

**SAVE THE DATE**  
Friday, April 17, 2009  
Annual Educational  
Conference

Weston BWI Hotel  
Old Elkridge Landing Road  
Baltimore, MD

Program Summary and  
Registration form enclosed

## President's Message

Richard L. Alcorta, MD, FACEP, President

### Limited Time Opportunity

As the current Maryland Chapter President, I want all practicing physicians who work in the emergency department, no matter their original specialty, to have the opportunity to earn the College's fellowship designation (FACEP). To that end, I have focused this article on how you, as a non-EM Boarded physician, could earn the title of FACEP. I have incorporated the National ACEP Standards for earning this title, which has an application deadline of December 31, 2009. Please read these requirements carefully, and pass them on to your colleagues.

### History of Fellowship

ACEP Fellowship was first established in 1982 to honor members who made special contributions to the College and the specialty of emergency medicine. Requirements for Fellow Status include Active membership status for three continuous years; board certification by ABEM, AOBEM, or ABP certification for pediatric emergency physicians; and additional service to the specialty. In October 2007, the ACEP Council created an alternate pathway to allow the specialty to honor the first wave of emergency physicians, known as Legacy Physicians. The eligibility criteria for members using this pathway are considerably stricter and apply only to a small number of ACEP members. The change was made to recognize those Legacy Physicians who have made significant contributions and helped build the specialty through their service

and dedication. The deadline to submit applications for this alternate path is Dec. 31, 2009.



Richard L. Alcorta, MD, FACEP

### Criteria for Election to Fellow Status *Fellows of the College shall meet one of the following two sets of criteria:*

1. Be active, life, honorary, or international members for three continuous years immediately prior to election and must have been certified in emergency medicine at the time of election by the American Board of Emergency Medicine, the American Osteopathic Board of Emergency Medicine, or in pediatric emergency medicine by the American Board of Pediatrics. Maintenance of Fellow status requires continued membership in the College. In addition, the following requirements demonstrating evidence of high professional standing must be met by candidates some time during their professional career prior to application.
  - A. At least three years of active involvement in emergency medicine as the physician's chief professional activity, exclusive of training, and;
  - B. Satisfaction of at least three of the following individual criteria during their professional career:

1. active involvement, beyond holding membership, in voluntary health organizations, organized medical societies, or voluntary community health planning activities or service as an elected or appointed public official;
2. active involvement in hospital affairs, such as medical staff committees, as attested by the emergency department director or chief of staff;
3. active involvement in the formal teaching of emergency medicine to physicians, nurses, medical students, out-of-hospital care personnel, or the public;
4. active involvement in emergency medicine administration or departmental affairs;
5. active involvement in an emergency medical services system;
6. research in emergency medicine;

continued on page 8

By David Hexter, MD, FACEP

EMS Board Member and Secretary, Maryland ACEP

Richard Alcorta, MD, FACEP

State EMS Medical Director and President, Maryland ACEP



David Hexter, MD, FACEP

### Helicopter Crash/Future of Medevac

**Program:** In the early morning hours of September 28, 2008, Trooper 2 crashed into a wooded area in Forestville, MD. Pilot Stephen Bunker, Paramedic Mickey Lippy, EMT-B Tonya Mallard, and patient Ashley Younger perished on a rainy, foggy night. Another patient, Jordan Wells, survived. Our deepest condolences go out to the families, friends, and loved ones of the providers and patient who were killed in the crash.

The tragedy of last September has prompted the stewards of our model trauma transport system to carefully evaluate whether and how we could make improvements. The Maryland State Police (MSP) Aviation Command has an excellent safety record; this was the first crash in more than 22 years. Nonetheless, this is one crash too many, and we owe it to the victims and our future patients and providers to do everything possible to assure the safest transport possible.

On October 8, 2008, the Trauma Decision Tree of the Maryland Medical Protocols for EMS Providers was revised to require that prior to helicopter dispatch, field providers consult with the receiving trauma centers for Category "C" (mechanism) and Category "D" (extenuating circumstances such as pregnancies, extremes of age, etc.) patients. This change was implemented to provide an additional resource to EMS personnel responding to an incident.

On November 27-28, a panel of national experts was convened to review and make recommendations regarding Maryland's emergency medical protocols that are used to identify, treat, and transport trauma victims. The panel issued the following preliminary findings:

- Maryland has a long-standing model EMS and trauma system that integrates all components.
- Maryland trauma outcomes are at or above national norms.
- Field trauma triage protocols are consistent with national guidelines.
- Helicopter over-triage appears to exceed other areas of the country.
- MSP Aviation Command has a good safety record.
- The role of the SYSCOM communications is unique and a national model and should be strengthened.
- Helicopter EMS is an essential component of an EMS and trauma system that can contribute to improved outcomes.
- MSP should change licensing to come under Part 135 of the FAA regulations.
- MSP Aviation Command should become CAMTS-accredited.
- Maryland should continue helicopter utilization review.
- Maryland may need fewer helicopters. This will require an in-depth, multi-disciplinary analysis; and the use of helicopters in certain other medical conditions should be considered.

A final report is anticipated from the panel in January 2009.

Ongoing monitoring of helicopter utilization since the crash has revealed a decrease of almost 50% in the number of missions, primarily due to a decrease in the number of requests. While some of this decrease is seasonal, there is an increase in the number of patients being transported via ground to local emergency departments and to nearby trauma centers.

A consultant has been engaged to provide options for number and locations of helicopter bases. The Maryland legislature will need this information as the current fleet of 12 helicopters is 12-17 years old, with an expected lifespan of 20 years. Senate Bill 527, passed during the regular 2008 session, directs a total of at least \$70 million from the sales and use tax over the next 3 years to be used for helicopter replacement. However, additional funds will be necessary to meet the higher licensing and accreditation standards that will be recommended by the expert panel in order to improve safety.

### STEMI Center Regulations:

MIEMSS has prepared the second draft of regulations that will designate Acute Cardiac Intervention Centers (ACIC's) for patients with ST-elevation myocardial infarction (STEMI). Highlights of the second draft include:

- To be designated as a Primary PCI Center, a hospital must have a Certificate of Need or waiver from the MHCC to perform primary PCI.
- To be designated as a STEMI Transfer Center, a hospital must be in an area of the State where transport to a Primary PCI Center is more than 30 minutes greater than transport to the STEMI Transfer Center.
- Primary PCI Centers must meet the door-to-balloon performance requirements as defined by MHCC in COMAR 10.24.17.
- STEMI Transfer Centers must have an agreement with a hospital capable of providing primary PCI, and meet the same

continued on page 9

## Report from Your Public Policy Committee

Laura Pimentel, MD, MMM, FACEP  
Chair, Public Policy Committee  
Treasurer, Maryland ACEP



Laura Pimentel, MD,  
MMM,FACEP

The public policy committee met in July, August, September, November, and January. Much of our activity centered around the issues debated by the Governor's Taskforce on Health Care Access and Reimbursement. We owe a debt of gratitude to our lobbyists Barbara Brocato and Dan Shattuck for their faithful representation of our interests at all of the Taskforce meetings. Our member, Dr. Joseph Fastow was one of two physicians on the Taskforce. We again thank Dr. Fastow for his participation. A draft of the final report to the governor may be found at [http://www.dhmh.state.md.us/hcar/pdf/nov2008/nov25/Draft\\_HCARE\\_Final\\_Report.pdf](http://www.dhmh.state.md.us/hcar/pdf/nov2008/nov25/Draft_HCARE_Final_Report.pdf)

The draft report contains 8 recommendations to the legislature. Most concentrate on measures to improve the supply of primary care physicians in the state. Recommendation 3 has the most direct applicability to practicing emergency physicians. This recommendation is to change the formula for reimbursement of non-participating physicians treating HMO patients. The Taskforce recommends reimbursement at the greater of:

“a. 140% of the rate paid by the Medicare program, as published by the Centers for Medicare and Medicaid Services, for the same covered service to a similarly licensed provider in the same geographic area as of August 1, 2008, inflated by the change in the Medicare Economic Index from 2008 to the current year; or

b. 125% of the average rate the health maintenance organization paid to similarly licensed providers under written contract in the same geographic area, as defined by the Centers for Medicare and Medicaid Services, for the same covered service as of January 1 of the previous calendar year.”

The Taskforce calculated that this change would increase reimbursement for these patients by approximately 25%.

Other significant activities of the Public Policy Committee have involved inviting legislators to attend our meetings to directly hear from our members the challenges facing emergency medicine. At the July meeting arranged by Dave Hexter, Senator Barry Glassman from District 35 in Harford County met with us at Upper Chesapeake Medical Center. We discussed the challenges of physician recruitment and retention, psychiatric patient disposition, reimbursement, and liability reform. The Senator was interested and receptive, promising to keep these problems in mind during the legislative session.

At the August meeting, Dr. Peter Beilenson, the Howard County Secretary of Health, attended. Dr. Beilenson described the Healthy Howard initiative he designed to provide healthcare services to uninsured residents of the County. He is hopeful that his model might serve as a pilot for universal coverage at the national level.

Our January meeting was held at Calvert Memorial Hospital. Dr. Kraig Melville arranged for the Maryland Senate President, Mike Miller, to attend. Senator Miller graciously listened to our concerns about emergency department staffing and recruitment, because of the state's uncompetitive reimbursement and high cost of living. Proposals raised by our members included an assignment of benefits bill and repeal of the prohibition on balanced billing. Emergency department overcrowding was reviewed as were concerns about malpractice premiums. Our lobbyist, Barbara Brocato, expressed the unique challenges faced by emergency physicians treating increasing numbers of uninsured and underinsured patients. Senator Miller expressed willingness to meet again to discuss possible liability reform, including good samaritan protection for EMTALA-mandated care.

We look forward to an active legislative session.

### Maryland ACEP Reaches 513 in Total Membership

This achievement gives us another councillor for greater representation at national ACEP. Thanks to all who encourage and promote membership in ACEP and Maryland ACEP.

## The Use and Overuse of Monitored Beds

Practice Management Committee

Stephen Schenkel, MD, MPP, FACEP and Joseph Twanmob, MD, FACEP,

Practice Management Committee

Some days does it seem like every patient you admit needs a monitored bed? Does your hospital run out of monitored beds on a regular basis resulting in ED boarders? Does it seem that some patients who are admitted to a monitored bed don't really need one? Has recent Joint Commission Stroke Center certification put more pressure on the use and need for monitored beds in your hospital? If you answered yes to any of those questions, you are not alone.

A recent practice management discussion began with an e-mail regarding the use of monitored beds for stroke and TIA patients. The line of discussion went something like this: stroke center certification requires admission of all CVA and TIA patients to a monitored bed, but monitored beds are already in short supply; does it make sense to use this relatively scarce resource in so generous a fashion?

Two aspects of the discussion rapidly clarified were that many hospitals—and therefore EDs—are in this position and few of us seem to have much science guiding our use of telemetry beds.

A year-old article may be able to help us answer some of these questions. [When Do Patients Need Admission to a Telemetry Bed?](#) by Esther Chen and Judd Hollander, appeared in January 2007's *Journal of Emergency Medicine*.<sup>(1)</sup> This review of the literature starts with the observation that the American Heart Association recommends that seven of the top 10 ED admission diagnoses require telemetry monitoring.<sup>(2)</sup> Rather than accept the AHA guidelines, though, the article reviews the literature and divides indications for telemetry monitoring into three buckets: conditions for which there is good evidence for cardiac

monitoring, conditions for which there is no evidence, and conditions falling in the middle.

*Conditions for which there is good evidence for cardiac monitoring: patients whose automatic defibrillator has fired, patients with atrioventricular block, patients with prolonged QT and associated ventricular arrhythmias, patients with acute heart failure or pulmonary edema, patients admitted for acute cerebrovascular disease.* Most of these conditions easily meet the test of obvious significance. Telemetry serves to watch for arrhythmias, so arrhythmic conditions should be those most obvious to benefit from monitoring. What about heart failure and cerebrovascular disease? Both of these conditions are closely associated with arrhythmias that require acute response, including atrial fibrillation with rapid ventricular response (in both cases) and ventricular dysrhythmias (in the case of stroke). It seems that in several studies, monitoring of CVA patients picked up otherwise undetected arrhythmias. Already we have an answer to the question raised by becoming a stroke center, but where are we supposed to find all of these monitored beds?

*Conditions for which there is no evidence for telemetry monitoring: patients requiring blood transfusion, patients evaluated for chest pain, patients with acute exacerbation of chronic obstructive pulmonary disease, stable patients with pulmonary embolism receiving anticoagulation.* Yes, you read that correctly. No need for cardiac monitoring for chest pain evaluation. This section combines evidence of low risk with lack of evidence regarding risk. It pulls data from both directly associated literature—notably studies that consider the rate of arrhythmia in low risk chest pain patients—and from connected literature not intended to study the benefits of monitoring, most notably making the point that patients with PE and DVT treated as

outpatients are not monitored. For the hospital trying to open monitored beds for other, more evidence-supported uses, the data regarding COPD exacerbation and low risk chest pain may prove most useful. How many patients are admitted to monitored beds each day in your hospital for those conditions?

*Conditions for which cardiac monitoring may be beneficial: patients evaluated for syncope, patients with gastrointestinal hemorrhage after endoscopy, patients with atrial arrhythmias receiving therapy for rate or rhythm control, patients with electrolyte imbalance, patients with subacute congestive heart failure.* This category is a bit of an open basket for all those areas for which some evidence exists to suggest cardiac monitoring, though it may be based on either limited or somewhat conflicting evidence. All five of these categories suggest risk for arrhythmia—and for two of them the indication for admission is an arrhythmia. As a result, there does not seem to be much gained here from arguing against admission to a monitored bed for patients in any of these categories.

With all of the associated evidence compiled in one location, it becomes clear that the common and expensive practice of electrocardiographic monitoring offers ample opportunity for further research.<sup>(3)</sup>

The practice management discussion revealed several other reasons for cardiac monitoring which may not yield easily to the available evidence:

- There is tremendous face validity to telemetry monitoring that is difficult to overcome. This has become particularly internalized into our hospital cultures in the

continued on page 10

## Maryland ACEP Nominates Dr. Jon Mark Hirshon for National ACEP Board of Directors

January 9, 2009

Bruce A. MacLeod, MD, FACEP  
Chair, Nominating Committee  
ACEP  
P O Box 619911  
Dallas, TX, 75261

Dear Dr. MacLeod:

On behalf of the officers and members of Maryland ACEP, it is with pride that we nominate Jon Mark Hirshon, MD, MPH, FACEP, FACP, FAAEM, for a position on ACEP's Board of Directors. For many years, Dr. Hirshon has been an integral and vital member of Maryland ACEP. Presently, Dr. Hirshon is Immediate Past President of Maryland ACEP, having completed the executive offices of Secretary and Vice President. Additionally, he has served on numerous chapter committees. His passion for public health issues is evidenced by his dedication to Maryland ACEP's legislative efforts. Dr. Hirshon consistently demonstrates excellence and integrity in chapter service and emergency medicine, and is always willing and ready to serve in any capacity asked of him.

He has been a national ACEP councillor for the past decade, and has served as a member of ACEP's Steering Committee. His vigor, integrity and untiring service to national ACEP and organized emergency medicine are evidenced by the following positions he has held:

- A. Chair of ACEP's Public Health Committee
- B. Liaison to the American Public Health Association
- C. Representative to the Institute of Medicine Forum on Smallpox: The Scientific Basis for Vaccination Policy Options
- D. Member of the Terrorism Response Task Force

E. Representative to the Institute of Medicine's meeting of the Committee on Smallpox Vaccination Program Implementation

F. Committee Member of the Tellers, Credentials and Elections Committee

G. Subcommittee Chair of the Public Health Review Section of ACEP's Scientific Review Committee

H. Research Forum Moderator

I. Representative to the American Public Health Association's "Flu Vaccine Leadership Forum"

J. Member of the Council Steering Committee

K. Member of the Finance Committee

L. National ACEP's International Ambassador to Egypt

M. Member and Subcommittee Chair of the Data Subcommittee for the National Report Card Task Force

Dr. Hirshon has received numerous Meritorious Service Awards in recognition of his exemplary service to national ACEP, Maryland ACEP, and as a medical journal reviewer.

Dr. Jon Mark Hirshon is a well-respected national and international leader in public health and emergency medicine. He serves as Vice Chair of the University of Maryland's Institutional Review Board, and as former director of the Charles McC. Mathias, Jr. National Study Center for Trauma and EMS. Dr. Hirshon has been the principal investigator on over \$4.5 million in federal research and training grants. He has taught emergency physicians, residents and medical students domestically and in the Middle East. Dr. Hirshon serves as a role model and mentor by practicing high quality clinical emergency medicine, while broadening the frontiers of scientific knowledge through collaborative research efforts.

His vision, leadership and contributions of time as a volunteer, while working to enhance the profession of emergency medicine, improve patient care, and his extraordinary efforts toward optimal emergency medicine practices are inspiring. His career has been dedicated to delivery of the very finest quality of emergency care, which has included not only his personal commitment to emergency medicine, but a greater calling to the education of others and himself, advocacy for patients, and support of organizations and causes beyond himself, all of which have benefited by his national and international efforts to further emergency medicine.

Maryland ACEP was also honored to nominate Dr. Hirshon as a "Hero of Emergency Medicine." His career constantly and consistently demonstrates his passion for emergency medicine, his belief in lifelong education, his commitment to public health and, most importantly, his dedication to the delivery of the highest possible quality of emergency care to those in need.

Clearly, Dr. Hirshon is a worthy candidate, and Maryland ACEP is honored to nominate him for a position on ACEP's Board of Directors.

Sincerely,  
Richard L. Alcorta, MD, FACEP  
President

## Maryland ACEP Wins Peer Review Contract from State of Maryland

The Department of Health and Mental Hygiene's Board of Physicians has awarded Maryland ACEP the contract for Peer Review Services in the specialty of emergency medicine for the period of January 1, 2009 to December 31, 2013. This is the second time Maryland ACEP has been awarded this contract.

One of the Board of Physicians (BOP) responsibilities is to determine when the care in a case does not meet appropriate standards of medical quality. Ultimately, the BOP carries the responsibility for disciplining physicians when review of a case or cases suggests poor care. In order to fulfill this duty of public protection, the BOP contracts with physicians to undertake case reviews. Maryland ACEP is now contracted to provide peer reviewers for the BOP.

The Board of Directors of Maryland ACEP decided to pursue this contract from the belief that local emergency physicians are the best judges of Maryland-based emergency care. We, as a state specialty society, have a responsibility to assist the BOP in

judging appropriate emergency medical care and we, as practicing emergency physicians, are best qualified to review the care provided.

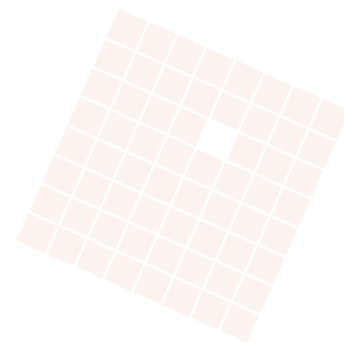
Peer reviewers are required to submit a single written report that is thorough, reliable, and completed in a timely manner. Reports must state an opinion on the quality of care provided and/or the adequacy of medical records produced. Peer reviewers must be objective in the analysis of the material presented and maintain complete confidentiality.

We seek members to participate in this process.

Emergency physicians volunteering to do peer review will be referred to the BOP by Maryland ACEP. The BOP will then run an internal licensure check and refer to Maryland ACEP. Approved peer reviewers are then provided with instructions and the materials to review. They must write a report based solely on the information given. Typically 30 to 60 days are given for the completion of a report.

A peer reviewer may be required to consult with the Board's administrative prosecutors. A peer reviewer may be asked to testify as an expert witness at a hearing arising from the case on which expert opinion has been rendered. Peer reviewers must agree to participate in the entire process if needed. Consultation and testimony are required only in a minority of cases.

If you are interested in participating in this worthwhile effort, please contact the chapter by phone 410-727-2237 or email [mdacep@aol.com](mailto:mdacep@aol.com). Financial compensation is provided for emergency physicians who serve as peer reviewers.



The next meeting of The EMS Committee of Maryland ACEP will take place on:

**WEDNESDAY MARCH 18, 2009 @ 1:00 PM**  
**MedChi- The Maryland Medical Society**  
**1211 Cathedral Street**  
**Baltimore, MD 21201**

As emergency physicians, we have the opportunity and responsibility to provide considerable insight and guidance to the pre-hospital community.

Provisions will be made for distance participation for those in remote locations.

Please RSVP with your availability for this meeting to [mdacep@aol.com](mailto:mdacep@aol.com) or 410-727-2237.

Thank you for your support of The EMS Committee of Maryland ACEP.

Terry Jodrie, M.D.  
Committee Chair

## EDUCATIONAL PROGRAM SCHEDULE MARYLAND ACEP 2009 EDUCATIONAL CONFERENCE

Friday, April 17, 2009

Westin BWI Hotel, Old Elkridge Landing Road, Baltimore, MD 21240

### 7:30–8:00am General Registration and Continental Breakfast

### 8:00–8:10 Welcome

### 8:10–9:00 New Drugs and Devices for 2009: What's Going to Change Your Practice

*Presenter - Joseph Lex, MD, FACEP, FAAEM*

Once again the FDA has approved use of a lot of new drugs, and you're going to see ads in medical journals or on television. This session cuts through the promotional bias and tells you what actually offers an advantage over what you are already using and what needs to be added to your armamentarium.

### 9:00–9:50 Gangs, Weapons, Non-Verbal Communication: A Visual and Sociologic Experience

*Presenter - William Mallon, MD, FACEP, FAAEM*

The number of individuals seen with tattoos has increased dramatically, and they are frequently encountered in the ED patient population. In many instances, tattoos are simply decorative or related to a current fad. However, some of these tattoos may be clinically relevant to emergency physicians, indicating gang membership, a history of incarceration or drug abuse, sexual orientation, and more. Tattoos may definitively identify a person, and are frequently a means to nonverbally communicate one's beliefs or lifestyle to others. The emergency physician who is knowledgeable about tattoos, gains immediate insight into his or her patients, and may gather clinically relevant data.

### 9:50–10:20 BREAK WITH EXHIBITORS

### 10:20–11:10 Punks and Drunks

*Presenter: William Mallon, MD, FACEP, FAAEM*

One of the greatest challenges in emergency medicine practice is the care of agitated and intoxicated patients. These patients are a frequent source of frustration, they utilize significant resources and time, and often harbor deadly diseases that may be missed, leading to litigation. Dr. Mallon will discuss the challenges in caring for these patients, and he will provide rational approaches to safe restraint and sedation of these patients in order to provide optimal management...in a calmer environment.

### 11:10–12:00 Care of the Critically Ill: Articles That Will Change Your Practice

*Presenter: Michael Winters, MD, FACEP*

Caring for the critically ill ED patient is challenging. As many critically ill patients remain in the ED for exceedingly long periods of time, the emergency physician must continue to provide current, up-to-date care to these very sick patients. Dr. Winters will discuss important articles from the critical care literature that will change critical care practice in the ED.

### 12:00–1:20pm LUNCHEON AND AWARDS

*Presenter - Richard Alcorta, MD, FACEP*

*President, Maryland ACEP*

Awards presented will include: Emergency Physician of the Year, Emergency Nurse of the Year, Emergency Pre-Hospital Provider of the Year and Legislator of the Year.

*Keynote Speaker: Robert Bass, MD, FACEP, Executive Director, Maryland Institute for Emergency Medicine Services Systems, will provide an update on Medevac Services in Maryland.*

Maryland ACEP Business Meeting

### 1:25–2:15 Coumadinosis: Pearls and Pitfalls That You Must Know

*Presenter: Sara Scott, MD*

Dr. Scott will review the current American College of Chest Physicians guidelines with regard to treatment of over-anticoagulation. Additionally, she will discuss the pearls and pitfalls of Coumadin use in ED patients.

### 2:15–3:05 MRSA: Now Playing in an ED Near You!

*Presenter: Kevin Reed, MD, FACEP, FAAEM*

Methicillin-resistant *Staphylococcus aureus* (MRSA) first arrived in the hospital setting in 1961, only two years after the introduction of methicillin. Emerging in the community setting in the early 1990s, MRSA is now responsible for the majority of skin and soft tissue infections in the US. Armed with the latest research and guidelines, practitioners will develop a game plan to tackle their next encounter with this "superbug."

### 3:05–3:20 BREAK WITH EXHIBITORS

### 3:20–4:10 The Top Five Legal Pitfalls in Emergency Medicine

*Presenter: Larry Weiss, MD, JD, FACEP, FAAEM*

Dr. Weiss will cover five areas of common legal concern for emergency physicians, specifically (1) physician documentation strategies, (2) problems created by emergency physician contracts (3) compliance with EMTALA, (4) compliance with federal billing laws and regulations, and (5) preparation of testimony in medical malpractice suits.

### 4:10–5:00 HIV Testing in the ED

*Presenter: Richard Rothman, MD, PhD, FACEP*

This session will provide pearls and updates required for recognition and treatment of urgent and emergency HIV related conditions. ACEP policy, Maryland law and challenges associated with HIV testing and screening in the ED will also be discussed.

### REGISTRATION - On site registration, add \$25.00

The educational symposium includes continental breakfast, lunch and two breaks.

Please Print:

Name \_\_\_\_\_  
 \_\_\_\_\_ MD \_\_\_\_\_ PA \_\_\_\_\_ Other  
 \_\_\_\_\_ DO \_\_\_\_\_ EMT  
 \_\_\_\_\_ RN, BSN \_\_\_\_\_ Paramedic

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Phone \_\_\_\_\_

Email \_\_\_\_\_

FAX \_\_\_\_\_

Hospital where you practice EM \_\_\_\_\_

Fees:

Include course syllabus, continental breakfast, 2 breaks and lunch

_____ MD ACEP member	\$220.00
_____ Non Maryland ACEP member	\$240.00
_____ Non ACEP Members	\$260.00
_____ Nurses, PAs EMTs	\$125.00
_____ Residents and Students	\$45.00

Make checks payable and send to:

MD ACEP  
 1211 Cathedral St.  
 Baltimore, MD 21201

To charge your registration, please complete the following information:

VISA \_\_\_\_\_ MasterCard \_\_\_\_\_ AmEx \_\_\_\_\_

Exp. date \_\_\_\_\_

Credit Card Number: \_\_\_\_\_

Amount of charge: \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Phone \_\_\_\_\_

Email \_\_\_\_\_

Questions and/or dietary restrictions, Call the chapter office at 410-727-2237.

Cancellation Fee: A \$50 administrative fee will be charged for canceled registrations. In the event of a course cancellation, full tuition will be refunded. No refunds will be granted five days prior to course date.

7. active involvement in ACEP chapter activities as attested by the chapter president or chapter executive director;
  8. member of a national ACEP committee, the ACEP Council, or national Board of Directors;
  9. examiner for, director of, or involvement in test development and/or administration for the American Board of Emergency Medicine or the American Osteopathic Board of Emergency Medicine;
  10. reviewer for or editor or listed author of a published scientific article or reference material in the field of emergency medicine in a recognized journal or book.
2. Be active, life, honorary, or international members for six continuous years immediately prior to election and eligible for membership at the close of business on December 31, 1999. Candidate must complete and submit application along with all documentation and supporting elements prior to close of business December 31, 2009. After that date, no further new applications for fellow status under the second set of criteria (subsection 2) will be considered. Furthermore, all applications received by close of business December 31, 2009, will have either final approval or disapproval no later than close of business December 31, 2010. Maintenance of Fellow status requires continued membership in the College. In addition, the following requirements demonstrating evidence of high

professional standing must be met by candidates sometime during their professional career prior to application:

- A. At least ten years of active involvement in emergency medicine as the physician's chief professional activity, exclusive of training, and;
- B. Satisfaction of at least three of the following individual criteria, of which one of the three must be number 7 or number 8, during their professional career:
  1. active involvement, beyond holding membership, in voluntary health organizations, organized medical societies, or voluntary community health planning activities or service as an elected or appointed public official;
  2. active involvement in hospital affairs, such as medical staff committees, as attested by the emergency department director or chief of staff;
  3. active involvement in the formal teaching of emergency medicine to physicians, nurses, medical students, out-of-hospital care personnel, or the public;
  4. active involvement in emergency medicine administration or departmental affairs;
  5. active involvement in an emergency medical services system;
  6. research in emergency medicine;

7. active involvement in ACEP chapter activities as attested by the chapter president or chapter executive director;
8. member of a national ACEP committee, the ACEP Council, or national Board of Directors;
9. examiner for, director of, or involvement in test development and/or administration for the American Board of Emergency Medicine or the American Osteopathic Board of Emergency Medicine;
10. reviewer for or editor or listed author of a published scientific article or reference material in the field of emergency medicine in a recognized journal or book.

In addition, the candidate must provide a written letter of recommendation from their chapter, as attested by the chapter president or chapter executive director, or two letters of recommendation from current Fellows of the College.

Provision of documentation of the satisfaction of the above criteria is the responsibility of the candidate and determination of the satisfaction of these criteria shall be by the Board of Directors of ACEP or its designee. Fellows shall be authorized to use the letters FACEP in conjunction with professional activities. Fees, procedures for election, and reasons for termination of Fellows shall be determined by the Board of Directors.

For more information on Fellow Status, contact ACEP Membership Services at 800-798-1822, ext. 5, or [membership@ACEP.org](mailto:membership@ACEP.org)

performance requirements as defined in 10.24.17 (door-to-balloon time will be measured from arrival at the STEMI Transfer Center to balloon up at the Primary PCI Center).

- Both types of facilities must have a single call access system, participate in the County Hospital Alert Tracking System, and participate in data collection and medical review including the accuracy of EMS triage.
- Physicians in the emergency department may authorize EMS to transport patients directly to the catheterization laboratory if the hospital meets certain requirements.

If you have an interest in these regulations, there will be an opportunity to comment on them when they are published in the Maryland Register.

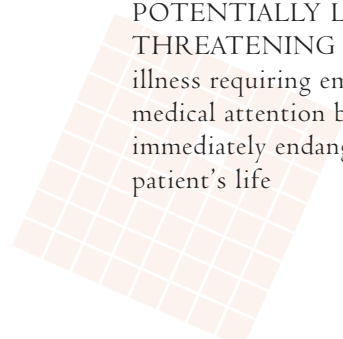
### Updates to the Maryland Medical Protocols for EMS Providers:

Highlights of changes effective July 1, 2009 to the Maryland Medical Protocols approved by the EMS Board include the following:

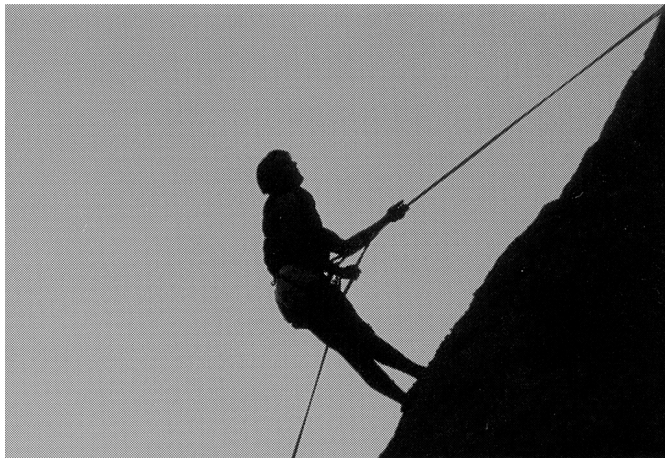
- Optional protocol for the Laryngeal Tube Airway Device (King LTS-D®)
- Optional protocol for the impedance threshold device (prevents air from entering the chest during chest recoil, doubling blood flow back to the heart during CPR)
- New medication ondansetron (Zofran®)
- Magnet for use in the event of failure of an Implantable Cardioverter Device (ICD)
- Nurse practitioners may now sign DNR forms (per Senate Bill 889 of 2008, which also gave

nurse practitioners authority to sign death certificates)

- CPAP moved from optional protocol to procedure section (now required)
- Modification of definitions:
  - o Priority 1 –Critically ill or injured person requiring immediate attention; unstable patients with **potentially** life-threatening injury or illness
  - o Priority 2 –Less serious condition YET **POTENTIALLY LIFE-THREATENING** injury or illness requiring emergency medical attention but not immediately endangering the patient's life



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setting of chest pain. Yet low risk chest pain might be the indication with the greatest evidence against the need for cardiac monitoring. (4)

- Hospital floors or sections with monitored beds may be staffed differently than floors or sections not designed for cardiac monitoring. These differences may include increased nursing, increased nursing assistance, more experienced nurses, or even staffing with regular hospital nurses and avoidance of locums in areas with monitored beds.
- It is frequently easier to add an intervention or a test than it is to remove one. This holds true even when there are downstream effects that adversely affect the institution as a whole. Thus, it is often easier to add telemetry as a single intervention on a single patient than it is to remove it as a matter of course in order to benefit ED and hospital flow. One local hospital automatically discontinues

telemetry after 24 hours. This approach, while attractive as a middle ground, requires tracking of monitored beds and may result in the physical shifting of a patient to another floor—and to what may be perceived as a lower level of care.

In the end, there are no simple answers. In this age of increasing health care costs, more rational and judicious use of resources is needed. We, as emergency physicians, may be well positioned to lead the discussion.

- (1) Chen E, Hollander J. When Do Patients Need Admission to a Telemetry Bed? *Journal of Emergency Medicine*, 2007; 33:53-60.
- (2) Drew BJ, Califf RM, et al. Practice Standards for Electrocardiographic Monitoring in Hospital Settings: an American Heart Association Scientific

Statement from the Councils on Cardiovascular Nursing, Clinical Cardiology, and Cardiovascular Disease in the Young. *Circulation*, 2004 Oct 26;110:2721-46. Accessed 1-19-09 at [http://www.guideline.gov/summary/summary.aspx?ss=15&doc\\_id=6181&nbr=3980#s23](http://www.guideline.gov/summary/summary.aspx?ss=15&doc_id=6181&nbr=3980#s23).

(3) For another take on this discussion, see Bukata R. Telemetry Admission Criteria. *Emergency Medicine and Acute Care Essays* 2007;31(8). Accessed 1-19-09 at <http://prod2.ccme.org/EMA/members/essays/downloadessay.aspx?id=08-2007>.

(4) Hollander JE, Sites FD, et al. Lack of Utility of Telemetry Monitoring for Identification of Cardiac Death and Life-Threatening Ventricular Dysrhythmias in Low-Risk Patients with Chest Pain. *Annals of Emergency Medicine*, 2004; 43:71-76.

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## Congratulations to...

Douglas Floccare, MD, FACEP on receiving the 2008 Medical Director of the Year Award from the Air Medical Physician Association.

Joel Klein, MD, on his appointment as President of Baltimore Washington Emergency Physicians, Inc.

Cynthia Webb, MD, on being named Chief of the Emergency Department at Union Memorial Hospital.

William Frohna, MD, FACEP who now serves as the Vice Chair of Med Star Emergency Physicians at Washington Hospital Center.

Keith Ghezzi, MD, on joining Alvarez & Marsal as Managing Director of its Healthcare Industry Group.

Robert Barish, MD, FACEP, on his appointment as Chancellor, Louisiana State University, Shreveport, LA.

## Maryland ACEP Welcomes New Members

Cameo Cozart-Chance, MD

Jeffrey Katz, MD

Bonnie Marr, MD

David Marx, MD, FACEP

Daniel Paluchowski, MD

Michael Somers, MD

Mercedes Torres, MD

Stelios Vantelas, MD

### Moved into MD Chapter:

Devon Davis, MD

Gregory Nabers, MD

## Thanks for Your Contributions to Emergency Medicine

Mark Olsyk, MD, emergency physician and Deputy Chief of Staff of the Veterans Affairs Maryland Health Care System collaborated on an article entitled "The Homeless Veteran" which appeared in *Maryland Medicine*, Autumn 2008 edition.

Joseph Twanmoh, MD, FACEP, for taking time recently to speak with medical students about the future economic climate of medicine. This meeting was sponsored by Med Chi, the Maryland State Medical Society.

Stephen Schenkel, MD, MMP, FACEP, for his public health update on hypothermia prior to President Obama's appearance in Baltimore, which appeared in *The Examiner*.

Editor's note: Please contact the chapter office, 410-727-2237 or mdacep@aol.com with information regarding any awards, accomplishments, etc., that members have achieved recently. Thanks!

Thanks to Gene Ransom, newly appointed Executive Director of Med Chi, for stopping by our Public Policy committee meeting. We look forward to working with you and the Med Chi membership.

Congratulations to the following Maryland ACEP members on their status as newly elected Fellows. These members were recognized at this year's Convocation Ceremony at ACEP's Scientific Assembly in Chicago.

Morgen Bernius, MD, FACEP

Michael Bond, MD, FACEP

Frederick Burke, MD, FACEP

Chirag Chaudhari, MD, FACEP

Don Coleman, MD, FACEP

Michele Delpier, MD, FACEP

Tanveer Gaibi, MD, FACEP

Jeffrey Greenwood, MD, FACEP

Christopher Jillson, MD, FACEP

John Jones, MD, FACEP

Bonnie Kerr, MD, FACEP

Jennifer McQuiston, MD, FACEP

Tiffany Megary, MD, FACEP

Linda Regan, MD, FACEP

Matthew Smith, MD, FACEP

Sharon Swencki, MD, FACEP

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We take this opportunity to applaud the following members' hard work in volunteering their time and expertise to serve on national ACEP's Committees. Keep up the good work and thanks!

### *Academic Affairs*

Amal Mattu, MD, FACEP

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### Condolences go out to:

Dr. Dan Morhaim on the loss of his brother, Glen, and to Dr. Jon Mark Hirshon on the loss of his sister, Constance. Our thoughts and prayers are with you and your families.