange thoughts and ideas on the future of GSACEP!

GSACEP Events at Scientific Assembly

GSACEP Strategic Planning Meeting
Wednesday, 10/12/2011
0800-1700
MTG Room: Union Square 25, 4th floor, Tower 3, Hilton Hotel San Francisco Union Square
For GSACEP Board Members and Committees

GSACEP Board of Directors Meeting
Sunday, 10/16/2011
0800-1030
MTG Room: Green Room, Grand Ballroom Level, Hilton Hotel San Francisco Union Square
Open to all GSACEP Members

GSACEP Reception
Sunday, 10/16/2011
1800-1930
MTG Room: Golden Gate 6, Lobby Level, Hilton Hotel San Francisco Union Square
Open to all GSACEP Members and reception Sponsors

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GSACEP Endorses Marco Coppola, DO, FACEP, for ACEP Council Speaker

For almost 22 years, The Government Services Chapter has been fortunate enough to have COL Marco Coppola, DO, FACEP, as a member. Now, it is our great privilege to endorse him for Speaker of the ACEP Council.

If you serve as a Councillor, you know that, for the past two years, Dr. Coppola has been Council Vice Speaker. You have observed him at the Council Meetings, and have seen that he acts with ease as a mediator between physicians of dissimilar opinions. That is because Dr. Coppola's own diverse background has enabled him to genuinely identify with and respect fellow physicians of diverse backgrounds and opinions. Having experienced the gamut of emergency medicine, from military to civilian, academic to community practice, contract management group employee to owner and partner of a democratic group, Marco brings a thorough perspective to the Council. In addition, he has served on a number of ACEP Council Committees, including Teller's, Credentials and Elections, and the Council Steering Committee. This background, coupled with his wit and good nature, has made Marco Coppola an excellent Vice Speaker, and will make him an excellent ACEP Council Speaker.

The GSACEP chapter certainly knows what an asset COL Coppola is. He is our only Board Member to have served twice as President of the chapter, giving us six years of leadership as he went from President Elect to President to Immediate Past President. Marco served as a GSACEP Councillor for 15 years.

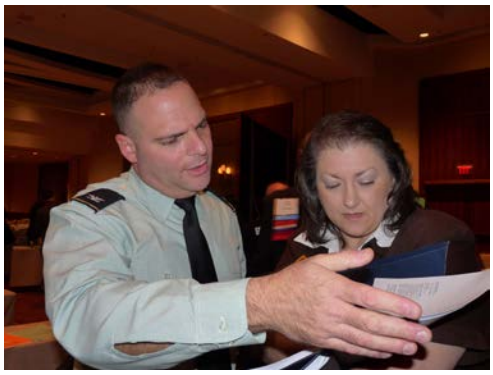
He chaired the GSACEP Membership Committee during the years of the chapter's greatest growth. He developed, with COL David Della-Giustina, MD, FACEP, our own Oral Board Review Course, and chaired it for many years. In 2007, in recognition of all he had done for us, and military medicine, Dr. Coppola received our chapter's highest honor, the Excellence in Military Emergency Medicine Award.

At that point, he had also served his country in Iraq. As a Colonel in the Texas Army National Guard, Dr. Coppola served as Commander of the Texas Medical Command.

To list Marco's accomplishments as a published author would take up several pages, and can't be accomplished in this article. He remains a full professor in emergency medicine, and is as comfortable in an academic setting as he is caring for a patient.

To this day, Dr. Coppola is involved in our chapter, though more as a mentor now than as a daily participant. For those of us who have known him from his days at Darnall Army Medical Center, or even earlier, as a resident, he remains a consistent leader with a strong vision of emergency medicine's future.

Most importantly, to many of us, he remains a true and close friend.



GSACEP Award Announcements

The GSACEP Board of Directors is in awe of the remarkable accomplishments of our members, despite the additional challenges of government service and deployments we endure. One way we recognize our colleagues is through the annual GSACEP Awards Program managed by the Awards Committee. The challenge of the awards committee has not been identifying deserving candidates, but publicizing the existence of our various awards. Below is a description of the various awards GSACEP offers each year and the timelines for selection. Please nominate the noteworthy activities of your fellow colleagues. Who knows? You may be the next winner!!

GSACEP USU Senior Student Award

Criteria for Nomination: The GSACEP USU Senior Student Award is intended to honor the senior medical student who best demonstrates the qualities and attitude of an exemplary military Emergency Physician. This is the resident you want working for you on the floor , the staff you can trust to bounce ideas off of, the doc commanders will go to in order to get things done, and one the patients and staff will look to for their knowledge, compassion and bedside manner. These candidates are future chief resident material. This award is given annually. Winners receive a certificate and free one year memberships to GSACEP, ACEP and EMRA.

Nominees must meet the following criteria:

- USUHS fourth year medical student in good standing.
- Outstanding work and professional activities

Selection and Presentation The USU Senior Student Award winner is selected by the USU Military and Emergency Medicine staff near the end of each academic year and the award is presented at graduation ceremonies.

GSACEP Resident Leadership and Advocacy Scholarship

Criteria for Nomination The GSACEP Resident Leadership and Advocacy Scholarship is intended to honor the Emergency Medicine residents showing outstanding dedication to the specialty. Based on prior performance and accomplishments, these residents are anticipated to become the future leaders in emergency medicine.

Nominees must meet the following criteria:

- Active resident in an accredited Emergency Medicine residency program.
- Active member of GSACEP
- Outstanding work and professional activities.

Any member of the Government Services Chapter of the American College of Emergency Physicians (GSACEP) may nominate himself/herself or another resident member for this award.

Annual call for nominees: Dec; Deadline for nominations: Feb

Selection and presentation The Resident Leadership and Advocacy award winner is selected by a majority vote of awards committee members and the GSACEP resident representative, the chair vote deciding in a tie situation. Awardees' are announced in the May timeframe and receive a scholarship funding attendance at the ACEP Leadership and Advocacy Conference in Washington, D.C where they will be able to meet with legislators from the state in which they currently reside, meet with GSACEP and ACEP leadership, and network with fellow residents and attending physicians.

GSACEP Rising Star Award

Criteria for Nomination The GSACEP Rising Star Award is intended to honor the junior Emergency Medicine staff that most exemplifies excellence and dedication to service. Similar in intent to sports-based "rising star" awards, the GSACEP Rising Star Award is given annually to a standout young EM physician who displays exceptional service to the Government Services Section and/or outstanding leadership in the profession.

Nominees must meet the following criteria:

- Between one and five years out of Emergency Medicine Residency Training
- Active member of GSACEP
- Outstanding work and professional activities.
- Notable service to professional Emergency Medicine organizations (preferably GSACEP).

Any member of the Government Services Chapter of the American College of Emergency Physicians (GSACEP) may nominate himself/herself or another member for this award using the GSACEP Rising Star Award Nomination Form. The leadership team of any hospital, military treatment facility, or military unit may also nominate someone for this award.

Annual call for nominees: Nov - Dec; Deadline for nominations: Feb

Selection and presentation The Rising Star award winner is selected by a majority vote of awards committee members, the chair vote deciding in a tie situation. The award is presented at the annual GSACEP Joint Service Symposium.

GSACEP Medical Director Leadership Award

Criteria for Nomination Any member of the Government Services Chapter of the American College of Emergency Physicians (GSACEP) may nominate himself/herself or another member for this award. The leadership team of any hospital or military treatment facility may nominate a GSACEP member for this award. The nominee must be a GSACEP member and must currently be in a leadership position in an emergency department. The nominee must demonstrate significant contributions to the department in the following categories:

- Quality Patient Care
- Operational Effectiveness
- Education
- Community Service
- Collaboration with Nursing
- Synergistic approach to leadership within the hospital or hospital system

The nominee must demonstrate collaborative relationships with nursing and ancillary departments to implement and improve operational and clinical standards based on evidence-based practice. The nominee will create and sustain a high degree of patient satisfaction with emergency care delivery and will implement creative and innovative strategies to address emergency department throughput.

Annual call for nominees: Nov-Dec; Deadline for nominations: Feb

Selection and presentation The Medical Director Leadership award winner is selected by a majority vote of awards committee members, the chair vote deciding in a tie situation. The award is presented at the annual GSACEP Joint Service Symposium.

GSACEP Excellence in Emergency Medicine Award

Criteria for Nomination Any member of the Government Services Chapter of the American College of Emergency Physicians (GSACEP) may nominate himself/herself or another member for this award. The leadership team of any hospital or military treatment facility may nominate a GSACEP member for this award. This award recognizes a leader with a record of significant contributions to military emergency medicine, resulting in noteworthy impact on the profession. The nominee must be a GSACEP member

Nominees must meet the following criteria:

- Active member of GSACEP
- Outstanding work and professional activities.
- A proven record of noteworthy, sustained, contributions to military emergency medicine.

Annual call for nominees: Nov - Dec; Deadline for nominations: Feb

Selection and presentation The Excellence in Military Emergency Medicine award winner is selected by a majority vote of awards committee members, the chair vote deciding in a tie situation. The award is presented at the annual GSACEP Joint Service Symposium.

Scholarship Winner Reflects on the ACEP Leadership Conference

By LCDR Ellie Ventura, MC, USN

Having done health policy research in the past, I have glimpsed work behind the scenes while physicians in the field continue to see patients in hospitals and outpatient clinics. However, thanks to GSACEP, the ACEP Leadership & Advocacy Conference in Washington, D.C. gave me, and my fellow residents, LCDR Gutierrez, and CPT Josh Simmons, the chance to see health policy happen at the national level.

Often times, emergency physicians serve as the sole advocates of the medically under-served. As military physicians, we may feel somewhat isolated from what civilian EDs experience daily. However, since the military faces threats of significant cutbacks in healthcare spending, we may have to overcome, as our civilian counterparts have, similar obstacles in providing services that may not be reimbursed, as well as finding ways for patients to obtain necessary but expensive medications.

At this conference, one of the main principles I learned is that there is no easy answer. It will take many different advocacy organizations and government entities to come to an agreement to provide quality healthcare to the largest number of people possible. Now that the healthcare reform bill has passed, several issues are at the forefront. ACEP is advocating getting rid of the sustainable growth rate formula where Medicare reimbursement is restricted to a certain percentage of Gross Domestic Product. Repealing the Independent Advisory Board is also a high priority for ACEP right now. The IPAB is not a friendly computer device; it is a panel of 15 people (most likely non-physicians) which was created to curtail government healthcare spending. This group may lead to further rationing of care and decreased reimbursement for emergency care. Finally, ACEP has recently launched the "Just 2%" campaign because there is a large public misperception that emergency department visits are responsible for skyrocketing healthcare costs. In reality, they account for a very small portion of every dollar spent. We need to continue to train more emergency physicians, advocate for tort reform, and find a way to accommodate all of the newly insured under the healthcare reform law.

For me personally, there were two very memorable experiences at this conference. The first was dinner one evening with the rest of the GSACEP attendees. We had very good French cuisine at small restaurant in Woodley Park. It was great to get to know people from other services and other residency programs. The second was going to Capitol Hill. I didn't realize that all that stands between me and my Congressman/woman is a metal detector. Our representatives are much more accessible than any of us realize.

Overall, the conference was a great event. I recommend that military residents apply for the GSACE scholarship in 2012, and that, for the sake of their long-term careers in medicine, they seek to be aware of our issues, and involved while in the military.

Update from SAUSHEC

By MAJ Jason Heiner, MC, USA, and LtCol Robert Thaxton, USAF, MC

This is the first in a series of articles from our residency programs. In coming months, we hope to hear from all of them, and to continue to receive updates from each.

LtCol Thaxton

These are exciting times for the San Antonio Uniformed Services Health Education Consortium (SAUSHEC) emergency medicine (EM) residency program! Our complement of over 30 emergency physicians are now under one roof with the recent move of the Wilford Hall Medical Center emergency services to Brooke Army Medical Center (soon to be renamed the San Antonio Military Medical Center and featuring a remodeled 60+ bed emergency department). Many of our emergency physicians have completed fellowships in critical care, emergency medical services (EMS), medical toxicology, or ultrasound. With our new ultrasound and EMS fellowships up and running, as well as our affiliated emergency physicians at the US Army Institute of Surgical Research and the AMEDD Center and School, Fort Sam Houston is becoming a unique opportunity for the scholarly minded to contribute and investigate many aspects of EM.

Our current SAUSHEC and nearby EM physicians at Fort Sam Houston are making an impact in the world of academic and military emergency medicine. Over the past three years they have produced more than a 15 book chapters (including standard references such as Rosen's Emergency Medicine: Concepts and Clinical Practice, Tintinalli's Emergency Medicine: A Comprehensive Study Guide, and Roberts & Hedges Clinical Procedures in Emergency Medicine) and more than 120 published manuscripts (featured in journals such as Annals of Emergency Medicine, Academic Emergency Medicine, the New England Journal of Medicine, Lancet, and the Journal of Trauma). With many fellowship trained physicians, the department also receives federal research funding. These busy physicians are truly advancing the practice of military medicine and combat care by mentoring tomorrow's EM physicians, changing the practice of EM through research, and deploying overseas to care for our service members during this Global War on Terror.

Clinical Corner
"I Feel Weak, Doc"
By CPT Joshua Simmons, MC, USA

A 76 year old female presented to the Emergency Department (ED) with a two-day history of generalized weakness and pre-syncopal episodes. Her past medical history was significant for Diabetes Mellitus (DM), hypertension (HTN), hyperlipidema, iron deficiency anemia, chronic renal insufficiency and peripheral neuropathy. Her reported outpatient medications include: telmisartan 40mg daily, insulin glargine 10 units at bedtime, metformin 500mg twice daily, felodipine extended release (ER) 10mg daily, hydrochlorothiazide 12.5 mg daily, diltiazem ER 120mg daily, pravastatin 40 mg at bedtime, aspirin 81 mg daily and vitamin D 50000 units every week. Review of systems was remarkable for a one day history of chills, but was negative for chest pain, shortness of breath, cough, fevers, nausea/vomiting, diarrhea, head injury, loss of consciousness, hematochezia, melena or abdominal pain. Her initial vitals on presentation were blood pressure of 74/47 mm Hg, heart rate of 88 beats per minute (BPM), respirations of 18 breaths per minute, oxygen saturation of 96% on room air and a rectal temperature of 99.6 degrees Fahrenheit. Her physical exam was largely unremarkable except for a slight systolic murmur on cardiac exam and negative guiac stool. Her initial laboratory evaluation was remarkable for a white blood count (WBC) of 12.3 x109/L, hemoglobin of 8.1 g/dL, glucose of 216 mg/dL, BUN of 51 mg/dL, creatinine of 2.19 mg/dL, sodium of 131 mmol/L, lactate of 2.5 mmol/L, BNP of 225 pg/mL. Other laboratory tests including serum ketones, troponin, thyroid panel, liver function tests and urinalysis were within normal limits. Her anemia, elevated creatinine and hyponatremia were all chronic findings and consistent with previous labs in our system. Her electrocardiogram (ECG) showed diffuse ST elevation in II, III, aVF, V3-V6 without reciprocal changes. Cardiology was consulted and they felt that the ECG was most consistent with pericarditis. A bedside echocardiogram showed a small effusion without any evidence of tamponade physiology. Chest x-ray (CXR) showed hazy opacities in the left costophrenic angle and in the retrocardiac area that were likely atelectasis versus developing pneumonia. She was given IV fluids with improvement in her blood pressure, started on empiric antibiotics for possible pneumonia with ceftriaxone and azithromycin and admitted to cardiology for possible pericarditis.

Overnight, the patient worsened significantly. She became persistently hypotensive associated with worsening bradycardia. The patient continued to receive large volume crystalloid resuscitation and she was transferred to the intensive care unit (ICU). During preparation for central line placement, the patient became unresponsive and briefly required chest compressions (1 minute) due to lack of palpable pulses. She was emergently intubated without complication. Her blood pressure was in the 50s-60s systolic with a heart rate in the 30s. Atropine and epinephrine were given with minimal improvement. Repeat ECG showed sinus bradycardia without evidence of heart block. Serial troponins were negative. Dopamine and norepinepherine pressor support was initiated with improvement in both heart rate and blood pressure. A repeat bedside echocardiogram was unchanged making tamponade unlikely. Her lactate worsened to 4 mmol/L and her WBC increased to 19 x109/L. She continued to remain afebrile without an obvious source for sepsis. She was transfused red blood cells for her low hemoglobin, however, she did not have any evidence of ongoing bleeding. A Swan-Ganz (PA) catheter was placed to further determine the etiology of shock. She was found to have a central venous pressure of 14, cardiac output of 4.2-5.5 L/min, systemic vascular resistance of 1010 dynes/sec/cm5 and a SvO2 of 50s-80s, which all suggest a non-distributive shock not consistent with sepsis. Over the course of the next day, the patient rapidly improved, was weaned off of pressors and extubated. She quickly returned to her baseline with blood pressures in the 160s systolic. Her blood and urine cultures were negative. She was transferred out of the ICU and had an uneventful further hospital course.

The differential diagnoses for hypotension and bradycardia include: sepsis, acute myocardial infarction, calcium channel blocker overdose, beta blocker overdose, cardiac tamponade, myocarditis, conduction block. The etiology of the patient's shock was suspected to be related to her medications.

This patient was suspected to have a calcium channel blocker (CCB) overdose. On review of her medications and after discussion with her husband, the patient was taking two calcium channel blockers (diltiazem and felodipine) for unclear reasons, both of which were extended release preparations. It was unclear if she was taking them as directed. There are two classes of calcium channel blockers, the dihydropyridines and the nonhydrodipyridines. Diltiazem is a nonhydrodipyridine CCB, which exerts it effects primarily on the L-type calcium channels in the myocardium. This class exerts a weak vasodilatory effect but a more profound depressive effect on cardiac conduction and contractility. Toxic levels of this class typically cause vasodilation, decreased inotropy and bradycardia. Felodipine is a hydrodipyridine which primarily blocks the L-type calcium channels in the vasculature. This class exerts a strong vasodilatory effect with little effect on the heart. Toxic levels of this class typically cause hypotension with reflex tachycardia because the conduction is not blocked. This patient had symptoms more consistent with nonhydrodipyridine toxicity. Another helpful finding is hyperglycemia, which can help distinguish this condition from beta blocker toxicity, which usually has hypoglycemia.

Continued on Page 7

Initial treatment should begin with IV fluids for hypotension. If needed, atropine or other vasopressors can be given for symptomatic bradycardia, although it may not work. In patients who present early after an ingestion or have taken extended release preparations, activated charcoal, gastric lavage and whole bowel irrigation may be consider, especially if lethal ingestion is suspected. There are several specific therapies for CCB overdose. As the mechanism of action for this toxicity is blockade of L-type calcium channels, IV calcium can be given to try and overcome this block, however, this often does not result in clinical improvement. Calcium gluconate or calcium chloride can be given and if there is an improvement in vital signs, additional doses can be given. Glucagon increases intracellular cyclic AMP, which can potentially increase cardiac contractility and heart rate. This can be given intravenously, however, patients should be pre-treated with an antiemetic, as this can cause vomiting.

Newer and likely more effective therapies include high dose insulin therapy and intralipid emulsion therapy. High dose insulin therapy is typically one unit per kilogram as a bolus, followed by 0.5 units per kilogram per hour with titration as needed until hypotension resolves. Glucose and potassium must be closely monitored. In CCB toxicity, patients will typically be hyperglycemic and may not require dextrose supplementation. Finally, lipid emulsion therapy (LET) should be considered. Data is limited, but there are case reports of significant improvement with this therapy. The lipid emulsion, which is basically the lipid portion of TPN, acts to bind up the circulating drug, which can then be excreted. It also provides a source of energy for the cardiac muscle. The recommended dosage is 1-1.5 ml/kg of a 20% solution as a bolus and then an infusion of 0.25-0.5ml/kg can be started. These patients should be admitted to the ICU for close monitoring, as they have a tendency to decompensate quickly, like this patient.

References:
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http://www.uptodate.com/contents/calcium-channel-blocker-poisoning. 2011.
Kerns W, Kline J, Ford MD. Beta-blocker and calcium channel blocker toxicity. Emerg Med Clin North Am 1994; 12:365.
Young AC, Velez LI, Kleinschmidt KC. Intravenous fat emulsion therapy for intentional sustained-release verapamil overdose. Resuscitation 2009; 80:591.

Attention Deployed Members

Remember that if you are deployed to a combat zone The Government Services Chapter of ACEP (GSACEP) and the Young Physicians Section have partnered with ACEP to provide free CME for service members who are unable to attend continuing medical education events.

To do this, we will send you a free 1-year online subscription to ACEP's Critical Decisions in Emergency Medicine. Each monthly issue of Critical Decisions contains two clinical lessons, summaries of articles from ABEM's Lifelong Learning and Self-Assessment reading list, reviews of ECGs, images, and drugs, and can provide 5 CME credits (60 credits per year). All you need is Internet access, and you can read the issues, take the CME tests, and print or save your CME certificate—all online.

Just notify the GSACEP office (gsacep@aol.com) of your deployment and your "preferred" e-mail address, and we'll take care of the rest.

Thank you for your service to our country.

A Chapter of the American College of Emergency Physicians

Government Services

EPIC

Winter 2011/12

Strategies for the Future

By Col Lee Payne, USAF, MC

I read an article recently that suggested strategic planning was no longer useful. In a world where individuals—not news agencies—such as protestors from the Arab Spring-- use social media and the internet to broadcast real-time events unfolding at their location to inform and influence world opinion and ultimately world leader actions, how can a strategic plan that looks three-to-five years into the future be of any use? Well, I believe the rapidity with which the world changes is all the more reason to take the time to think about your organization's current situation, assess your environment, forecast future trends, and set goals and objectives to guide where you go in the future. Things move so quickly today, we often make decisions—sometimes very poor decisions—due to lack of a strategy and guiding direction. To that end, your GSACEP Board of Directors has begun work on a Strategic Plan to chart our course for the future.

We were fortunate to obtain the services of Dr. Michael Gallery, PhD, FASAE, CAE, former ACEP COO, and current President of OPIS, LLC, to assist us in our strategic planning process. On 12 October, just prior to Scientific Assembly, the Board, Committee Chairs, and invited guests sat down to take stock of GSACEP's current status and determine where the Chapter needs to go in the future. We were very fortunate to have Dr. Stephen Scherr, Director of the Palo Alto Veterans Administration Healthcare System, and Dr. Janet Henderson, Assistant Chief of Medicine and Director of the Emergency Department at the VAMC Hampton, VA, join us and provide valuable input concerning our VA membership.

We began by assessing our current mission statement: "To promote quality emergency care and advance the specialty of emergency medicine within the military and federal healthcare system." While certainly laudable goals, the participants felt these statements did not represent our true mission which is to serve you our members. The new mission statement—subject to some changes as we work through this process—is: "Enable military and federal emergency physicians to thrive". We wanted something simple, a phrase that could be remembered, and that reminds us that you are who we serve. If you are successful, things like advancing emergency care in the military will be served by our membership.

Dr. Gallery used a balanced scorecard approach segregating our goals into three main areas: Financial, Membership, and Organizational Effectiveness.

Our Goals:

1. Strengthen and diversify the financial foundation of GSACEP

2. Grow ownership in GSACEP by providing greater value to members

3. Increase organizational effectiveness.

We then moved on to defining objectives in each of these areas. Attempting to define SMART Outcomes: Specific, Measurable, Achievable, Relevant, and Timely. We chose 1-3 objectives in each of the three areas, trying to keep our targets manageable, as most strategic plans fail because they are too comprehensive and not actionable.

These outcomes still need some additional definition and we will appoint a task force, chosen from our membership, to further evaluate these objectives, and provide the board with more fidelity on the exact targets within the objectives.

Continued on Page 3

In This Issue

From the Editor's Desk

MAJ Rachel Villacorta-Lyew, MC, USA

Welcome to another issue of EPIC as we wrap up our year as a chapter in 2011 and prepare for an even more exciting year in 2012 for GSACEP!

Scientific Assembly 2011 in San Francisco was a major and noteworthy event for our specialty, not only for the academic lectures, networking opportunities, and the goods the various vendors provided, but for the development of future goals and strategies for both ACEP and GSACEP. This process occurs a few days before the CME portion of Scientific Assembly and is open to elected chapter councillors and ACEP members. In this issue, we offer a few different perspectives from the events of the week by our current president, Col. Lee Payne, a first time chapter councillor, CPT Cameron Olderog, and our resident representative, CPT Josh Simmons.

So, where am I going with all of this? Our annual chapter meeting, The Government Services Symposium, is quickly approaching in April 2012 at the Village at Squaw in the beautiful Lake Tahoe region of CA. I truly hope to see the majority of our members there for the stellar academic program developed by the conference committee led by LTC Melissa Givens, and LTC Bonnie Hartstein. But, I would also like to see more people involved in the various committees and membership activities. Come to the GSACEP Board Meeting on Monday evening, April 2, and talk to the chapter leadership throughout the meeting about your interests, and what membership has done/can do to help you.

The GSACEP Chapter Awards will be presented at GSS 2012. Please nominate and support colleagues you feel have gone above and beyond to serve the specialty of Emergency Medicine. You will find the updated schedule of activities for GSS 2012 at gsacep.org, and the nomination forms for the awards in this issue, and online. The deadline for submission of nominations for the awards is January 15, 2012.

As the holiday season is in full swing, all best wishes for a safe and healthy holiday with your family and friends, and in our Emergency Departments. Please keep a special place in your hearts for our deployed service members. Thank you for all you do!

GSACEP Board Openings

The GSACEP Nominating Committee, chaired by GS President Col Lee Payne, MD, FACEP, is asking for individual recommendations for the GSACEP Board.

In order to qualify for a Board position, a candidate must be

1. A GSACEP Active Member

2. Be committed to serve at least two years

3. Show involvement in GSACEP/ACEP activities

For any position, please submit a cover letter explaining why this person, or yourself, should hold GSACEP office. Please limit this to one page. Please also provide your CV. Send materials to the attention of Col Payne at lee.payne@peterson.af.mil or paynelee@msn.com

Board openings are for President-Elect (requires a three-year commitment);

Secretary-Treasurer (three-year term); Councillor (three positions, two-year term each).

Deadline to submit materials to Col Payne: Monday, January 16, 2012.

The Scientific Assembly Experience

By CPT Josh Simmons, MC, USA

For those of you who have not been to the yearly American College of Emergency Physician's Scientific Assembly, it is a great opportunity to learn from leaders in the field. Some of the smartest Emergency Physicians were there to teach in their areas of expertise. The hardest part of the conference was deciding which lectures to go to and which I would have to miss. Some of the most useful lectures that I went to were reviews of the literature for the previous year. Amal Mattu, Jerry Hoffman, Mel Herbert, Stuart Swadron, Corey Slovis, and Scott Weingart were just a few of the well-known people that presented. Also, there were many break-out sessions on echocardiography, procedures, advanced airway management, and advanced ultrasonography. In addition to lectures about Emergency Medicine, there were topics that we don't often get a chance to learn about, but that are important to us, regarding finance, health policy, malpractice and time management.

Along with the presentations, there were exhibitors for just about anything and everything in Emergency Medicine. For those looking for new jobs, the vast majority of the employment groups had displays there. New devices, techniques and drugs were also on display. Some of the most popular seemed to be the simulation mannequins, ultrasound devices, and the devices for procedures that you could practice with. After the lectures were over for the day, there were still plenty of things to do. There was a party thrown by one of the EM employment groups at the legendary Fillmore, where show posters lining the wall illustrated the thousands of acts that have performed there. In my down time, there was plenty to see and do in San Francisco. Next year, Scientific Assembly will be in Denver, and I look forward, hopefully, to seeing some of you there.

President's Column continued from Page 1

Our Outcomes:

In the next three years GSACEP will accomplish the following outcomes:

1. Increase dues incrementally as needed
2. Increase return on equity by x%
3. Increase non-dues revenue by x% and decrease the percentage contribution of the annual conference to total revenue
4. Increase VA membership by x% annually
5. Increase conversion from candidate to active member by x% per year
6. Increase member participation in GSACEP activities by x%
7. Increase average length of leader participation by x%
8. Have leaders who are prepared for their leadership roles in terms of their knowledge and experience

We have made great strides in recent years in our chapter. We are among the ACEP chapters that continue to grow. Right now, we have almost 900 members, placing us in the 10 top chapters in the country! If we reach 901 members by the end of the year, we will grow from eight to nine councillor positions. We have developed and grown national ACEP leaders. COL Bob Suter, Army Reserves, served as national ACEP President. Col. Linda Lawrence served as ACEP President while on active duty with the Air Force. COL Marco Coppola recently completed his tenure as ACEP Vice –Speaker of the Council, and, we are proud to report, was elected Council Speaker for the next two years. One cannot underestimate the importance of that national leadership involvement and how it reflects upon our chapter. It has allowed many of us to serve on national committees, lecture at Scientific Assembly, put GSACEP members in key positions on the Council Steering Committee, and influence who is selected to lead our national organization.

In addition, GSACEP members are key contributors to the Emergency Medicine Foundation (EMF), and the National Emergency Medicine Political Action Committee (NEMPAC). Medicine in the United States will be changing in many ways in the coming years. It is critical that your specialty be represented and be able to influence the decisions that will be made to protect our specialty, emergency medicine practice, and most importantly—our patients. Thanks to our success as a chapter GSACEP members will be part of shaping the future of emergency medicine!

The chapter is on very sound financial footing thanks in large part to several successful annual conferences and the dedicated stewardship of our executive director, Ms. Bernadette Carr, and our esteemed Secretary-Treasurer, Dr. Dave McClellan. This is an extraordinary accomplishment as less than a decade ago our future appeared to be in jeopardy due to our financial situation.

However, we are not resting on our laurels, and our strategic plan helps chart our direction for the future. I look forward to your input on our Strategic Plan. More importantly, my hope is that this will encourage more of you to become active in the chapter and participate in building the future of military and federal emergency medicine within ACEP!

The Council Experience: Perspective from a First- Time Councillor

CPT Cameron Olderog, MC, USA

Each year, over 300 members of ACEP assemble two days before Scientific Assembly kicks off to represent the members of ACEP on important issues facing the college. This year, I was elected by GSACEP members to represent them at the council. I did not know what to expect coming into this experience, but I learned a lot about how ACEP works and issues that face emergency medicine physicians.

Councillors and Alternates:First Row: Maj Torree McGowan, MD, FACEP; MAJ Rachel Villacorta-Lyew, MD; CPT Cameron Olderog, MD; James Eadie, MD, MBA, FACEP; CPT Josh Simmons, MD; Janet Henderson, MD, MPH, FACEP; LTC Bob Gerhardt, MD, MPH, FACEP; COL Marco Coppola, DO, FACEP, Council Speaker. Back Row: COL(ret) Cloyd Gatrell, MD, FACEP; Col Lee Payne, MD, FACEP; CDR Tom Vanhook, MD; LTC Dave Barry, MD, FACEP

Through the council each year, ACEP chapters and members at large submit amendments for consideration. These amendments address matters facing emergency medicine physicians including ACEP bylaws, patient care, medico-legal, and health care policy, issues. The amendments are then brought to the council for consideration. There are too many amendments for everyone to discuss them together, so the amendments are separated into three reference committees based on category. I attended the reference committee on bylaws amendments. While this may sound tedious and boring, I learned a lot about how ACEP works. I had never read the bylaws before, so it was interesting to see what is included and what people want to change. In the reference committees, councillors and members at large can speak in support of or against each amendment. This process is how the amendment is debated and how an ACEP member has a voice in these considerations. After all the debating and discussing, the reference committee comes up with a recommendation to the entire council. The recommendation is either to accept the amendment, reject the amendment, or to change it. All of this occurs on the first day of the council meeting.

It is a long and tiring day, but it is not over yet. That evening, the councillors have the opportunity to meet all of the candidates for the elected positions on the Board of Directors. The councillors have the responsibility of electing these representatives. There were three candidates for ACEP President this year, one candidate for Speaker, three for Vice Speaker, and seven for ACEP Board of Directors. There are speeches, information from the candidates, and time to talk to the candidates on this first day so the councillors can decide who would best represent the membership.

The second day, the entire council is together on the floor again, and it is on this day that voting occurs. Voting begins with the conference committee recommendations on the amendments and then there is time for additional comments to be made from the councillors. Some of the amendments do not require much further debate, such as the bylaws amendments where details were hammered out in the reference committee. But some topics garner more debate, like legalization of marijuana and nationalized health care. After debating is done, a vote is taken. Once all the amendments have been voted on, the officer elections are held. You have an opportunity to hear from the incoming and outgoing ACEP Presidents as well.

My experience as a first-year councillor was wonderful. It was a little overwhelming at first, but all the experienced councillors were very helpful explaining things and guiding me through the parliamentary procedure, schedule and issues. The most valuable part for me was to see the process. It was amazing to see how each ACEP member has a voice in ACEP policy through the council, and that the council voice matters in the policy decisions the ACEP Board of Directors makes. There will be openings at GSACEP this coming year for council positions. I would encourage new people to consider getting involved to see this process first-hand. Please contact me if you have any questions, or would like to be involved.

GSACEP Member List of New ACEP Fellows

Mark Antonacci, MD, FACEP
Vincent L Ball, MD, FACEP
Richard Barrow, MD, FACEP
Scott A Bier, MD, FACEP
Daniel J Brown, MD, FACEP
Norak Chieng, MD, FACEP
Jimmy L Cooper, MD, FACEP
John J Devlin, MD, FACEP
Brian E Downing, MD, FACEP
Mark E A Escott, MD, MPH,FACEP
Todd R Fowler, MD, FACEP
Everett T Fuller, MD, FACEP
Phillip J Goebel, MD, FACEP
Craig Goolsby, MD, FACEP
Nathaniel V Greenwood, DO, FACEP
Guyon J Hill, MD, FACEP
Michael Juliano, MD, FACEP
Tristan Knutson, MD, FACEP
Michael M Levinson, MD, FACEP
Anantha Krishna Mallia, DO,FACEP
David A Masneri, DO, FACEP
Torree M McGowan, MD, FACEP
Anthony Lamar Mitchell, MD,FACEP
James K Palma, MD, FACEP
Michelle M Perez, MD, FACEP
Abigail C Raez, MD, FACEP
Ali S Raja, MD, MBA, MPH, FACEP
Devin Rickett, MD, FACEP
James W Sadock, MD, FACEP
Robert Sarlay, Jr, MD, FACEP
Gillian Schmitz, MD, FACEP
Cynthia Shen, DO, FACEP
Edwin Yaeger, DO, FACEP

GSACEP Excellence in Emergency Medicine Award Nomination Form

Criteria for Nomination
Any member of the Government Services Chapter of the American College of Emergency Physicians (GSACEP) may nominate himself/herself or another member for this award. The leadership team of any hospital or military treatment facility may nominate a GSACEP member for this award. This award recognizes a leader with a record of significant contributions to military emergency medicine, resulting in noteworthy impact on the profession. The nominee must be a GSACEP member

Nominees must meet the following criteria:

- Active member of GSACEP
- Outstanding work and professional activities.
- A proven record of noteworthy, sustained, contributions to military emergency medicine.

Annual call for nominees: Nov - Dec
Deadline for nominations: 15 Jan

Selection and presentation
The Excellence in Military Emergency Medicine award winner is selected by a majority vote of awards committee members, the chair vote deciding in a tie situation. Awardees' are announced in the Feb timeframe. The award is presented at the annual GSACEP Joint Service Symposium.

This form must be completed entirely. Do not indicate "see C.V."

Nominator Information

The nomination form, nominee's curriculum vitae, a letter explaining why the nominee merits the award and specifically relating to their background to the award criteria and letters of support. Packages will be submitted to: Col Lee Payne, USAF, MC at lee.paynee@peterson.af.mil or Ms. Bernadette Carr atgsacep@aol.com. Please send as a pdf file, or fax your form to 866-277-8620.

Nominated By: _____ Date Submitted_____

Address: _____

City, State, ZIP: _____

Nominator's Signature _____E-mail_____

Nominee

Name of Nominee: _____ Telephone: _____

Address: _____

City, State, ZIP: _____E-mail_____

Nomination Form

Please state why this person should be honored with this award, with specific attention to the criteria listed above. Paragraph or bullet format is acceptable and is **limited to 750 words**. Complete and submit as separate document.

Complete the following even if listed on CV.

ACEP Offices Held (National and Chapter):

Committees (National, Local/Name of Committee, and Length of Service):

Other Emergency Medicine-Related Services (Title and Length of Service):

Other Activities of Special Merit (Civic, Institution, etc.):

Letters of Support

Up to 3 letters of support may be submitted. Letters should demonstrate collaboration and be submitted from individuals who work with that nominee. Letters are optional unless package is a self-nomination then least one letter from supervisor or senior leader must be submitted and attest that the individual is in good professional standing.

GSACEP Rising Star Award Nomination Form

Criteria for Nomination
The GSACEP Rising Star Award is intended to honor the junior Emergency Medicine staff that most exemplifies excellence and dedication to service. Similar in intent to sports-based "rising star" awards, the GSACEP Rising Star Award is given annually to a standout young EM physician who displays exceptional service to the Government Services Section and/or outstanding leadership in the profession.

Nominees must meet the following criteria:

- Between one and five years out of Emergency Medicine Residency Training
- Active member of GSACEP
- Outstanding work and professional activities.
- Notable service to professional Emergency Medicine organizations (preferably GSACEP).

Any member of the Government Services Chapter of the American College of Emergency Physicians (GSACEP) may nominate himself/herself or another member for this award using the GSACEP Rising Star Award Nomination Form. The leadership team of any hospital, military treatment facility, or military unit may also nominate someone for this award.

Annual call for nominees: Nov - Dec
Deadline for nominations: 15Jan

Selection and presentation
The Rising Star award winner is selected by a majority vote of awards committee members, the chair vote deciding in a tie situation. Awardees' are announced in the Feb timeframe. The award is presented at the annual GSACEP Joint Service Symposium.

This form must be completed entirely. Do not indicate "see C.V."

Nominator Information

The nomination form, nominee's curriculum vitae, a letter explaining why the nominee merits the award and specifically relating to their background to the award criteria and letters of support. Packages will be submitted to: Col Lee Payne, USAF, MC at lee.paynee@peterson.af.mil or Ms. Bernadette Carr atgsacep@aol.com. Please send as a pdf file, or fax your form to 866-277-8620.

Nominated By: _____ Date Submitted_____

Address: _____

City, State, ZIP: _____

Nominator's Signature _____E-mail_____

Nominee

Name of Nominee: _____ Telephone: _____

Address: _____

City, State, ZIP: _____E-mail_____

Nomination Form

Please state why this person should be honored with this award, with specific attention to the criteria listed above. Paragraph or bullet format is acceptable and is **limited to 750 words**. Complete and submit as separate document.

Complete the following even if listed on CV.

ACEP Offices Held (National and Chapter):

Committees (National, Local/Name of Committee, and Length of Service):

Other Emergency Medicine-Related Services (Title and Length of Service):

Other Activities of Special Merit (Civic, Institution, etc.):

Letters of Support

Up to 3 letters of support may be submitted. Letters should demonstrate collaboration and be submitted from individuals who work with that nominee. Letters are optional unless package is a self-nomination then least one letter from supervisor or senior leader must be submitted and attest that the individual is in good professional standing.

GSACEP Medical Director Leadership Award Nomination Form

Criteria for Nomination
Any member of the Government Services Chapter of the American College of Emergency Physicians (GSACEP) may nominate himself/herself or another member for this award. The leadership team of any hospital or military treatment facility may nominate a GSACEP member for this award. The nominee must be a GSACEP member and must currently be in a leadership position in an emergency department. The nominee must demonstrate significant contributions to the department in the following categories:

- Quality Patient Care
- Operational Effectiveness
- Education
- Community Service
- Collaboration with Nursing
- Synergistic approach to leadership within the hospital or hospital system

The nominee must demonstrate collaborative relationships with nursing and ancillary departments to implement and improve operational and clinical standards based on evidence-based practice. The nominee will create and sustain a high degree of patient satisfaction with emergency care delivery and will implement creative and innovative strategies to address emergency department throughput.

Annual call for nominees: Nov - Dec
Deadline for nominations: 15Jan

Selection and presentation
The Medical Director Leadership award winner is selected by a majority vote of awards committee members, the chair vote deciding in a tie situation. Awardees' are announced in the Feb timeframe. The award is presented at the annual GSACEP Joint Service Symposium.

This form must be completed entirely. Do not indicate "see C.V."

Nominator Information

The nomination form, nominee's curriculum vitae, a letter explaining why the nominee merits the award and specifically relating to their background to the award criteria and letters of support. Packages will be submitted to: Col Lee Payne, USAF, MC at lee.paynee@peterson.af.mil or Ms. Bernadette Carr atgsacep@aol.com. Please send as a pdf file, or fax your form to 866-277-8620.

Nominated By: _____ Date Submitted_____

Address: _____

City, State, ZIP: _____

Nominator's Signature _____E-mail_____

Nominee

Name of Nominee: _____ Telephone: _____

Address: _____

City, State, ZIP: _____E-mail_____

Nomination Form

Please state why this person should be honored with this award, with specific attention to the criteria listed above. Paragraph or bullet format is acceptable and is **limited to 750 words**. Complete and submit as separate document.

Complete the following even if listed on CV.

ACEP Offices Held (National and Chapter):

Committees (National, Local/Name of Committee, and Length of Service):

Other Emergency Medicine-Related Services (Title and Length of Service):

Other Activities of Special Merit (Civic, Institution, etc.):

Letters of Support

Up to 3 letters of support may be submitted. Letters should demonstrate collaboration and be submitted from individuals who work with that nominee. Letters are optional unless package is a self-nomination then least one letter from supervisor or senior leader must be submitted and attest that the individual is in good professional standing.

GSACEP Fellowship in Leadership and Advocacy Nomination Form

The GSACEP Fellowship in Leadership and Advocacy is designed to develop and groom future military and federal emergency medicine leaders. The fellowship combines elements of mentoring, with skills in organization, education, advocacy, and involvement.

The fellowship serves to provide both an orientation to organized medicine and leadership development to ensure our future military and federal emergency medicine leaders succeed in the combined military and civilian organized medicine setting.

Program Goals

- Develop leaders who are prepared for their leadership roles in terms of knowledge and experience.
- Provide orientation and skills to allow potential leaders to promote military and federal emergency medicine locally and nationally.
- Increase participation in GSACEP activities and committees, developing long-term leadership for the organization

Criteria for Nomination

Nominees must meet the following criteria:

- Active Resident in an accredited Emergency Medicine residency program or young faculty <5 years out of training.
- Two years obligated service remaining in military or VA service.
- Active member of GSACEP
- Possess a track record of outstanding work and participation in professional activities.
- Commit to all elements of the GSACEP fellow expectations.
    - Since fellowship requires a significant time commitment and potential monetary expense, nominees are required to obtain written command support for cost-sharing and TDY expectations.
    - Deployment and other service related duties prohibiting completion will be considered.

Any member of the Government Services Chapter of the American College of Emergency Physicians (GSACEP) may nominate himself/herself or another resident member for this award.

Annual call for nominees: Nov - Dec
Deadline for nominations: 15 Jan

Expectation of Fellows

Over the course of their one year fellowship, GSACEP Fellows will participate/contribute in the following ways:

- With GSACEP leadership assistance, apply for membership on one ACEP committee of your choice.
- Volunteer as a member of one GSACEP committee of your choice.
- Participate in GSACEP Board of Directors conference calls and attend BOD meetings at conferences outlined below.
- Write one article for the GSACEP Newsletter, "The EPIC".
- Act as Alternate GSACEP Councillor for the annual ACEP Council Meeting. (October timeframe)
    - requires attendance at ACEP Council Meeting (night prior to Council meeting and two nights of the meeting)
    - GSACEP provides 3 nights hotel and $150 per-diem to offset the cost.
- Represent GSACEP at the ACEP annual Scientific Assembly. (October timeframe)
    - Attend ACEP and GSACEP committee meetings as well as GSACEP Board of Directors Meeting.
    - GSACEP provides 2 nights hotel and $100 per-diem to offset the cost.
- Attend GSACEP annual Government Services Symposium two consecutive years in a row. (Mar/Apr timeframe)
    - Attend GSACEP committee meetings as well as GSACEP Board of Directors Meeting.
    - GSACEP provides 3 nights hotel and $150 per-diem to offset the cost.
- Attend annual ACEP Leadership and Advocacy Conference. (May timeframe)
    - GSACEP provides 3-4 nights hotel and $100 per-diem to offset the cost.

Selection and presentation

Fellowship in Leadership and Advocacy award winners are selected by a majority vote of Board of Directors members, the president vote deciding in a tie situation. Awardees' are announced in the Feb timeframe and receive scholarship funding as outlined above in the expectations of fellows.

This form must be completed entirely. Do not indicate "see C.V."

Nominee Information

The nomination form, nominee's curriculum vitae, a letter explaining why the nominee merits the award and specifically relating to their background to the award criteria and letters of support. Packages will be submitted to: Col Lee Payne, USAF, MC at lee.paynee@peterson.af.mil or Ms. Bernadette Carr atgsacep@aol.com. Please send as a pdf file, or fax your form to 866-277-8620.

Name of Nominee: _____ Telephone: _____

Address: _____

City, State, ZIP: _____E-mail_____

Nomination Form

Please state your interest in the GSACEP Fellowship in Leadership and Advocacy. Specifically address the nomination criteria listed above and how your participation will benefit you, GSACEP, organized military and federal emergency medicine, and/or your command. Paragraph or bullet format is acceptable and is **limited to 750 words**. Complete and submit as separate document.

Complete the following even if listed on CV.

ACEP Offices Held (National and Chapter):

Committees (National, Local/Name of Committee, and Length of Service):

Other Emergency Medicine-Related Services (Title and Length of Service):

Other Activities of Special Merit (Civic, Institution, etc.):

Letters of Support

A written letter of support from the nominee's command recognizing the significant time (TDY commitment) and monetary expense (cost-sharing as outlined in the fellow expectations) required of a GSACEP fellow is required for consideration.

Up to 2 additional letters of support may be submitted. Letters should demonstrate collaboration and be submitted from individuals who work with that nominee. Letters are optional unless package is a self-nomination then least one letter from supervisor or senior leader must be submitted and attest that the individual is in good professional standing.

GSACEP USU Senior Student Award

Criteria for Nomination

The GSACEP USU Senior Student Award is intended to honor the senior medical student that best demonstrates the qualities and attitude of an exemplary military Emergency Physician. This is the resident you want working for you on the floor , the staff you can trust to bounce ideas off of, the doc commanders will go to in order to get things done, and one the patients and staff will look to for their knowledge, compassion and bedside manner. These candidates are future chief resident material. This award is given annually. Winners receive a certificate and free one year memberships to GSACEP, ACEP and EMRA.

Nominees must meet the following criteria:

- USUHS fourth year medical student in good standing.
- Outstanding work and professional activities.

Selection and Presentation

The USU Senior Student Award winner is selected by the USU Military and Emergency Medicine staff near the end of each academic year and the award is presented at graduation ceremonies.

GSACEP Reception at Scientific Assembly 2011

Once again, GSACEP was able to host a great reception at this year's conference hotel, The Hilton, in San Francisco, thanks to the support of our sponsors: Emergency Medical Associates, Sonosite, Verathon, T-System, and Zonare. These five sponsors have been consistent supporters of our chapter, and we're deeply grateful.

A Chapter of the American College of Emergency Physicians

Government Services

EPIC

Summer 2012

The President's Column : Collaboration, Structure, and Recognition

By LTC J. Dave Barry, MC, USA

Our Board of Directors had an especially productive spring and early summer. I'd like to take this opportunity to update you on the projects we're working on for you. Under the direction of our immediate past president, Col. Lee Payne, we revised the chapter's strategic plan, focusing and honing the chapter's goals and measures of effectiveness. This year I hope to build on those objectives by concentrating on a couple noteworthy themes: collaboration, structure and recognition.

Collaboration with other like-minded organizations builds ties within the EM community and expands Government Services scope of influence, allowing us to act as better proponents of issues important to our members and, in turn, more effectively serve them. Government Services has a strong tradition of leadership in the EM community both within national ACEP and in various other EM-focused organizations. The initiative, drive, and leadership of our members is a key resource that we look to utilize not just outside the chapter but also internally. Building leaders prepared for their various leadership roles in terms of knowledge and experience is a major objective outlined by our Board of Directors. Collaboration and mentorship within our chapter is a key component to this objective. Although our annual conference, Government Services Symposium, and the 'collective wisdom' section of our website (including pre-deployment and operational medicine resources, past EPICs and the Annals of Navy EM) serve to promote internal collaboration, I urge you to voice additional ideas you may have.

A strong foundation is essential for GSACEP to best serve the interests of its membership. This was the impetus for Col. Payne's initiative to solidify the chapter's strategic plan, the development of well -defined objectives by the Board of Directors, and an expansion of our committee structure. But the real challenge is building on this foundation by promoting member participation. Involvement in the organization not only serves to improve EM for future members, but also helps to sharpen your own leadership skills, share and discuss contrasting ideas and viewpoints, foster long-lasting friendships and realize the wide-ranging opportunities available in an EM career both in and out of national service. So, I ask you to participate by sharing your needs and ideas with the Board.

In the near future, we plan to send you a survey to query your opinions on what topics and services are most important to you. After completing the survey (or right now), expand your involvement by joining one of our committees (listed in our Board of Directors section of gsacep.org , and listed here on page 2 of The EPIC), running for GSACEP office, or contributing to an initiative important to you. As an example of a noteworthy initiative, GSACEP recently submitted a resolution to the national ACEP council to educate all EM physicians on the wide-ranging problems of TBI (traumatic brain injury) and PTSD (post-traumatic stress disorder) in the millions of post-war veterans now entering the civilian ranks. Your ideas and passion could be the start of our next resolution.

Finally, it never ceases to amaze me how productive, selfless and accomplished our various members have been. Our Board recognizes this and has expanded the chapter awards and sponsorship opportunities. We profile our Excellence Award winner, COL Dave Della-Giustina, and new award recipients, COL Frank Christopher, and LCDR David Bruner, in this issue of the EPIC. The various award and scholarship opportunities are outlined on the GSACEP website under "What's New at GSACEP." Please take the time to nominate all of your deserving colleagues and acknowledge their widely diverse achievements.

The common theme here is inclusiveness: Inclusiveness by collaborating with our EM brethren in other organizations; inclusiveness in our membership by supporting the priorities of our deployed providers, residents, medical students, VA and active duty members; inclusiveness in participation by serving on GSACEP committees, contributing to initiatives, and/ or nominating your colleagues for awards. I hope you will join me and the Board of Directors in these aspirations.

I look forward to hearing from you, working with you, and serving your interests.

In This Issue

GSACEP at Scientific Assembly 2012

Tuesday, October 9, 0900-1100
Location: Embassy Suites, Creston Salon A, 3rd Floor
GSACEP Board of Directors Meeting
All members invited.

Tuesday, October 9, 2000-2200
GSACEP 35th Anniversary Celebration & Honoring
ACEP Council Speaker COL Marco Coppola DO, FACEP
Denver Museum of Art
RSVP required. Look for formal notice in the mail in August

From the Editor's Desk

MAJ Rachel Villacorta-Lyew, MC, USA

Happy Summer to you and welcome to another edition of the GSACEP EPIC! A tremendous amount has happened since our last edition. In this issue are highlights from two outstanding organizational events- The Government Services Symposium, April, 2012, and the ACEP Leadership and Advocacy Conference, May, 2012. GSS 2012, at beautiful Squaw Valley, had excellent educational lectures, networking opportunities, and occasions for recognizing members within our organization for advancing emergency medicine.

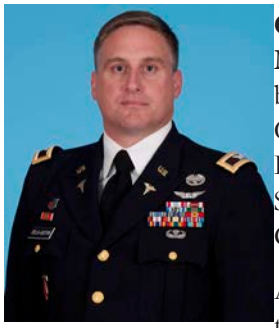
The national Leadership and Advocacy Conference is always an energizing event where the movers and shakers of emergency medicine and anyone with a story to share about something they'd like to change about our healthcare system interact with the policy makers of our government. Check out a couple of new perspectives by our scholarship winners.

On the horizon in October 2012, is the ACEP's national Council meeting and their academic Scientific Assembly in Denver. Our chapter will be sponsoring and presenting a resolution to the national assembly called the Joining Forces Roundtable to promote the recognition and treatment of the increasing population of veterans. Any ACEP member is welcome to take part in the council proceedings up to the voting process. It is an impressive process that takes place prior to the Scientific Assembly. As always, the lectures at Scientific Assembly are fantastic. Also of note, the GSACEP chapter is celebrating its 35th anniversary. Be on the lookout for an invitation to our reception and network with your fellow GSACEP members!

Lastly, I'd like to encourage fellow members to get more involved in the committees of our chapter which include membership, communications and education. This organization exists for its members and it's the members who drive the activities of the organization. The time commitment is variable, but your involvement is vital to have an effective Government Services Chapter. Contact a committee chair for more information!

Enjoy this edition of EPIC!

The 2012 GSACEP Award Winners



COL David Della-Giustina, MD, FACEP, is the 2012 recipient of the Excellence in Military Emergency Medicine Award for lifetime contributions to Military Emergency Medicine. COL Della-Giustina has been Chief of the emergency department at Madigan Army Medical Center (WA) for the past 10 years. COL Della-Giustina has also served as the program director for the Madigan- University of Washington Emergency Medicine Residency from 1998- 2003 and as the Emergency Medicine Consultant to the Army Surgeon General from 2002-2007. He was President of GSACEP from 1999-2000, and a Councillor for GSACEP from 2001 to 2004.

A graduate of the United States Military Academy, COL Della-Giustina received his MD education from the Uniformed Services University of the Health Sciences, and completed his emergency medicine residency training at Madigan. He served as the Associate Program Director of the Emergency Medicine Residency and the Hospital and Departmental Research Director at Darnall Army Community Hospital, Ft. Hood, TX, from 1995 to 1998 before heading to Madigan.

In his distinguished career, COL Della-Giustina has deployed four times, with U.S. Special Operations Command, from 2004 to 2007, in Operation Iraqi Freedom and Operation Enduring Freedom. He received the Combat Medical Badge for providing patient care while under direct fire from the enemy in Iraq.

At Madigan, COL Della-Giustina not only developed the residency program into one of the best and well-respected medical training programs in the Army and the military, but has promoted the evolution of the subspecialty fellowship programs within emergency medicine at Madigan and beyond. He played a major role in establishing the ultrasound fellowship at Madigan, and in solidifying it as a program of excellence. Furthermore, he utilized and applied military experience to advance wilderness medicine and has been integral in developing the wilderness medicine fellowship at Madigan.

COL Della-Giustina holds several university faculty appointments and is often an invited lecturer at GSACEP and at ACEP's Scientific Assembly on numerous occasions. COL Della-Giustina has published many peer-reviewed articles, and is a regular contributor to emergency medicine textbooks. He is a recipient of the 2004 Surgeon General's Physician Recognition Award for Lieutenant Colonel given annually to the most outstanding Lieutenant Colonel physician in the Army based on multiple areas (leadership, teaching, research, clinical, military) and of the 2002 American College of Emergency Physicians National Faculty Teaching Award given annually to 10 physicians for outstanding teaching in emergency medicine.

After 25 years of military service and a medical career demonstrating contributions in the multiple facets of emergency medicine spanning clinical, academic, and leadership excellence, it is an honor to present COL Della-Giustina with the Excellence in Military Emergency Medicine Award.

COL Frank Christopher, MD, is the first recipient of the GSACEP Medical Director Leadership Award for his contributions to the emergency department. COL Christopher has been Chief of the Department of Emergency Medicine and recently transitioned to Deputy Commander for Clinical Services at Womack Army Medical Center, Ft Bragg, NC. Prior to taking this position, COL Christopher was the first physician to command a battalion in combat since Vietnam.

Through his leadership, WAMC's emergency department has accomplished much. It has increased its critical care capacity while reducing the time to provider and overall length of stay for all patients. He was involved in expanding the WAMC ambulance services to meet the needs of a growing military installation. Under his leadership, the department pioneered the model Sexual Assault Nurse Examiner (SANE) program in the Army for their capability to perform forensic exams, having been profiled in the AMEDD Mercury newsletter and The Paraglide. COL Christopher also established the presence of a licensed clinical social worker and the DEM after-hours pharmacy to enhance quality of care for their patients.

COL Christopher established a committee overseeing medical, nursing, and EMT training at all levels which includes a monthly interdepartmental Grand Rounds program attracting speakers of national recognition and averaging over 100 attendees per month. COL Christopher facilitated WAMC joining the Mid Carolina Trauma Regional Advisory Committee, improving cross-jurisdiction and interfacility treatment (and protocols) for trauma patients across the spectrum of injuries. As part of this consortium, WAMC is setting conditions for future establishment as a Level 3 regional trauma center. COL Christopher established the WAMC Department of Emergency Medicine as an educational experience for community emergency medicine at a high volume military treatment facility with a large troop and family population for PGY-3 EM residents at other military programs.

COL Christopher's extraordinary leadership manifests itself in other ways through operational medicine. He is the creator of the in-theater (Iraq) military premedical training centers (winning the Surgeon General's Excalibur Award) and co-creator of the Army Medical Simulation Training Center concept; providing sustainment training for pre-hospital care personnel across the Army.

Continued on page 4.

LCDR David Bruner, MD, is the first recipient of the GSACEP Rising Star Award presented to a young physician who displays exceptional service to GSACEP and leadership to the field of Emergency Medicine.

LCDR Bruner merited this award for many reasons. Recognized as a leader by his peers, he was Chief Resident at Naval Medical Center- Portsmouth in 2008-09 and recipient of the Resident's Attending choice for Junior in both 2010 and 2011.

In addition to his role as Assistant Program Director for Curriculum Development at NMC, Portsmouth's Emergency Medicine Residency Program, he has strong research and writing experience. He has been published in a number of emergency medicine journals and served as a reviewer for several journals. LCDR Bruner is Editor-in-Chief of the Annals of Navy Emergency Medicine and has held that position since 2009.

For the last several years, he has participated as faculty at GSACEP's annual conference, and served this year on the Planning Committee. At national ACEP, Dr. Bruner served on the ACEP Education Committee from 2010-11. He was named Distinguished Fellow in the ACEP Teaching Fellowship program in 2010.

Honorary Membership

Please congratulate our Government Services Chapter's very own executive director, Ms. Bernadette Carr, for her recognition and award as an Honorary Member of the American College of Emergency Physicians.

Ms. Carr single-handedly leads the most geographically diverse chapter within ACEP with remarkable passion, dedication, and humble selfless service. During her 15 year tenure, the chapter has more than doubled its membership from 447 to over 914 members across the globe in varied government services. In addition to the geographical diversity of the chapter membership, there remains the constant challenge of member turnover and the repeating challenge of developing future leaders from an often junior pool of emergency physicians as members transition out of the military. Bernie is the glue and corporate knowledge that not just holds the chapter together but has propelled the chapter into being a leader within ACEP. Under her guidance, more chapter members have risen to the highest levels of ACEP leadership as well as expanded their involvement in ACEP committees and Council activities. In addition, the chapter is financially solvent and secure which has been tested to extremes during the past decade of war during which many of the members have prominently served and continue to serve. Under Ms. Carr's leadership, the role of emergency medicine within the military and VA has strengthened due to activities and partnerships within GSACEP and ACEP. In addition she has selflessly served on ACEP Committees and Task Forces, namely National Chapter Relations, Membership, Public Relations, and the Chapter Executives Task Force .

Thank you Bernie for all that you have done on behalf of GSACEP and its members.

Research Forum at The Government Services Symposium 2012

Here are the results of the Research Forum at The Government Services Symposium 2012:

Best Resident Poster: LCDR Elliott Ross - NMCSD
Title: Portable Pulse Oximetry vs. Arterial Blood Gas Analysis in a Field Environment at Altitude

Best Staff Poster: CPT Jason Heiner - SAMMC
Title: Clinical effects and antivenom use for snakebite victims treated at 3 U.S. hospitals in Afghanistan

Best Resident Oral Presentation: LCDR Joe Kotora - NMCP
Title: Comparison of 3 commercially available vented chest seals for prevention of tension pneumothorax in a communicating pneumothorax porcine model

Best Staff Oral Presentation: Gillian Schmitz - UCSD
Title: Primary vs. secondary closure of cutaneous abscesses in the ED: a RCT

Winner of the New Speakers Forum

LT Luke Day, MC, USN: Medical Decision-Making and Error in Medicine

President Elect's Column

By Col Christopher Scharenbrock, USAF, MC

What a great honor to be selected as the President-elect for Government Services Chapter of the American College of Emergency Physicians. So many outstanding individuals who have been a part of this organization and I believe that we have a truly noble purpose as physicians who take care of our nation's treasures -- the men and woman who have signed on the dotted line to defend our great country.

I was working a recent shift in the Emergency Department here at Travis Air Force Base in sunny northern California. I was covering the urgent care shift seeing countless kids with colds, minor injuries, retirees who couldn't get appointments. There was the occasional immediate gratification case that attracted me to the specialty -- like the two year old girl with a Nursemaid's whose eyes lit up the moment she realized her radial head was reduced. The next patient though wasn't promising to be as easy: a 45 year old Veteran Affairs patient with hip pain who the triage nurse was saying was demanding an MRI.

In my opinion he didn't need an MRI -- but he needed a doctor. A quick review of his chart revealed that he had been medically retired from the Army as a corporal, most likely because of his diagnosis of bipolar disorder. Further review of pharmacy records showed he was supposed to be on a multitude of medications including Lithium which he was clearly not taking.

As I stepped into the room, I encountered a mountain of a man (at least fifty pounds bigger than me) in relatively good shape who was none too happy. He had managed to go to three other civilian hospitals that day for his hip pain that had been worsening over several weeks and received what sounded like cursory evaluations, one plain film, and a recommendation to see an Orthopedics doctor and get an MRI.

He'd called to set those appointments up and lacking insurance was at least per his recollection told "No". His prescriptions for pain medications were unfilled as he said he didn't have the money to fill them, though he also mentioned later in the interview that he smoked two grams of marijuana per day (No doubt home-grown; this is California, after all).

He had taken the names of all the providers he had seen and mentioned his plans to report them to the state medical board. So, in summary; a non-compliant veteran bounced from hospital to hospital, claiming he couldn't get into the VA, imposing and unhappy.

Well…what a great case! I think he was surprised when I listened to his story, put him in a gown and actually examined his hip. He was point tender on the posterior margin of the greater trochanter, exacerbated by internal and external rotation. His hip otherwise ranged well, and was afebrile. Plain films looked fine, and I told him he had greater trochanteric bursitis and that we could try injecting it.

I did wimp out and order CBC, CRP, and ESR which, of course, were normal. I talked with the Ortho PA on-call about the case to make sure they had no problem with me doing the case. After a sterile prep, I put 10mg Decadron with 2.5 cc of one percent Lidocaine into the bursa with complete relief of his pain within about 30 seconds.

He left the department practically skipping (a scary thought -- of course I recommended that he should still see his PCM since a little Lithium in his diet might be for the greater good).

As I reflect on the case, I was wondering what other stories this gentleman might have. Was he like the reserve Army sergeant who was generally considered a screw-up, but was the gunner for my HMMVV that put a 50 caliber round directly in the center of the engine of a vehicle careening toward our convoy stopping a potential suicide bomber?

The past decade of war has produced millions of veterans who will need our care. TBI, PTSD, Wounded Warriors have become the new lexicon. I wonder what we as federal emergency physicians can do to better take care of veterans like this one.

I can guarantee that he will be a customer for life in our department -- he'll someday have an even greater malady, no doubt an EP down the road will gain a currency case. Not all military hospitals have memorandums of understanding to take care of veterans. The arrangement here at DGMC allows the VA to reimburse DGMC for the care provided (75 percent CMAC), allowing the hospital to hire additional VA staff to help us take care of their patients. Other regions of the country may have ample VA hospitals to take care of their patients, but I have to wonder why so few board certified Emergency Medicine physicians are employed in the VA healthcare system? And what a great transition for the military EM physician who has either served a career in the military or for various reasons will separate when their commitment is up to be able to find a great job in a VA facility.

I think that's where we need to go: our nation's veterans as well as our retirees, soldiers, sailors, and airmen and their families have sacrificed and they deserve the very best.

Resident Scholarship Winner Reports on ACEP's LAC

By Capt Katherine Racicot, USAF, MC

This past May, I attended the ACEP Annual Leadership and Advocacy Conference in Washington, DC as one of the GSACEP resident scholarship recipients. First, I would like to thank the leadership of GSACEP for your help in providing me with this wonderful opportunity. The Leadership and Advocacy conference is one of ACEP's most popular events, second only to the yearly Scientific Assembly. The goal of the conference is two-fold, with a focus on creating effective leaders as well as teaching participants how to advocate for our specialty at the local, state, and national level. Although there were many "veteran" attendees, 25% of the attendees were residents, and there were many other first-timers who, like me, were totally new to the policy side of emergency medicine.

The first day of the conference was devoted specifically to first-timers like myself and involved several lectures on introduction to advocacy and current issues in healthcare, as well as group sessions on how to deliver powerful presentations. The second day was devoted to issues facing the specialty, such as liability reform, changes in Medicaid reimbursement, and consequences of the Affordable Care Act. One of the highlights of this day was a presentation from an alumnus of my residency at Wright State, Dr. Nathaniel Schlicher, who was instrumental in successfully advocating for a halt to the Washington State zero-tolerance Medicaid emergency payment policy. Had this law gone into effect, it would have denied Medicaid payment for ED care given to patients diagnosed with one of about 500 conditions deemed by the state to be "non-urgent." Dr. Schlicher and the Washington state chapter of ACEP were able to advocate for their patients and make policymakers recognize that this law violated the "prudent layperson" standard, i.e. the public should not be expected to be able to recognize what is and what is not an emergency. This presentation inspired me by showing how someone who seemed not all that different from me, someone new to advocacy and policy-making, was able to make a difference on a state level, simply by standing up for what he knew was the right thing for his patients.

Feeling ready to tackle the issues, we set off to a day of meetings on Capitol Hill with various legislative representatives. Along with a group from Ohio ACEP, I met with the Legislative Directors for Senator Rob Portman and for Congressman Mike Turner, from my district in Dayton, Ohio. I was nervous going into these meetings, but I quickly learned that just like anyone else who I talk to about my job, these legislators responded to my stories about my patients. One of the issues we discussed was the abundance of new synthetic drugs, such as "bath salts." The house has already approved H.R 1254 (Synthetic Drug Control Act of 2011), and three similar bills have been proposed in the senate (S. 409, S. 605, and S. 839). I believe that talking about patients I have seen who have suffered serious morbidity and even mortality from these drugs helped the issue stick in the policy-makers' minds and helped show a more human side to a potentially dry piece of legislation. In a similar vein, we discussed the growing shortages of critical emergency department drugs. As emergency medicine physicians, we witness firsthand the consequences that can result for our patients when we are faced with drug shortages. Again, I felt that telling stories of the patient I needed to intubate with no etomidate or succinylcholine or the patient with a hypertensive emergency who I couldn't treat with labetalol secondary to a drug shortage helped drive the issue home. Congress is currently considering a House and Senate version of drug/device user fee legislation that includes measures which would require drug manufacturers to report any potential shortage to the FDA. If the FDA has this information in a timely manner, it will hopefully be able to work with other manufacturers to produce the drug or to reallocate resources to ensure the right drugs are in the ER when we need them.

Actually going to Capitol Hill and meeting with people from the legislature solidified many of the lessons of the conference. I learned how important it is to clearly communicate my message and to make information both easily understandable and memorable when interacting with staffers who meet with hundreds of constituents per day. One of the biggest things I took away from this conference is both how easy and how rewarding it is to become involved in emergency medicine advocacy. I would encourage both residents and attending physicians to not only stay active in GSACEP but to also make contact with their state ACEP chapter. There are many resources on the ACEP website, such as the 911 Network and NEMPAC, ACEP's political action committee. There is truly no better advocate for the specialty of emergency medicine than an emergency medicine physician, and I thank GSACEP again for giving me this opportunity.

"All Politics is Local"

By MAJ Christopher Weissman, MD, MHA

I had the incredible opportunity to attend the 2012 ACEP Leadership and Advocacy Conference. The phrase that continued to come to my mind throughout the conference was "all politics is local". The structure of the conference was to empower members with healthcare policy information and facilitate relationships with their local representatives. The ultimate goal was to position members to effectively advocate for patients and the specialty at the local level. For those, like me, with an interest in healthcare policy, this conference was nirvana. There were two big issues on the minds of many of the conference attendees. One was the Supreme Court's pending decision on the constitutionality of the health insurance mandate of the Affordable Care Act. A second issue related to how individual state budgetary crises would impact Medicaid reimbursements. The example case for the second issue was the 12-month odyssey Washington ACEP experienced.

The Washington state Healthcare Authority (HCA) manages the state's Medicaid system. The HCA planned to implement a policy for retrospective reimbursement denials for over 500 diagnoses deemed "unnecessary" and limit patients to 3 ED visits per year. This plan was in response to the perception that overutilization of the Emergency Department is a primary driver of "wasteful" Medicaid spending. In actuality, ED visits are only 2% of all healthcare expenditures. Washington ACEP, the Washington State Medical Association (WSMA) and Washington State Hospital Association (WSHA) participated in a workgroup with the HCA and corroboratively created an alternative plan. The HCA later rejected the plan. Washington ACEP took legal action and won a stay against implementation of the original policy. The workgroup met again and arrived at another compromise which the HCA later rejected...again. The workgroup then took a multi-facet approach by appealing to every "friend" who would listen: the state legislature, CMS, patient advocacy groups, a media campaign… anything to stop the HCA from enacting this policy. Eventually, the Governor suspended the policy in favor of allowing the workgroup to create an alternative plan. The plan addresses some of the drivers of ED overutilization: access to primary care and inappropriate opioid use by patients. Implementation begins July 1, 2012 and success will be based on the level of Medicaid savings. Washington ACEP leveraged every relationship, from local representatives to other specialty organizations and even the Emergency Medicine Action Fund; this lead to a patient-centered policy authored by the primary stakeholders to solve a state legislative issue.

My personal highlight of the conference came on the 3rd day when all the members went on scheduled visits with congressional representatives from their area. I went with the lone representative from Hawaii ACEP, Dr. Elizabeth (Libby) Char, on her scheduled

Left to Right: MAJ Christopher Weissman, MD, MHA, Senator Inouye (D-HI), and Dr. Libby Char

visits. Dr. Char is a former EMS director in Honolulu and was born and raised in Hawaii. We were able to meet with staffers from the offices of each House member and a staffer from Senator Akaka's office. But, the highlight was meeting Senator Daniel Inouye. He is 87 years old and serving his 10th term. He is the longest current serving senator. He is the President Pro Tempore of the United States Senate and Chairman of the Senate Appropriations Committee. More importantly, he is a World War II veteran and Medal of Honor winner from one of the most decorated units of the war. He recounted that he had aspirations of being an orthopedic surgeon prior to losing his right hand in the war. He personally meets with any constituent from HI who makes an appointment to see him in Washington. He knows the island and his constituents well. He knew about the hospital closures in and around Honolulu. He knew about the paucity of specialty care in surrounding islands and challenges of transporting those patients to Honolulu for care. His only concern related to healthcare is how he can leverage his position to help his constituents.

The conference was an incredible experience. I appreciated the importance of establishing relationships with my local representatives. We have the same interest...they want to represent their constituents to the best of their abilities (and be re-elected), while we want to advocate for our patients and specialty in a way that ensures quality, evidence-based medical care. Aiding in finding solutions to problems at the local level is a way of ensuring both agendas are met. The Leadership and Advocacy conference positions members to use relationships with local lawmakers to help them cultivate patient-centered healthcare policies for their constituents. Again, all politics is local.

A Chapter of the American College of Emergency Physicians

Government Services

EPIC

Spring 2013

The President's Column

By LTC J. Dave Barry, MC, USA

To say it's been a busy year for our chapter may be a bit of an understatement; we certainly have had quite a few ups and downs. The cancellation of our Government Services Symposium was a significant setback, but in the present environment of fiscal uncertainty, the board made the right decision. I want to thank again those who dedicated time and energy to organizing and planning GSS, including; The conference planning committee, chaired by MAJ Rachel Villacorta-Lyew; the specialty leaders, COL Ian Wedmore (Army), CAPT Andrew Johnson (Navy), and LtCol Mark Antonacci (Air Force); our Executive Director, Bernadette Carr; our distinguished invited speakers and conference faculty; our exhibitors and supporters, and so many others .

Many of our members may not be aware of the significant achievements we've made this year, so I'd like to take a moment to fill you in. Our membership is at an all-time high, with our total membership (primary and secondary) rising to over 1100 members. This makes Government Services the 9th largest chapter in ACEP, and we've earned additional voting spots on the ACEP Council. We now have a total of 11.

After working with Hagan Barron for almost two years on the project, GSACEP through Hagan is finally able to offer members who moonlight disability insurance. You can get info on our website, gsacep.org, or contact Christa Lee at Hagan Barron: clee@haganbarron.com

In 2012, our chapter authored a resolution to support our 300,000 veterans diagnosed with PTSD/TBI by tasking ACEP to collaborate with other professional societies to share educational resources related to the treatment and referral options in the management and sequelae of PTSD/TBI and promote research opportunities related to their diagnosis, management and treatment. This resolution was approved almost unanimously at the 2012 Council meeting in Denver in October.

Our chapter was just awarded a total of $17,750 by ACEP in support of two noteworthy projects spearheaded by two of our members. The chapter received $15,000 in support of a project developed by Col Lee Payne to document and catalogue the rich History of Military Emergency Medicine.

LCDR Brad Butler was provided $2,750 to complete the "Core man" lecture series project. This money will allow us to reproduce lectures of core emergency medicine topics relevant to medics. For details, please see article below.

As you see, it's been a busy year for GSACEP. Despite the fiscal uncertainty, I'm happy to say our chapter remains strong, both in numbers and finances. As my year as president closes, I'm excited and inspired by the energy and enthusiasm of our newly elected officers. With the vision and passion of both our new Board members, as well as current members of the Board, I look forward to future accomplishments. It has been my pleasure and honor to serve as president of your chapter. I look forward to continuing to serve with you in the following years.

GSACEP Receives Two Chapter Grants

GSACEP was recently awarded a $15,000 grant from national ACEP for work on its ambitious project, The History of Military Emergency Medicine. Conceived by Col Lee Payne, MD, MBA, FACEP, the project aims to interview the leadership of military medicine from its "founders" in the 1970s through to the present day. By talking to past and present leaders, the chapter hopes to obtain a comprehensive picture of this evolving specialty in its unique environment but one that has always added benefits to the practice of civilian emergency medicine.

In Part I of the project, these leaders will be interviewed by history professionals whose experience is in conducting structured historical interviews. In Part II of the project, the chapter plans to develop the material as an historical text that is also a textbook for the young men and women who are training to be military emergency physicians.

When complete, the edited material will be placed in the Archives of the Uniformed Services University of Health Sciences. Opportunities will exist for marketing the project and ACEP's participation at this event which will occur in the National Capital Region.

An executive summary of the collection's contents and overview will be provided to all emergency medicine residency programs on a flash drive. This will also include information on how to access the entire History of Military Emergency Medicine source document collection.

Access to the collection will be made available by request on the GSACEP website

Given the scope of this project, it might take as long as three or four years to complete. However, we plan to get underway with interviews of the pioneers of military emergency medicine right now.

Continued on page 2

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GSACEP Receives Grants continued

We also recognize that this will be a costly project, but one that is truly necessary and beneficial. We will be seeking other grants and financial support, but we also ask you to please consider donating. If you visit our website, gsacep.org, you will be able to access a donation page, or to donate sums above $1000, contact the chapter at gsacep@aol.com.

GSACEP also received a national ACEP grant for $2750 to create, publish, and distribute the "Core" man Lecture Series. This series was developed by GSACEP member and Navy Reservist LCDR Brad Butler, MD, FACEP, during his deployments. While on Active Duty in Okinawa, Japan, in 2010, and during his deployment to the Role III Hospital in Kandahar, AFG, last year, LCDR Butler realized the need for an easy to use core lecture series to enable emergency physicians to give brief lectures to our corpsmen and medics, who are always hungry for education. To this end, he created a series of brief, one-page lectures. The ACEP grant will enable GSACEP to put together PowerPoint presentations for this core series and distribute them on CD to our members. LCDR put together a "quad service" group of emergency physicians and emergency medicine residents to complete this project. A special thanks to LT Lauren Oliveira (NMCSD EM residency), CAPT Brian Kitamura (Army National Guard member and Maricopa Medical Center EM resident), CAPT Patrick Glynn (US Air Force and Maricopa Medical Center EM resident) and CAPT Tom Bostwick (US Coast Guard (ret) and Maricopa Medical Center EM Faculty) for their work on this project.

In This Issue

From the Editor's Desk

MAJ Rachel Villacorta-Lyew, MC, USA

Here is an especially robust and hearty issue of EPIC! With the unfortunate cancellation of Government Services Symposium, we have lost the opportunity to network and share information face to face. As the chair of the conference planning committee, I was particularly disappointed but remain optimistic that our organization will continue to find ways to strengthen our military and government service connections in the practice of emergency medicine. With the sequester looming over an already bleak financial and political climate, we will have to create innovative opportunities for members to network and obtain practice specific CME credits. Please participate in the upcoming surveys to help GSACEP develop and tailor these opportunities to your needs.

Take a few moments to peruse this issue as it highlights many of the strengths of our emergency medicine colleagues and our organization among the GSACEP chapter awards recognizing the achievements of our members, ACEP grants to further improve the practice of military emergency medicine, and the way ahead outlined by our specialty leaders. Also, please recognize the increasing involvement and presence of our Veteran's Administration colleagues with the recent election of our new council members. I believe with the evolution of our government's financial priorities and their involvement in foreign policy, the partnership among the medical communities of the military and VA will need to become stronger than ever to face new challenges.

There are great things we have done and are continuing to do as a specialty and as an organization! Thank you for all of your contributions!

President Elect Column: Turning Obstacles into Incentives

By Col Christopher G. Scharenbrock, USAF, MC

As I am about to start my year as President of GSACEP, I have to admit experiencing sadness that we were unable to hold GSS 2013 in San Antonio this year. The Conference Committee, led by MAJ

Rachel Villacorta-Lyew, had developed an outstanding curriculum, with great speakers, and topics relevant to military and VA Emergency Medicine. However, the loss of central funding was a big blow to the prospects of having adequate attendance to make the conference a fiscally responsible activity this year.

The Board of Directors will meet in the near future to discuss the way forward for future conferences. With current national budgetary uncertainty, I think there's a good chance that funding for CME TDY's may be a thing of the past. If that's true, federal physicians will still need CME credits to maintain state licensure and will need to budget some of their hard-earned dollars to meet those requirements. While there are many inexpensive online CME venues that can be accessed to meet CME requirements, it is my hope that our membership, and others, will see the value in attending future symposia from GSACEP.

Why? Well, the registration fees for GSACEP are lower than most other conferences, with no additional fees for attending an Ultrasound program, LLSA review, or Oral Board Course, all of which have been included in over-all curriculum these past years. There is also no other emergency medicine conference that has so many speakers with unique military emergency medicine experience. Finally, and certainly not least, it is an outstanding venue to network with other military and federal emergency physicians. It is also a way to recognize our talent by presenting special awards at the meeting, and to enjoy ourselves in off-hour activities. I know the Board of Directors will do whatever we can to maintain a meeting with the best possible value for our members.

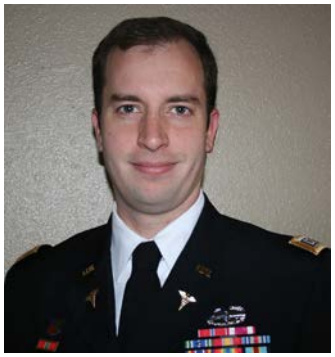
So, after cancelling my hotel reservations and changing my flight plans to take me home to California instead of San Antonio, I decided that this is only a temporary setback for GSACEP and to look forward to our organization competing on a level playing field to attract attendees to a world-class conference next year. In the words of Ralph Waldo Emerson, "Fractures well-cured make us more strong". Let's use these current difficulties to become better.

Finally, as Chair of the Awards Committee, I would like to thank all those who nominated members for awards. After a slow start, we received award packages that were well-written with candidates who were all outstanding. The Board reviewed the packages, and after considerable discussion, chose this year's winners. I encourage you to read about them in another portion of this newsletter. The criteria for awards is unlikely to change significantly over the next year. As you watch your colleagues do outstanding things over the coming months, start considering them for GSACEP awards in 2014. It's never too early (or too late) to recognize outstanding performance.

Newly Elected GSACEP Board Members

Congratulations to our newly elected Board members. They will assume their new roles on the GS Board this month, March 2013.

President Elect: Maj Torree McGowan, USAF, MC



Resident Representative: CPT Daniel Brillhart, MC, USA

Councillor: LCDR David Bruner, MC, USN

Councillor: Chad Kessler, MD, MHPE, FACEP

Councillor: MAJ Nadia Pearson, MC, USA

The 2013 GSACEP Award Winners

EXCELLENCE IN MILITARY EMERGENCY MEDICINE AWARD: COL Ian Wedmore, MD, FACEP

This year's recipient of GSACEP's highest award, Col Ian Wedmore, MC, USA, has excelled across three military career paths – clinical, operational and academic. He has served as faculty at Madigan Army Medical Center EM residency since 2005 in multiple positions including Interim Chief, Dept. of Emergency Medicine, 2009-2010. Col Wedmore currently serves as Fellowship Director, Austere and Wilderness Medicine, which he started. He has faculty appointments at three medical universities and over 200 presentations at the local, regional, national, and international levels. A respected researcher, Ian has contributed to over 39 publications, served on five editorial boards, and been an editor of two books. In 2005, he was awarded the Medical Corps Surgeon General's "A" designator for academic achievements in Emergency Medicine. In 2011, he received the international diploma of mountain medicine.

His contributions to operational medicine are even more impressive. He has probably more deployments than any military emergency medicine physician. He is a highly decorated and respected leader in the Special Operations Forces (SOF) community. COL Wedmore has deployed to both Iraq and Afghanistan on numerous occasions and five times served in Command Surgeon roles. Ian is the recipient of multiple military awards to include the Bronze star with 3 Oak Leaf Clusters, the Combat Medical Badge, the Airborne Badge and the Air Assault Badge. In addition, he has taken his experiences and battlefield skills and weaved them through his academic career fostering innovation and improving combat care.

Since 2004, COL Wedmore has served as Emergency Medicine Consultant to the Army Surgeon General. He has led Army EM through some challenging times with diplomatic and collaborative style. He is a longtime GSACEP and ACEP member and frequent lecturer at Government Services Symposium. Over the past several years, he has helped to introduce new curriculum, and he has been a staunch advocate for the meeting during some challenging times. He is a role model servant leader.

MEDICAL DIRECTOR AWARD: LTC(p) Timothy Barron, DO, FS, FACEP

As Joint Task Force Chief, Department of Emergency Medicine, Ft Belvoir, VA, LTC Tim Barron, MC, USA, was instrumental in designing the new Fort Belvoir Community Hospital ED. Essentially creating a 21st century Emergency Department de novo, with limited resources in an austere fiscal climate was nothing short of herculean. As part of this process, Tim Barron implemented a state of the art Fast Track and created an ED "rapid response team" that responds to any part of the hospital to promptly retrieve patients for emergency care. Through it all, LTC Barron managed this process with his trademark enthusiasm and equanimity. Despite a record-breaking 51,000 encounters last year, 204 employees, and a budget of 14 million dollars in his department, Tim still manages to see patients every week with a provider satisfaction score of 99% -- and he directs the Fort Belvoir EMT training program for the AMEDD to include the 68W and CLS sustainment training program.

In short, Tim Barron inspires confidence in his staff, colleagues, superiors and patients alike. He possesses a rare combination of superior clinical ability, leadership, administrative excellence and military bearing that makes him a role model for junior officers and civilian staff alike. It is no wonder that he was a below zone promotion to O-6.

LTC Barron, a recipient of the Bronze Star, had already departed for his third deployment when GSACEP notified him that he was to receive the 2013 GSACEP Medical Director Award. We're glad the news has finally caught up with him.

RISING STAR AWARD: MAJ Tristan Knutson, MD, FACEP

Assistant Program Director at Madigan Army Medical Center, Ft. Lewis, WA, MAJ Knutson, MC, USA, has impressed his peers by his dedication to senior residents, meeting with them regularly for advice and professional development. He has also had multiple positive initiatives as Assistant Director. Under his leadership, the residency was able to easily transition from one reading curriculum to another, and overhauled its feedback system. He personally conducts a monthly journal review with all senior residents.

As a faculty member at Madigan, Tristan deployed once to Iraq, and later volunteered for a second deployment to Afghanistan. He has served on multiple departmental and hospital committees, and has a substantial number of publications, textbook chapters and poster presentations to his credit.

MAJ Knutson's work ethic is what truly sets him apart and makes him unique. He leads by example, showing up early for every grand rounds, journal club, simulation day, and live tissue lab. Not once has he complained about being overworked, or compared his workload with that of his peers; in fact, he keeps asking for more.

In sum, Tristan Knutson is a Rising Star in military emergency medicine and a worthy recipient of GSACEP's Rising Star award for 2013.

LEADERSHIP and ADVOCACY AWARD: CPT Laura Cookman, MD

CPT Laura Cookman, MC, USA, has been impressing her leadership and peers since she arrived in the residency program at Madigan Army Medical Center, Ft. Lewis, WA. Staff and peers awarded her EM-1 of the year; EM-2 of the year, and selected her to be Chief Resident in her final year of residency. CPT Cookman also currently serves as resident liaison on the Board of Washington ACEP, and attended SA as an Alternate.

Her leadership skills and academic achievements have repeatedly put her at the forefront in her young career. She received the Distinguished Military Graduate Award from the Army ROTC upon her graduation from Wake Forest University. She was valedictorian of her class at George Washington University School of Medicine. Now, she can further hone her skills as a recipient of GSACEP's Fellowship. "I am very honored to receive this fellowship. I look forward to working with GSACEP over this next year and more years to come," says CPT Cookman.

LEADERSHIP and ADVOCACY AWARD: CPT Brett A. Matzek, MD

Chief Resident at Darnall Army Medical Center, Ft. Sam Houston, TX., CPT Brett Matzek, MC, USA, plans to be a career military physician. His understanding that his role as a physician and officer requires strong leadership skills led him ultimately to seek the GSACEP Fellowship. Recognizing that there is no "formal" training on leadership, CPT Matzek sought leadership roles at Darnall including the procedure lab coordinator, and Chief Resident. "I believe the LAC fellowship will give me the opportunity to become more involved with both GSACEP and ACEP though Board meetings and by taking a more active role among the leadership. It will help me establish relationships that will prove very useful in the small world of emergency medicine. By attending the LAC in DC, I will further gain the skills needed to interact and communicate with Congressional leaders. These skills, no doubt will benefit me, but also benefit emergency medicine as a whole. The more active leaders we have, the bigger voice we have."

Abstract Competition Winners

While GSS 2013 was cancelled, we still received a number of outstanding abstract submissions. Of the 19 submitted, these are the winners:

1st Place:

Low-dose ketamine vs. morphine for acute pain control in the ED - a randomized, prospective, double-blinded trial.

*CPT Steven G. Schauer, DO - EM Resident (PG3), San Antonio Military Medical Center (SAMMC), San Antonio, TX.

Co-authors include Maj Josh Miller, LtCol Vik Bebarta, Victoria Ganem, Maj Sarah Abel, and Capt Sean Ray of SAMMC.

2nd Place:

Prescription stimulant misuse in a military population - prevalence and risk factors.

*MAJ Jennifer N. Kennedy, DO - EM Resident (PG3), San Antonio Military Medical Center (SAMMC), San Antonio, TX.

Co-authors include LtCol Vik Bebarta, Col Shawn Varney, Victoria Ganem.

3rd Place:

Transcricothyroid ultrasound for confirmation of endotracheal tube placement by U.S. military EM providers

*Capt Michael Rabener, MMS, DSc-EMPA-C; Staff PA, San Antonio Military Medical Center (SAMMC), San Antonio, TX.

Co-authors include MAJ Eric Chin, CPT Chase Donaldson

Report from the Consultants

The State of Army Emergency Medicine

By Col Ian Wedmore, MC, USA, Army Emergency Medicine Consultant to the Surgeons General.

It is unfortunate that the DOD is under the negative effects and potential stress of the sequestration as there are quite a number of good things happening in Army Emergency Medicine.

GME: Emergency Medicine remains one the most popular and competitive specialties. This year we had at least two applicants for every training spot. This includes the fact that Georgia Heath Sciences University/EAMC took an additional three candidates and CRDAMC an additional candidate. Thus, we will have 36 resident starts in 2014. Our fellowships continue to increase in number and diversity. This year we have training starts for EMS, Wilderness Medicine, Sports Medicine, and three critical care starts.

Deployments: Deployment requirements are basically steady from last year, which is down from 2 years ago when we were still involved in IZ, but still remain substantial. This is for both 62A deployments as well as for those filling 62B deployments. The good news is that almost all deployments are either 4.5 or 6 months long.

Operational Fills: For the first time this year we have had greater ability to send new graduates to ED spots as opposed to operational positions. This is due to a number of subspecialists helping to fill the Brigade surgeon requirements. Hopefully this trend will continue and allow new graduates to spend the first year after residency in an ED before filling an operational position.

Conferences: This is the one piece of not so good news. Because of sequestration money can only be used for conference TDYs that are considered mission essential. In short, what this means is that you can really only be funded if your presenting or can somehow directly tie the conference to a wartime mission. CME is not a mission essential requirement. Any conference funding requires regional as well as OTSG and Secretary of the Army Approval. Don't ask for funding solely for CME; it will not be supported. Hopefully this will improve before too long.

Assignments: Assignments for next year are 99% complete and your RFOs should be in soon if not already. If not please contact MAJ Jason Lee, our branch manager.

Air Force Update

By LtCol Mark Antonacci USAF, MC, Air Force Emergency Medicine Consultant to the Surgeons General

Overall things are looking good for 2013.

Assignments: Summer assignments will be released earlier than usual this year. This is due to a software upgrade to the system AFPC use to load assignments (MilPDS). By the time this goes to print, all summer assignment notifications should be sent. If you are moving this summer and have not received your assignment notification, please contact LtCol. Glover at AFPC and me. We will actually be slightly over-manned for AF Emergency Medicine physicians once the smoke clears this summer. This makes it nice once you get to your location, but makes it a lot more challenging to get residents their base of preference.

Deployments: Despite adequate manning, we still struggled to meet our deployment requirements. We are currently still sending folks to ground taskings at Bagram, Manas, Al Udied. We have several CCATT taskings each block and now have four TCCET teams each block as well (each one with an emergency physician). And, of course, at any given time we have a number of folks supporting special ops units/missions. I expect we will continue to have at least this many taskings for the next couple rotations. One important potential change on the horizon is the projected implementation of "AEF Next." As mentioned in my last couple updates, this change (which will involve the entire Air Force) will move us from the current 1:3 deploy to dwell ratio (6 months deployed, 18 months at home) to a 1:2 deploy to dwell (6 months deployed, 1 year at home). We have had several reclamas which inevitably lead to short-notice taskings. Reclamas due to manning I should be able to predict, but if you can foresee a potential issue please let me know as soon as possible so we do not have to task anyone at the last minute.

GME: We were again one of the most competitive AF specialties in the last JSGME Selection Board. We had 50 applicants for 34 positions (including 2 matched for Emerg. Med/Flight Med). For fellowships, we had Critical Care (2), EMS (1), Toxicology (1), and Ultrasound (1) available. We filled the 2 Critical Care and the EMS positions. I expect similar numbers and the same fellowships available for this year's GME selection board.

Conferences: As mentioned in my recent message, the conference approval process has become much stricter. I don't know how long this scrutiny of conferences will last, but I will continue to forward any conference package submitted to me for review as long as it has reasonable justification. Keep in mind that these packages are supposed to be submitted at least 90 days prior to the start of the conference. Also, remember that the package that is routed through me to the Sec. of the Air Force Administrative Assistant (SAF/AA) has nothing to do with funding. You may have additional approval processes for funding and local approval through your chain of command. Believe me, I know how painful this process is and I am looking forward to some loosening of the restrictions. I am sure we all are. At the same time, I don't expect any significant improvements in the immediate future. But check the Kx Conference webpage for the latest info.

Continued on page 6

Air Force Update continued

ED Process Improvement Project: We have seen a worsening of almost all our metrics over the last couple months. This is largely a result of increased volume due to the moderately severe flu season with some other specific local factors at some locations. Increased manning after the summer moves should be a help, but of course we will have the typical summer manning shortage before then. Please make sure you are maximizing the concepts of the AFSO events at your location prior to the summer crunch. Processes like rapid triage, nursing protocols, team assessments, keeping vertical pts vertical, and holding/bridge orders can all help to make everyone's life easier. I encourage you all to take another close look at your processes and eliminate waste. Obviously some processes may be outside your control. If you need help, please let me know what I can do.

As always make sure you are minimizing risks. Two great ways to minimize risk: Follow established procedures to prevent patients from leaving the ED with abnormal vitals without your knowledge. Make sure your processes for following up on abnormal labs and radiology procedures is effective.

Thanks for all you do and let me know if I can assist in any way.

Navy Update

By CAPT Andrew Johnson, MC, USN, Navy Specialty Leader

DEPLOYMENTS:

We are more stressed as a community in regard to deployments than at any time during my tenure as Specialty Leader. I was looking forward to seeing a tapering off of our operational requirements this year but have seen no relief, and we've picked up a long-term mission on the Black Sea that was previously covered by the Reserves

EM has the following habitual operational requirements:

16 MEU positions (a few are slated to be phased out)
3 JSOC positions
2 Black Sea STP positions
2 Army IA FST positions
1 Djibouti position
1-2 ERSS positions
5 MLG positions
2-5 Kandahar positions (depending on RC support)
3 CBIRF positions (applying to convert 1 to IM)
1 Comfort/Mercy
TOTAL= 36-39 positions

Of the total EM provider force, almost 1/4 (35) are non-BSO 18/non-clinical billets (XO, senior operational, White House, etc.). This leaves a pool of 117 individuals being used to fill the above missions, so approximately 1/3 of the clinical workhorses at any one time are being used to fill these missions. An additional 5-7 providers on average have medical issues that disqualify them from deployment.

The bottom line is that the message we are receiving from the planners is that we are overmanned, and there has been little flexibility or support in using creative solutions for manning problems, backfill requirements, or attempts to reassess and eliminate excess capacity in these missions. Navy Emergency Medicine's number one priority is to support the fleet; however, the current planning and manning model appears to be suboptimal. We are victims of our own success and in high demand, which is not a bad thing. I am working with the Chief of the Medical Corps to get us a seat at the planning table to make sure our voice is heard as requirements are determined.

2013 SLATE:

I released the 2013 slate last week and feel like the overall ability to meet individual requests was more difficult this year. Specifically, I wasn't able to give most new graduates or junior staff their first choices for assignment. In fact, not a single new graduate received orders to a CONUS location west of the Mississippi. The popularity of commands is somewhat cyclical, and this year Southern California was the most requested location. In addition, there weren't many billets opening up among those commands. On the other hand, there wasn't nearly as much of a demand for Europe as there has been in a past. Every year has had a different flavor in terms of what is in demand. I will start surveying the community at the end of the summer regarding future plans and requests for 2014.

TRAVEL:

If you are seeking funding to attend an educational conference for CMEs, I would warn you that the process is now extremely onerous and success is far from guaranteed. Do not make firm travel plans until you have received official approval from both BUMED for the conference and your command for funding. Now that the sequestration process has taken place, the initial word has been that only mission essential travel will be funded. Until the budget process for the next few fiscal years is resolved, look at local or online solutions for your CME needs. Permissive TAD can still be approved by your local command.