MACEP News

February 2006 ▫ Volume 31 ▫ Number 3

Save the Dates

MACEP RETREAT AND STRATEGIC PLANNING SESSION
March 21, 2006
Henderson House, Weston

MACEP ANNUAL MEETING
May 17, 2006
MMS Conference Center, Waltham

ACEP LEADERSHIP AND ADVOCACY CONFERENCE
May 21-24, 2006
Washington, DC

President's Message

Assaad Sayah, MD, FACEP

There has been no time in my career that I was more proud to be an emergency physician than the last few months. It seems that we have been repeatedly front and center in healthcare events and news nationally and statewide. It is encouraging to witness first hand the national and local attention focused on emergency medicine.

On September 27, a delegation from Massachusetts joined thousands of emergency physicians, nurses, and patients, in Washington, DC, to send a wake-up call to Congress to urge them to pass legislation HR 3875 supported by ACEP- legislation that will recognize emergency medicine as an essential community service, end the boarding of admitted patients in hospital EDs, and help solve the professional liability crisis in emergency medicine.

Massachusetts Public Health Commissioner Paul Cote graciously accepted our invitation and attended our October board meeting. During the meeting, the board emphasized that ED crowding is a daily occurrence in our state that affect both providers and patients. There are fewer hospitals, and EDs are constantly stretched beyond limits on daily basis caring for patients boarded in emergency departments awaiting staffed hospital beds or specialized placement. The ED is not the best place to provide the long-term care these boarded patients require and deserve, given the crowded conditions a and the constant influxof the sickest and most injured patients. If this situation is not resolved, we fear that the state's health community will be unable to respond to additional demands from disasters or pandemics.

The discussion with the Commissioner also included EMS Cardiac point of entry. The board suggested that DPH assembles a committee to include all stakeholders to look at this important issue in a collaborative manner and develop a statewide plan based on current evidence based practices that includes parameters for prehospital and hospital performance, patient outcome and appropriate checks and balances. Additionally, we visited various other issues including EMS and ambulance diversions, access to care for the uninsured and emergency care and boarding of the mentally ill. The discussion was collegial and Commissioner Cote shared with us some of the priorities of DPH and promised to keep the dialogue opened with MACEP. Based on the discussion with DPH and Commissioner Cote, the EMS cardiac point of entry task force with representation of various stakeholders, met late January. The goals of this task force include developing draft guidelines that will be presented at a public forum in late spring. That work is ongoing as I write this.

> **"This is a wake up call for our policymakers to seriously address the medical liability crisis in Massachusetts."**

On November 2nd, members of MACEP joined physicians from other specialties to answer the call of Mass Medical Society and converge on Beacon Hill for "Doctors Day". There, we spent the day meeting with policy makers regarding various issues related to healthcare in our state including access, scope of practice, and malpractice reform.

The national report card on the State of Emergency Medicine was published by ACEP on January 10th. This report graded all 50 states in four major categories of emergency care. I am pleased to note that Massachusetts came in second after California with a B grade. However, in spite of this overall grade which was due in part to the state's large number of board certified emergency physicians and highly trained nurses, we ranked 40th in the nation on the number of EDs and trauma centers available for care. In addition, we scored a D- for our medical liability environment. A score driven by the costs of malpractice, and the subsequent loss of physicians and

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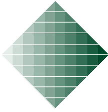

MACEP News

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back-up specialists to other states who are managing that issue better than Massachusetts. This report card is a wake up call for our policymakers to seriously address the medical liability crisis in Massachusetts. Our state and federal officials must work to get us the necessary resources to maintain the24/7 readiness of emergency medicine and the appropriate backing from our specialists. This message was clearly supported by the call of President Bush for Medical Liability reform in his latest State of the Union Address.

The good news from the Hill is that last-minute action by Congress has averted a major cut in the Medicare reimbursement rate that would have limited physician resources and access to care for millions of Americans, not just the elderly. By "freezing" Medicare physician payments at last year's level, Congress has avoided a 4.4 percent reduction in payments that was dictated by the flawed 'sustainable growth rate' (SGR) formula. "Congress has applied a new bandage, but we still need to fix the underlying problem," said Dr. Frederick Blum, president of the American College of Emergency Physicians. The financial 'cliff' has been avoided for 2006, but the nation's emergency physicians are urging Congress to replace the Medicare payment formula with a realistic formula that recognizes reasonable inflation costs.

Currently MACEP continues to work on local legislation and regulatory issues. MACEP has advocated for the primary seat belt law in the House and will turn its attention now to the Senate in hopes of finally achieving success. We continue to monitor closely proposed bills that would lessen requirements for motor cycle helmets.

On the regulatory front, MACEP has joined with the Massachusetts Medical Society, the Massachusetts Hospital Association, the Association of Behavioral Health Systems, and the Massachusetts Psychiatric Society to request that recent DMH regulations on restraints and seclusion be delayed in the interest of patient care until they can undergo careful evaluation.

Before ending my message, I would like to remind everyone of the upcoming daylong retreat and strategic planning session on March 21, 2006 at Henderson House in Weston. Given the results of the National Report Card on the State of Emergency Medicine recently released by ACEP, and not withstanding our relatively good grades in many areas, we need to focus on the many areas that measured poorly or were not measured at all. I believe that with your help we will make further in roads on many of the issues that continue to face us. With this in mind, I hope those of you who are able to participate will bring fresh ideas, renewed energies and long lasting commitment to become part of the college's future as we confront the many challenges of our specialty. Your input will provide MACEP with valuable information as we inventory our accomplishments, build on the changes we have attained since the last retreat, and to plan for the needs that have yet to be met.

MACEP intends to continue to serve our members and to insure the voice of emergency medicine with its unique perspective is heard in this challenging time for all aspects of health care.

Employment Opportunity

BOSTON - Full time Pediatric EM academic faculty position at Tufts-New England Medical Center and The Floating Hospital for Children, the principal teaching hospital for Tufts University School of Medicine in Boston. Must be BC/BP in Pediatric EM or have duel residency training in pediatrics and emergency medicine. Outstanding research and teaching opportunities working with medical students, pediatric and EM residents. T-NEMC is an ACS Level 1 Pediatric Trauma Center, sees 40,000 visits/year in a state of the art facility with dedicated Pediatric area, pediatric nursing and Child Life services in the Department. T-NEMC is one of twelve Agency for Healthcare Research and Quality (AHRQ) Evidence-based Practice Centers and is one of only two designated United States Cochrane Centers. Academic appointments in EM and Pediatrics.

Contact Brien Barnewolt, MD
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The View From The Hill

Ronna Wallace
Legislative Consultant

SEATBELTS

Will Massachusetts finally have a primary seatbelt law on the books by the summer?

It certainly looks that way right now, but a lot could happen in the next few months. After several years of tie votes, last week, the House of Representatives voted by a slim 76-74 margin to give police the authority to pull over drivers and cite them for not being buckled up. Under the current law, citations may only be issued if drivers are stopped for another infraction. MACEP, as a long-time proponent of the bill and an active member of the SAFE Coalition, argued that "primary enforcement" would save lives, as well as reduce injuries and medical costs, by prompting more people to wear seat belts. The measure moves on to the Senate, which has passed the bill in previous sessions, making that branches' support likely. Governor Romney is also on record in support. MACEP would like to thank Dr. Jim Feldman, whose tireless advocacy will hopefully be rewarded with passage of the bill in this session. You too can make a difference and balance the pressures brought by those in opposition by making a call to your state senators urging them to support a primary seatbelt law when it is brought to a vote.

HEALTH CARE ACCESS

After months of stalled negotiations, the Health Care Access Conference Committee is finally making progress.

Three members of the House and three members of the Senate are charged with reconciling the House and Senate passed proposals, which differ significantly in terms of coverage, cost and funding mechanism. The stakes are high. A health care access ballot initiative is awaiting, proponents of which have promised to advance in the absence of a legislative solution, and millions of dollars in federal reimbursements are at risk. MACEP continues to monitor the committees' progress closely.

RESTRAINT REGULATIONS

MACEP is actively opposing new regulations proposed by the Department of Mental Health, expected to be effective April 3rd.

Among the proposed changes is a requirement that a restraint may not exceed two hours prior to a subsequent review by a physician for further restraints. It is felt that this requirement will be difficult, if not impossible for certain hospitals to implement and will cause undue time and administrative burdens on emergency physicians. Joining MACEP is its opposition is the Massachusetts Psychiatry Society, Massachusetts Hospital Association, Massachusetts Medical Society and the Massachusetts Association of Behavioral Health Systems.

ACEP REPORT CARDS

When is a failing grade a good thing? When it draws attention to the need for change.

The recent release of ACEP's National Report Card, especially the D-grade for the Commonwealth's medical liability environment, drew the attention of the state legislature, prompting one member to call for a comprehensive study of the problem. Although the Report Card on the State of Emergency Medicine gave Massachusetts an overall "B" grade, the rating was reduced because of the poor medical liability climate, renewing fears that Massachusetts will lose quality physicians to other states with more hospitable environments. In response to the report card, **Senator Richard T. Moore (D-Uxbridge)**, Chair of the Joint Committee on Health Care Financing, announced his intentions reactivate two commissions established in the late state budget to study proposed reforms of the medical liability system, and the feasibility of creating specialty courts.

THE STATE BUDGET

Also on MACEP's legislative agenda is the state budget. The budget season officially got underway this month with the filing of House 1, the Governor's budget recommendations for the 2007 fiscal year. The budget is important because it contains funding for all state funded or subsidized programs, from education to health care. MACEP closely monitors funding for all public health and safety programs, including MassHealth, mental health and substance abuse and EMS Regional Councils. Also closely watched are the outside sections of the budget, frequently used to bypass the traditional, slower legislative process and get non-budget related initiatives signed into law more quickly.

THE LEGISLATIVE SCHEDULE

The state legislature is in the second half of the 2005/2006 biennial session. Formal sessions will continue through the end of July, when the legislature will recess for the remainder of the year. Any bill not signed into law by that time, or on the Governor's desk awaiting his signature, will die. Legislation for the 2007/2008 must be filed by early December. MACEP will be, after a careful review, looking at filing legislation with an eye to the needs of our members and their patients.

EMS quality improvement matters. We help EMS medical directors ensure that their EMS agencies comply with OEMS QI regulations and their affiliation agreements by:

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Mark Your Calendars For MACEP's Retreat

All members should have received their invitation to MACEP's upcoming Retreat and Strategic Planning Meeting to be held on March 21, 2006 at Henderson House in Weston. Our guest facilitator for the day is ACEP Council Speaker, Dr. Todd Taylor. We encourage you to make plans to attend as we shape the future agenda of our chapter.

Included with your invitation is a survey that we hope you will take the time to fill out and return so that your input and ideas can be incorporated into the day's discussions even if you cannot attend on the 21st.

Risk Management CME

MACEP continues to offer its *Risk Management in Emergency Medicine* course on its website. Successful completion of the course and test provides 6 CME credits for ACEP Category I and AMA Category 1. Those credits can be obtained yearly. In addition, those insured by ProMutual are offered, upon successful completion of course and the test with a grade of at least 90%, a discount on their insurance premium that is good for four years. Specific details are available at www.macep.org.

Case Management: Pleural Effusions

Michael D. Zwank, MD
Boston Medical Center

CASE #1

CC: Shortness of breath.

HPI: A 69-year-old woman with a history of advanced COPD (on home O_2 2-3 liters) who presents with two week history of gradually worsening non-productive cough and shortness of breath. This has progressed to the point that she is no longer able to walk across her bedroom without feeling dyspneic. She does not recall any obvious precipitant. She denies any orthopnea, PND, increased swelling in her legs, hemoptysis, fevers, chills or URI symptoms. She has been compliant with her medications.

ROS: Otherwise negative.

PMHX: COPD as noted, DM II, HTN, Hypercholesterolemia, Depression.

SOCIAL HX: She quit smoking 14 years ago after a 50-60 pack per year history. She lives in assisted living. Denies alcohol abuse or IV drug abuse.

FAMILY HX: Her brother died of lung cancer.

MEDICATIONS: Advair 250/50, Duonebs, Combivent inhaler, Avandia, Glipizide, Toprol, Aspirin, Pravachol, Lasix, Klonopin, Paxil.

PHYSICAL EXAM

VITAL SIGNS: 98.8 110/80 90's 36 77% RA 92% neb.

GENERAL APPEARANCE: Obese, obvious respiratory distress speaking in three word sentences.

HEENT: No pallor, nasal mucosa clear.

NECK: Supple, no obvious JVD.

HEART: Regular, normal S1S2, no murmur.

LUNGS: Diminished breath sounds, no rales/ronchi/wheezes.

ABDOMEN: Obese, normal bowel sounds, non-tender, non-distended.

EXTREMITIES: 2+ pitting edema to knees bilaterally, cool hands, no cyanosis.

NEURO: Alert, oriented to person, place only, subtle confusion, motor/sensory grossly intact.

EKG: Sinus rhythm, rate 84, RAE, small QRS complexes not meeting criteria for low voltage. Otherwise normal.

CXR: *See image below.*

ED COURSE: A thoracentesis was performed with ultrasound guidance. One liter of amber colored fluid was removed. The patient's respiratory status improved significantly. Subsequent analysis showed the effusion to be exudative. A CT scan of the thorax showed atelectasis and infiltrate at the left base. The patient was treated for pneumonia and discharged home with follow up scheduled in the pulmonary clinic.

QUESTIONS:

1. What are the most common causes of pleural effusions?

The amount of fluid in the pleural space depends on a dynamic process of production and reabsorption. If either of these processes is disturbed, a pleural effusion will result. Two categories of pleural effusions exist: transudates and exudates. Transudates are generally caused by increased hydrostatic pressure as in congestive heart failure or by decreased osmotic pressure as in cirrhosis with ascites. Exudates are caused by leakage across a membrane usually from lung/capillary injury or inflammation and are most commonly caused by bacterial pneumonia, malignancy and pulmonary embolus. While this is not an exhaustive list of causes, these are by far the most common causes.

See COPD, page six

Portable

UPRIGHT

COPD continued

2. What are the indications for thoracentesis?

Traditionally, it is recommended that any pleural effusion which layers more than 10 mm on a lateral decubitus chest x-ray should be tapped. Likewise any symptomatic patient with a large pleural effusions can be tapped for therapeutic reasons (as in the case presented). Very often, the time pressures in the emergency department preclude a diagnostic thoracentesis from being performed. However, as described below, with the benefit of readily available ultrasound, the procedure is much safer than with traditional methods.

3. What are the diagnostic criteria to distinguish exudate from transudate?

Three criteria, commonly referred to as Light's criteria have been used to identify exudative pleural effusions: Pleural fluid LDH/serum LDH ratio of more than 0.6, Pleural fluid protein/serum protein ratio of more than 0.5, and Pleural fluid LDH more than two thirds of the upper normal limit for serum.

4. What other studies are important?

In the proper clinical setting, cytology (usually large volume), cell count/hematocrit (both in a standard purple top), pH (in a standard ABG syringe), glucose (in a plain red top), gram stain (also in a sterile red top), culture (in a sterile culture container) and others are all appropriate laboratory tests to order. Don't forget to obtain the serum protein and LDH at the same time.

5. What technique should be used for thoracentesis?

In most cases, the patient should be seated upright. After the effusion is identified and the site anesthetized, sterilized and draped, a 20-guage catheter is inserted in the midscapular or posterior axillary line. The procedure should be performed by or under the guidance of an experienced individual.

6. What are the common complications from performing thoracentesis?

Pneumothorax is the most common complication. Re-expansion pulmonary edema is a rare but life-threatening complication of unknown etiology and seems to be unrelated to the absolute volume of fluid removed.

7. How much fluid can be safely removed from a large pleural effusion?

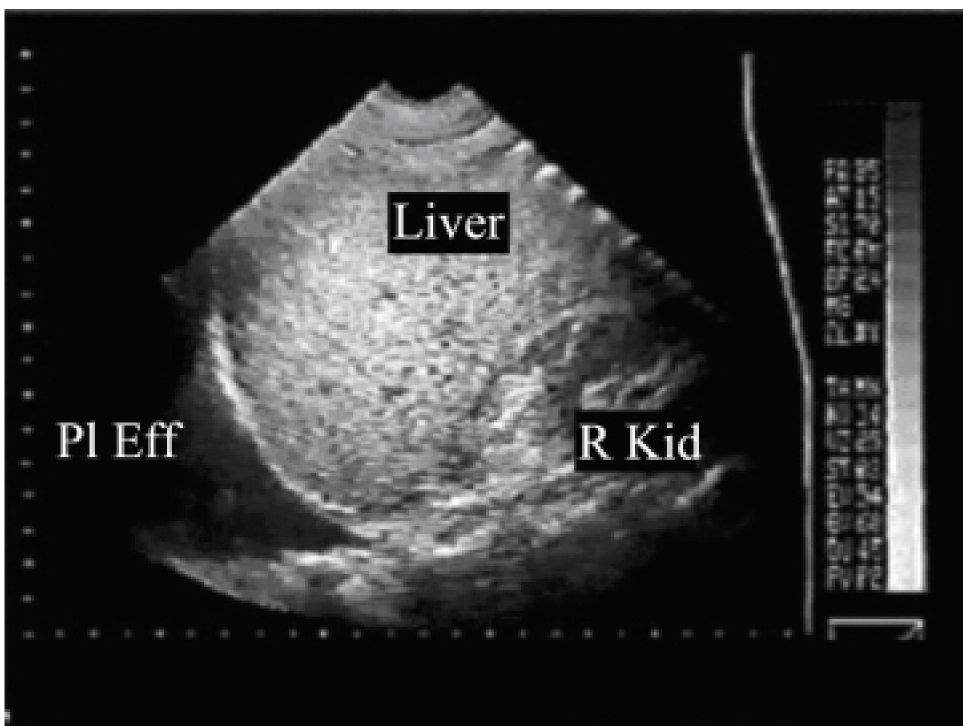
How much fluid can be safely removed from a large pleural effusion? Traditionally, 1000 cc has been taught as usually safe. There are no large population studies which correlate complication risk with increased fluid removal. In a prospective study of 941 thoracenteses, Jones and colleagues showed no correlation between volume removed and complication rate (with volumes as high as 3200 cc removed).

8. How does a pleural effusion appear using ultrasound?

The effusion is a hypoechoic or anechoic (black) region found above the diaphragm. Often, the lung parenchyma can be seen within the effusion.

9. Does ultrasound guidance reduce the complication rate from performing thoracentesis?

Complication rates using traditional methods have been reported as high as 20-50% in the literature. Numerous studies have showed significantly lower complication rates when ultrasound guidance is used. In the previously mentioned study by Jones and colleagues, the rate of pneumothorax complication was only 2.5%. In an alarming but informative study by Weingardt et al, the puncture sites of 26 failed thoracentesis attempts were examined with ultrasound. Errors in needle placement included directing the needle below the diaphragm, above the fluid collection, into consolidated lung, or over solid organs including the spleen, liver, and kidney. With ultrasound guidance, thoracentesis was successfully performed in 88% of the cases.



CASE MANAGEMENT REFERENCES

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MACEP congratulates new Life Fellows and Fellows inducted at the ACEP Scientific Assembly last October.

NEW LIFE FELLOWS:

Richard Aghababian, MD, FACEP
Gary Fleisher, MD, FACEP
John Foley MD, FACEP
Errol Green, MD, FACEP
Joel Hellmann, MD, FACEP
Gordon Josephson, MD, FACEP
William Kasdon, MD FACEP
Jane Mailloux, MD, FACEP
Margaret Oakland, MD FACEP
Stephen Playe, MD, FACEP
John Santoro, MD, FACEP
Gary Stenik, MD, FACEP
Thomas Stair, MD, FACEP
Alan Woodward, MD, FACEP
Jennifer Leaning, MD, FACEP

NEW FELLOWS:

Paul Biddinger, MD, FACEP
William Fernandez, MD, FACEP
Deborah Greene, MD, FACEP
Blake Spirko, MD, FACEP
Angela Sweeny, MD, FACEP
Stephen Traub, MD, FACEP
Stacy Weisberg, MD, FACEP

Help on Medicare Part D Formulary

Centers for Medicare and Medicaid Services (CMS) is allowing access to the Prescription Drug Plan Formulary and Pharmacy Network Files via the internet for a modest monthly fee. Information on the public use file may be found on the CMS website at http://new.cms.hhs.gov/NonIdentifiableDataFiles09_PrescriptionDrugPlanFormularyandPharmacyNetworkFiles.asp.

In addition, physicians can also call in their questions every Tuesday from 2-3. To participate, dial the conference phone number 1-800-619-2457 and reference the password "Part D."

Another resource is a computer/web based formulary review being offered by Epocrates. To access the free online drug: http://www2.epocrates.com/products/online.

Massachusetts College of Emergency Physicians

2005-06 Calendar of Events

February 28, 2006	**March 21, 2006**	**April 25, 2006**	**May 17, 2006**
MACEP Board Meeting MMS Conference Center* Waltham 4:30 - 6:30 pm	Board Meeting / Retreat and Strategic Planning Henderson House, Weston*	MACEP Board Meeting Radisson Hotel, Marlboro 4:30 - 6:30 pm	MACEP Annual Meeting MMS Conference Center, Waltham

May 21-24, 2006
ACEP Leadership and Advocacy Conference
Washington DC

For more information, please call (781) 890-4407 or visit our website at www.macep.org.

**Please note: Change of location*

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