

CONNECTICUT COLLEGE OF EMERGENCY PHYSICIANS

NOVEMBER 2005

“The U.S. healthcare system is collapsing, and nowhere is that more apparent than in the nation’s emergency departments”. — ACEP president Fred Blum



Nearly 4,000 physicians and nurses assembled on Capitol Hill to express their support for the bipartisan Access to Emergency Medical Services Act, which recognizes emergency medical care as providing essential public services that should receive public funding, just as police and fire departments do. There’s a summary of H.R. 3875 on page 5.

JOBS IN CONNECTICUT PAGE 7

ALSO INSIDE:

Careers in EM: PAUL KROCHMAL

Tom Nowicki on: SIMULATION MEDICINE

**CCEP ANNUAL MEETING WEDS., NOV. 16, 7:00AM – 3:00PM
ROCKY HILL MARRIOT**

SIMULATION MEDICINE

BY THOMAS NOWICKI

Welcome to the future! Simulation Medicine has come a long way from the days of Resusci-Annie. Modern day high-fidelity simulators have not only added legs, but have allowed these mannequins to come to “life”. We can now achieve realistic patient encounters by setting the mannequin in an appropriate environment and creating carefully planned scenarios.

In medical education there are continuing pressures to turn out more highly trained specialists with fewer hours of training. In order to achieve this, we are faced with the task of increasing our teaching efficiency both in residency and post-graduate education. Fortunately, high-fidelity simulators now provide us with the tools to achieve this goal. In order to utilize a simulator to its fullest potential the instructor must develop a specialized skill set combining understanding of the equipment, the subject matter and the teaching process.

Realistic scenarios begin with history taking, just as they would in a standard patient encounter. The participant can talk to and listen to these mannequins, as well as examine and perform procedures on their simulated patient. The control center for the simulator can be hidden behind a one-way mirror, or brought into an individual's place of practice.

Knowledge of the mannequin's capabilities is vital to a successful encounter. By adjusting

factors like vocal cord position, tongue or pharyngeal edema, trismus and cervical range of motion, the airway can be manipulated to create a straight forward/uncomplicated case or the feared can't ventilate/can't intubate situation. Rather than being verbally fed information, participants are required to collect data directly from the mannequin as they would with a real patient. Students can auscultate breath, heart and bowel sounds. Pulses are palpable and correlate with blood pressure while the respiratory rate can be counted from the chest rise. A full and realistic monitoring system mimics those used in clinical practice showing a full set of vital signs and even end-tidal CO₂. The simulator can sense when appropriate ventilation is being provided and can provide a rush of air when decompressing a tension pneumothorax. The supporting environment is just as vital to a successful educational experience. Having all of the equipment used in the actual work setting is important. An array of devices from airway

adjuncts to defibrillators can be used on the simulator. Current simulators are quite impressive with the many features they possess, well beyond those described here and future generations of mannequins will be even more life-like.

Unfortunately there is a tendency to focus on the “toy” and forget the content. To generate a successful program requires significant manpower and many hours of planning.

Understanding the student needs and developing a well thought out clinical scenario are key. Interestingly, debriefing after the session typically requires significantly more time than the actual scenario. The simulator and equipment paired with a well-constructed scenario allows students to immerse themselves in the session and perform as they would during a real patient encounter. The ability to discuss a challenging

case in detail immediately afterward is a luxury we are rarely afforded. Not only can these high-fidelity simulators be used for teaching, but they can also serve as assessment tools. Imagine walking into a patient room and assessing one of these simulated patients to test your skills rather than sitting in a room with an oral board examiner. Many of the common patient cues that we rely on are absent in the artificial environment of the current oral board format.

Our specialty is well suited to benefit from this practical technology. Simulation Medicine is beginning to be

incorporated into residency curriculum and will likely become commonplace in the near future. There are many post-graduate courses that also rely on the usage of these high-end tools. Historically anesthesia has taken advantage of these simulators the most, although they are emerging frequently in courses relating to difficult airway management in emergency medicine. As future models continue to improve we will be able to create even more realistic patient encounters covering more diverse topics. Simulation has been clearly proven to provide efficient teaching and improve skills in many other specialties including the military and aviation. Medicine has adopted this approach and will continue to collect data in support of its usage. If you have the chance to meet one of these modern mannequins, feel free to ask how they are feeling and assess more than just their ABC's.

Tom Nowicki is the Associate Residency Director at the UConn Integrated Residency in EM.



(from L to R) Tom Nowicki, UConn resident Scott Graham, and Steve Donahue.

Careers In Emergency Medicine: Paul Krochmal

This is an occasional interview that we run when we come across an emergency physician with an interesting career. As it turns out EM is rich with interesting folks with interesting careers. Paul Krochmal sat down with us on a crystal clear summer morning over breakfast at the Stony Creek Market in Stony Creek, CT

EPIC: You lived through ye olde days of emergency medicine you're a link to the past for some of us. Where did your career start?

PK: Yea, I'm an old dog, 58. I graduated from medical school in 1975 and did a residency in internal medicine. Back then there were very few EM programs. Three in the country. One was at Jacoby in the Bronx where I was already working. One was in Los Angeles and the third, I think, was in Cincinnati. Back then it was possible to become board certified in internal medicine with two years of medicine and two years of another discipline they accepted. So I did two years in emergency medicine and was board certified in internal medicine in 1979.

EPIC: Were there many people taking this route?

PK: No. We had six residents in the whole program, 3 per year. Imagine a big tertiary center trying to get by with just six emergency medicine residents. The only service I remember working on, other than the ER, was psych and orthopedics, for a month. We spent all the rest of our time in the ER. We did our pediatrics in the ER. We didn't go upstairs to do all the other rotations that the residents do now. Then again, my program was only 2 years.

EPIC: So after you finished...

PK: Didn't have a clue about what I was going to do. But I was visiting my parents in Connecticut and heard that Waterbury needed a doc, so I stopped by and it was a nice community hospital. They hired me. I was still living in New York and commuted back and forth. Then a friend of mine mentioned that Beekman Downtown was looking for an assistant director. I interviewed and got the job. I thought, "Wow, two months out of my residency and I'm an assistant director". I didn't want to stiff Waterbury so I worked in New York Monday to Thursday and Friday through Sunday in Waterbury. Twelve hour shifts. Did the seven days a week routine for quite some time. I'd come up on Thursday, stay with my parents, do laundry, and get back to New York by Monday. I was young and the hours weren't a lot because it didn't include any nights. Eventually I stayed in New York and took the assistant job full time. Probably did this for six months, then became the acting director. Then this guy calls me up from Queens General, this guy in charge of ambulatory care, who says he heard good things about me as a doc and a director and wants to recruit me. I say I've been acting director for about a week and he says, "That would make you our best candidate!" That's how I became the director at Queens. Truth is I didn't have a clue. I was young.



EPIC: Queens General is a pretty down 'n dirty place, right?

PK: Right, but they paid \$10,000 more, which was big bucks back then. But when I got to Queens there were some surprises in store. Like, they were renovating the OR's and the OR's they were using in the interim were in another building. We were a trauma center and when we got an unstable stab wound or something that had to go to the OR we had to transport them in an ambulance to move them down the block. This went on for a few years. And moonlighters, lots of moonlighters. It was all very fast and loose. Basically no credentialing process. I'd say, "Hey, wanna moonlight for me Monday?" That's it. What credentialing? It was unbelievable.

EPIC: Do you remember any good cases from those days?

PK: Yes. , My favorite case — you may not call this a good case, but it's my favorite — got me a reputation as a brilliant diagnostician, all because of my cool emergency medicine training you understand, (snickers). They brought in this guy who was weak and couldn't talk, looked terrible and we didn't know what was wrong with him. He looked like he may need to be intubated but he sorta managed to lift his right hand and point to his right shirt pocket. I looked in his pocket and saw a note that said, "I have Myasthenia Gravis". I gave neostigmine and he got better and everyone thought I was brilliant. I love it.

EPIC: What came after Queens General?

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Careers In EM (continued from page 3)

PK: I became the head of the Carney Hospital Emergency Department, in Dorchester, Mass. The Boston City Hospital residents rotated through Carney. One of my favorite rotating residents back then was a young woman named Gail D'Onofrio who is now my boss and Chair Apparent at Yale. By the time this actually gets published she might be the head, formal head. She's the interim now. Anyway, she was a great resident. I was at Carney from '83 to '88. My dad was becoming old and ill and there was a job at St. Raphael's so I moved back to Connecticut. I always figured I'd go somewhere big, but here I was working 12 miles from where I grew up. I haven't strayed much since. I was at Middlesex briefly, and now I'm at Yale. Actually now I'm sitting on a beautiful spot at Stony Creek having a fine breakfast looking out over the harbor. One of the nicest moments of my week, I'm sure.

EPIC: How long have you been at Yale?

PK: 9 years, I think.

EPIC: What's your impression of the residents now compared to back then. During the frontier years when you started EM training you had to be a sort of pioneer, yes? Maybe that's not quite so true now. What do you think?

PK: I think the Yale residency is now maturing and attracting incredibly good residents. I'm in awe of the first year residents, both last year and this year. I think we've always had good people but it's clear that either medical schools are doing a better job teaching them, or we're attracting better candidates as emergency medicine catches on. We expect a lot from these residents and they do a great job. They carry a lot of patients and I'm very impressed with how quickly they're learning, how quickly they get it.

EPIC: So, do you miss the administrative life? You're working what a typical staff doc works, right? Or do you have a deal?

PK: Um, the answer to all those questions is that I've been a Yale part-timer working 12-hour day shifts, working every Saturday and Sunday, having every Monday - Friday off just having a really great life. I had so much time off I got married. But in emergency medicine there's what's known as *need-creep*. Somehow those two 12-hour shifts became three nine-hour shifts. I was doing that for a while and well, I never missed having people work for me. Then Gail D'Onofrio, Chair-Apparent, asked me to assume some administrative responsibilities, like being in charge of the ER PA's. I love our PA's, I think they are the best people in the world. You want me to say that again so the transcript is right? I love our PA's they're the best people in the world. Somehow with *need-creep* I'm now thirty hours a week clinically, and ten hours a week administrative. That adds up to forty so

I'm now full time. The average full timer at Yale works 26 hours a week clinical. I do thirty. I'm considered clinical faculty, most others are considered academic faculty. I don't have to generate research. They do.

EPIC: How many times have you taken the boards?

PK: Well the first one I took was in 1980, and since then I've taken it every 9 years — that's instead of 10. So that if I flunked it, I could take it again. But I always passed. Times 3. Actually I just took it at the 5-year point, really just for a lark, so I'm good till I'm 67.

EPIC: Speaking of board exams, what's your take on the ED docs out there who got caught in the EM certification bind. Docs who were trained in another discipline who were disinclined to retrain or change careers, internists or other folks who chose a career in emergency medicine but missed being grandfathered. You've no doubt hired and worked with many of these guys.

PK: Well, it's a really interesting question, and yes I've lived through the transition. I came to Connecticut in 1988 from a directorship in Boston. I was hired as the chairman of Emergency Medicine at the Hospital of St. Raphael's in New Haven, which is a large, busy department. It wasn't staffed in any way like today's standards. What we did then was truly not acceptable, but it was the norm. Moonlighting Derm residents as attendings, you know the score. There just wasn't a big enough pool of EM certifiable doctors. What I did was recruit a few good internists that I thought might have emergency medicine in their blood. I hired some very good people who had trained at Yale in internal medicine and came to St. Raphael's to be teaching attendings. I asked them to consider moonlighting for me, and a few of them ended up liking emergency medicine a lot. Eventually came to work full time in the ER.

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EVERY CCEP MEMBER IS CORDIALLY INVITED TO EVERY CCEP BOARD MEETING

This is the schedule for the rest of the year:

October 27, 2005	Board Meeting 8:00AM — CHA – Connecticut Room
November 15, 2005	Board Dinner Meeting 7:00 PM — Rocky Hill Marriott
December 15, 2005	Board Meeting 8:00 AM — CHA – Archives Room



U Conn interns this year: Matthew Barr, Michael Tocci, Scott Graham, Mark Dziejcz, Richard Paulis, Peter Kleuser, Lauri Bolton, Heather Dodds, Bang Chau, Joby Mathews. (Not pictured: Khalilah Hunter-Anderson and James Suozzi)

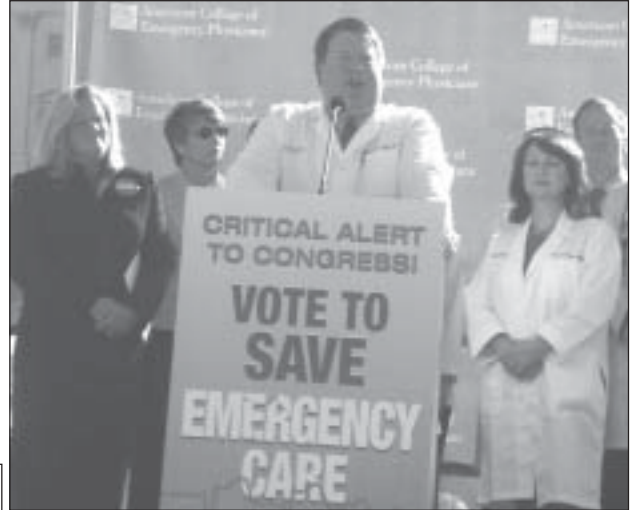
CCEP in D.C...



Congressman Bart Gordon



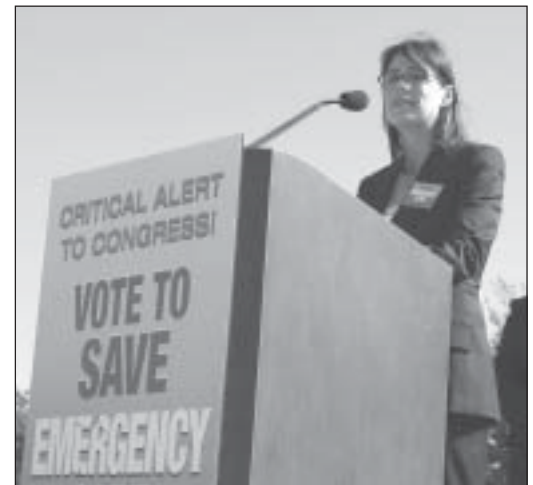
Charlie Bizilj (from Johnson Memorial, with Christopher)



ACEP president Rick Blum



Connecticut folks



ER actress Maura Tierney

H.R. 3875

“More patients are seeking emergency care than ever before, but fewer emergency department resources are available. A national investment is urgently needed to ensure that EDs can meet increasing demands. This legislation goes a long way toward that goal”, says Congressman Pete Sessions (R-TX). Sessions, along with Bart Gordon (D-TN), are co-sponsors of the bill.

In a nutshell, H.R. 3875 will:

- Recognize hospital EDs as the backbone of the nation’s safety net.
- Increase Medicare payment for EM services by 10%. This recognizes that EDs serve a disproportionate share of Medicaid and uninsured patients.
- Increase Medicare payments to hospitals for ED visits by 10%, if the hospital reaches standards for prompt admissions. This addresses the practice of boarding of admitted patients in EDs.
- Extend liability protection for commissioned officers of the Public Health Services and employees of federally funded health clinics to emergency physicians for care provided uninsured patients under EMTALA.

Careers In EM (continued from page 4)

I promised them that as long I was the chair at St. Raphael's they would never lose their job despite not being board certifiable in emergency medicine. I thought they were giving up significant career opportunities to work for me. I said that I would protect them for as long as I could. These were two very good emergency physicians.

But in 1994, there was a shift in the administrative sands of St. Raphael's and I became a free agent. Both of those internists-come-emergency docs remained at St. Raphael's. But their careers would eventually become unstable and they've since left. One of them decided that he needed the EM credentials and returned to Yale as a resident in emergency medicine. This is after many years of being an attending. He's now their chief resident. John Foggie.

EPIC: Many hospitals now have written bylaws disallowing the hiring of nonboardable emergency docs.

PK: And that's what bylaws should say if that's what they say for the other specialties.

It's bigger than just a staffing issue. What I've come to think is that, in the long run, for a hospital that's serious about its ER, it's a good thing to have all docs boarded in their specialty. But, no doubt about it, it's tough for those docs caught between generations.

FT: They're mobility is restricted...

PK: I don't think anyone that's a skilled and established physician is in much danger, at least in community hospitals. The medical staff in community hospitals, if they like someone that's been there for years they won't put up with letting him or her get fired just because of their credentials. Medical staffs of most community hospitals just won't let it

happen. They're more connected to the ED than at the tertiary centers. At big hospitals it's different, the medical staff at the big places isn't as connected with the ED docs. Hartford and Yale.

EPIC: There seems to be a few hospitals in the state that have a pension for turning over emergency docs and/or their directors. What's up with that?

PK: I've thought about this a great deal, being a physician who was turned over in one of those hospitals. I think that hospitals that have inherent problems that they don't deal with will continue to have them. The ED isn't the place to outsource services. You can have Xeroxing done off-site, cars and clothes made in China, radiographs read in Australia in the middle of the night. But you

shouldn't outsource the ER. The problems need to be dealt with. Saying it's a failure of ED leadership doesn't solve problems. I guess the director himself or herself could be an issue, but usually the problems are bigger than the director. If you hire an outfit from the outside, a big national group, well it's very good at staffing but maybe not good at dealing with local problems. And it's the local problems that are always the most important.

Look at overcrowding as a big issue that brings the ER to the attention of leadership. You can't solve overcrowding without looking upstairs. Hiring a great director/leader who whips the staff into shape and runs a great operation isn't going to solve it. The hospital administration has to help solve it. Really help. Whoever you bring in has to be strongly supported by the hospital administration, not left on his or her own to deal with issues that are bigger than the ED.

In my case I was very lucky in having a great chief of medicine. He saw overcrowding as a hospital problem and worked hard to lower inpatient length of stay, which helped. It didn't solve the whole problem, but we improved our overcrowding numbers by about 50%, just thanks to him. As it turns out most ED problems are not just ED problems. Brilliant hey?

EPIC: Your article about the costs of holding admitted patients dwelling in the ED... was it the Annals?

PK: It was turned down by the Annals. They weren't interested in overcrowding. It was actually in the Journal of Emergency Medicine. It got a lot of press and I got a lot of support.

EPIC: People are still quoting it.

PK: What I tried to show in that paper was not just that we had a problem but that it was a hospital problem, not just an ED problem. What I was able to show was that not dealing with that problem costs the hospital money. At first the administration didn't believe that not dealing with it was costing them hundreds of thousands if not millions. But, as I said, I eventually got their support. Also, we got an inpatient team to help with admitted patients that were stuck in the ED. In other words, these poor

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The Connecticut EPIC is published quarterly by the Connecticut College of Emergency Physicians. Opinions expressed within this newsletter do not necessarily reflect the College's nor ACEP's point of view.

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JOBS IN CONNECTICUT

HARTFORD HOSPITAL

Expansion position — Fall 2005 opportunity for EM Board Certified physician interested in clinical care and teaching. Excellent work environment, compensation, and job security. Contact Robert D. Powers, MD, rpowers@harthosp.org or (860) 545-4135

MANCHESTER

Per-diem EM residency trained and BE/BC physicians to work in the ED at Manchester Memorial Hospital. We are also looking for PA/APRNs with ED experience to staff our PromptCare. Please contact: Robert F. Carroll, MD, FACEP, HYPERLINK "<mailto:RCarroll@echn.org>" RCarroll@echn.org, 860-647-6475 (Office) 860-647-6412 (Fax)

MIDDLESEX

Fulltime ED position for BE/BC ABEM MD. Contact Mike Saxe, MD, FACEP at msaxe@midhosp.org or 860-344-6693.

MILFORD HOSPITAL

Looking for a few per diem EPs for our Fast Track and Main ED. Board certified physicians preferred. Contact Jay Walshon MD, 203 876-4100. HYPERLINK "<mailto:jay.walshon@milfordhosp.org>" jay.walshon@milfordhosp.org

NEW BRITAIN GENERAL HOSPITAL

Immediate full time physician and midlevel needs. Outstanding base pay, incentive pay and benefits. Contact Jeff Finkelstein, MD at finkelstein@nbgh.org. We are committed to excellence in clinical care and customer satisfaction. Web site www.NBGH-ER.com

ST FRANCIS

Two full time emergency physicians and 2 full time PAs/ APRNs needed for service expansion at St. Francis Hospital and Medical Center. Contact Steve Wolf, MD, Interim ED Chairman at 860-714-6107 or email:swolf@stfranciscare.org.

NORWALK HOSPITAL

EM-Residency Trained, ABEM/AOBEM certified/prepared EP with EM experience to work in a modern 47,000 visit ED with a lucrative schedule of 180 8-hour shifts/year (1440 hours). Norwalk Hospital is a progressive, teaching, 270-bed Level II Trauma Community Hospital located in Fairfield County on Long Island Sound, not far from New York City. Preference will be given to experienced, nights-only applicants. Available mid-November, 2005. CONTACT: Michael Carius, MD, FACEP, Chairman, Department of Emergency Medicine, Norwalk Hospital. Phone 203-852-2281. E-mail Joanne Kopko with CV or for information, application.

NEW MILFORD HOSPITAL

New Milford Hospital, located in northwest CT is seeking full time, part-time and per diem PAs to staff its mid-volume ED and Hospitalist program, providing both weekday and weekend coverage with 8 and 12 hour shifts. Excellent benefits and wages package. Individuals should be NCCPA certified with ED experience. Please send a current CV to Thomas Koobatian, MD, Director, Emergency Medicine, New Milford Hospital, 21 Elm Street, New Milford, CT 06776, or email koobatian@newmilfhosp.org

BRIDGEPORT

Great full and part time opportunities for residency trained Emergency Physician. Join 12 other emergency physicians at this Level 1, Yale EM residency training site. \$15 million expansion in progress. Participate in both bedside and didactic training of residents and PA students. Work at a hospital with an exceptional medical staff and services including the only burn unit in CT., established PTCA and open heart programs, Pediatric unit with residency and PICU. Competitive salary and benefits. Contact Michael Werdmann, MD atpmwerd@bpthosp.org or 203-384-3923.

WEST HAVEN VA MEDICAL CENTER

We are looking for additional staffing for nights and weekends. Our ED is primarily an adult, Internal Medicine-type patient population with no trauma, OB, or Peds. Emergency physicians or those boarded in Internal Medicine with ED experience would be most comfortable in this environment. Compensation has recently become extremely competitive for those with appropriate Boards. Contact: Craig Zalis, MD, Director, Emergency Services, West Haven VAMC, 950 Campbell Ave, West Haven, CT 06516. HYPERLINK "<mailto:Craig.zalis@med.va.gov>" Craig.zalis@med.va.gov (203) 932-5711 x 2991 (private), x 4483 (secretary), x 4777 (ED)



Yale residents (L>R): Chris Lingan, Basmah Safdar, David Young and co. 'at a conference' (Scientific Assembly in DC)

Careers In EM (continued from page 6)

patients weren't just our problem. No small deal.

EPIC: Do you have any advise as a guy who's been around the track a few times? Any words of wisdom for the newly graduated attending working without a net for the first time in a nonacademic ED in Connecticut?

PK: Never get angry. That would be my advice.

EPIC: Huh. That's good.

PK: It doesn't gain anything and it's not worth it. You're the only one who feels bad. The person that you're angry at thinks you're a loser.

EPIC: That would include never getting angry at a patient, a nurse, a tech, an administrator, anyone?

PK: That'd be right. My actual theory about yelling at people is this: I think that anyone who makes less money than me or anyone whom I have any kind of professional or administrative power over, if they have to take my orders, I let them yell at me but I can't yell at them. That's down the hierarchy. Up the hierarchy you can yell, at your own risk of course.

EPIC: So when do you think you'll start to fade from the Emergency Medicine scene?

PK: Uh....(long pause). I'm now board certified until I'm 67 and I like working and being an emergency doc. I like patients, I love the house staff. I love the PAs I'm working with. Until some body offers me a great salary for just doing interviews I guess I'm gonna stay.

11TH ANNUAL MANAGEMENT OF THE DIFFICULT AIRWAY

HARTFORD HOSPITAL SIMULATION CENTER

DECEMBER 2, 2005

7:30AM - 5:00PM

This emergency airway management course provides a nice balance of lecture based material and hands on experience. A high fidelity human simulation lab and large animal lab allow immediate experience and decision-making.

CME Approved for 6.5 hrs ACEP Category 1 credit

\$325 full day \$125 didactic session only
Enrollment limited to 36 participants

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