

# Winter 2006

A CHAPTER OF THE AMERICAN COLLEGE OF EMERGENCY PHYSICIANS  
GOVERNMENT SERVICES  
EPIC



## PRESIDENT'S MESSAGE

LTC JOHN McMANUS, MC, USA

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

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

#### Characteristics of a Good Mentor: Who should I Seek?

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

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

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

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

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

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

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

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

#### Roles of Mentorship

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

#### Phases of Mentorship

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

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

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# GSACEP ELECTIONS 2007

The following GSACEP Board of Directors openings occur in 2007:

President Elect

Councillor

Councillor

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

Active Members will also be able to vote online at [gsacep.org](http://gsacep.org).

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

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

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

The Councillor position is for two years.

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

If you're interested, please contact [gsacep@aol.com](mailto:gsacep@aol.com). If you have questions, call 877-531-3044.

*The opinions and assertions in this issue are solely those of the authors, or GSACEP, and are not necessarily those of the Department of Defense or any other US government agency.*

# MILITARY NEWS

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

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

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

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

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

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

## IMPORTANT GSACEP DATES

**December 22, 2006:** Notify GSACEP office, [gsacep@aol.com](mailto:gsacep@aol.com) if you are interested in running for elected office.

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

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

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

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

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

## BOARD OF DIRECTORS AND COMMITTEES

### Board of Directors

#### President

LTC John McManus, MD, MCR, FACEP  
[john.mcmanus@cen.amedd.army.mil](mailto:john.mcmanus@cen.amedd.army.mil)

#### President Elect

CDR James V. Ritchie, MD, FACEP  
[Jvritchie@mar.med.navy.mil](mailto:Jvritchie@mar.med.navy.mil)

#### Immediate Past President

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[Robert.DeLorenzo@cen.amedd.army.mil](mailto:Robert.DeLorenzo@cen.amedd.army.mil)

#### Secretary-Treasurer

CDR(R) David S. McClellan, MD, FACEP  
[Dsmccllla@aol.com](mailto:Dsmccllla@aol.com)

### Councillors

LTC. Marco Coppola, DO, FACEP  
[DrMarcoCoppola@aol.com](mailto:DrMarcoCoppola@aol.com)

LtCol William Gibson, DO  
[william.gibson@lackland.af.mil](mailto:william.gibson@lackland.af.mil)

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[carr@gsacep.org](mailto:carr@gsacep.org)

### EPIC Editor

Bernadette Carr

### Conference Committee

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Capt James Eadie, MD  
Capt Julio Lairet, DO

*For more information about GSACEP, please call our office at 877-531-3044. Our office hours are 0900 to 1700 EDT, or visit our website at [www.gsacep.org](http://www.gsacep.org)*

# LINDA LAWRENCE ELECTED PRESIDENT ELECT OF ACEP



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

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

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

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

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

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## JSS 2007 EMERGENCY MEDICINE ON THE RIVERWALK CALL FOR ABSTRACTS

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

### Abstract Submission Requirements:

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

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

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

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## NOMINATIONS FOR EXCELLENCE IN MILITARY EMERGENCY MEDICINE

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

### Eligibility

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

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

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

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

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

## Preview of GSACEP Conferences 2007

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

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

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

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

### Sunday, March 18:

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

### NEW THIS YEAR on Sunday, March 18<sup>th</sup>:

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

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

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

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

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

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

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

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

### Concluding Thoughts

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

# 2006 National ACEP Council Actions

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

## Summary of 2006 Council Resolutions

### Resolutions Not Discussed by the Council

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

### Resolutions Defeated (D) or Withdrawn (W)

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

### Non-Bylaws Resolutions

Requires a 3/4 vote is required to amend or overrule.

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

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

### Bylaws Resolutions

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

### College Manual Resolution

Requires a simple majority vote for adoption.

- Resolution 5 Eligibility Criteria for Fellow Emeritus

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

#### Resolution 4 Fellow Emeritus (as amended)

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

#### Resolution 5 Eligibility Criteria for Fellow Emeritus

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

section:

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

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

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

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

#### Resolution 16 Universal Basic Health Care (as amended)

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

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

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

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

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

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

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

#### Resolution 22 Egregious Testimony (as amended)

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

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

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

#### Resolution 24 Emergency Department Leadership (as amended)

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

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

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

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

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

(Continued on page 7)



## ADVOCACY IN THE FAST LANE PART TWO

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

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

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

### **Write to your Congressman**

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

Actually speak to your Congressman

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

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

### **Letter to the Editor**

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

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

### **Donate to NEMPAC**

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

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

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

### **Serve on a Task Force**

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

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

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

## GSACEP WELCOMES

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

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

## Research Point of Contacts

United States Army Medical Research Institute for Infectious Diseases (USAMRIID)

MAJ Kermit Huebner  
[kermit.huebner@us.army.mil](mailto:kermit.huebner@us.army.mil)

Uniformed Services University of the Health Sciences  
MAJ Chetan Kharod  
[ckharod@usuhs.mil](mailto:ckharod@usuhs.mil)

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

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

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

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

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

**Army**  
Carl R. Darnall Army Medical Center  
Research Director: MAJ Alex Rosin  
[Alex.Rosin2@CEN.AMEDD.ARMY.MIL](mailto:Alex.Rosin2@CEN.AMEDD.ARMY.MIL)

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

## Council Actions (continued from page 5)

### Resolution 27 Responsibility for Admitted Patients (as amended)

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

### Resolution 28 Psychiatric Bed Availability (by substitution)

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

### Resolution 29 Procedural Sedation (as amended)

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

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

GSACEP

328 Eighth Avenue, Suite 142

New York, NY 10001

[WWW.GSACEP.ORG](http://WWW.GSACEP.ORG)