



# MEP NEWS

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June, 2003

*"Montgomery Emergency Physicians is the recognized leader in providing exceptional emergency medical care. We improve the health and promote the well being of the individuals and organizations we serve."*

Montgomery Emergency Physicians, LLC.

## Patient Satisfaction – Everyone Be Happy!

We recently received the latest patient satisfaction scores from the Jackson Organization. Congratulations are in order for everyone! The overall raw score of 4.09 is above the 4.02 in the previous period and places the department in the 87<sup>th</sup> percentile for Emergency Departments. Both the Main ED and Pediatric ED increased their overall raw scores placing them in the 85<sup>th</sup> and 91<sup>st</sup> percentiles, respectively.

The words "patient satisfaction" evoke strong feelings in most of us; quality of care, pressure to meet expectation, would you like fries with that.....! We all have been "doing" patient satisfaction for a very long time. A question that may be fairly asked is what difference does it make? Some may say, "I take good care of patients, as quickly as I can and move on to the next patient". "Isn't that enough"? For some, I confess, it is. For most patients, however, the

provision of high quality care includes attention to many aspects of care; patient satisfaction among them.

For me the magic of emergency medicine rests in our ability to gain our patient's trust. It is, I believe, a gift most experienced emergency medicine providers learn early in our careers. Some use humor, others are able to intensely focus and listen to our patients, still others go above and beyond to assure follow up. We each have our own strengths and leverage them to build trust. Once that is established our patients are more likely to follow a prescribed course of treatment and follow up as suggested. They may even find that they have enjoyed the experience! Which brings it back to each of us and the job we do daily. When you are running flat out, trying to treat patients, juggle phone calls from private docs and find multiple lab values



and X-rays, ponder this simple snapshot. A patient you've just cared for is walking out of the ED, stops for a moment and turns to come over to you. They extend their hand to you, look you in the eye and say, "thank you for really caring about me". I don't know about you, but those are some of the moments which make my day.

You may see some of the FISH philosophy sprinkled above (Be There, Choose Your Attitude, Make Their Day and Play). Seems like a great motto for caring for patients and each other. Keep up the great work and.....  
*Congratulations!!*

**-Angelo Falcone, MD**

### MEP LEADERSHIP

**MEP President**  
David G. Srour, MD  
**Emergency Department Chairman**  
Angelo L. Falcone, MD  
**SAAC Director**  
Julia LaJoie, MD  
**Director Pediatric Medicine**  
Scott Freedman, MD  
**Staff Development**  
David N. Klein, MD  
**QI**  
Brett A. Gamma, MD  
**Web Services**  
Thai McGreivy, MD  
**Director of Mid-level Providers**  
Mark Kline, PA

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## *Pediatric News: Scott Freedman, MD* Spring 2003 Neighborhood Service Projects

One of our principle goals at MEP is supporting the mission and vision of Shady Grove through stewardship. To that end, we recognize how vital it is to reach out to our neighboring community. With only a little effort, we can serve as role models and educators to the children and families of Montgomery County. This spring we provided the following service projects:

- Adrienne Suggs MD – in early March spoke to juniors and seniors at Sherwood High School for Medical Careers Program as part of the Montgomery County School System.
- Scott Freedman MD, Dermot Garrett (Patient Care Rep), Fabiola Sanchez RN, Nancy Polansky RN, Holly Wimpee EDT, Gus Keriakos EDT, all participated in



"Every 15 minute Alcohol Awareness" Program

the Montgomery County "Every 15 minute Alcohol Awareness" High School Program on March 31st. This year Wooten High School was featured. Our role was to conduct an "unsuccessful" mock resuscitation of a teenage drunk driver. A videotape will be provided for the

high school students and will be shown as part of a senior assembly as well as over the Montgomery County cable network. The goal is to present a graphic depiction of the risks associated with acute alcohol intoxication.

- Dr. Nicole Carter participated in Career Day for 8<sup>th</sup> graders at Martin Luther King Middle School in Germantown this past month. Nicole met with 4 different middle school classes and shared with them her training and experiences as a pediatrician.
- Dr. Suggs presented a lecture on child sexual abuse at the Governor's Conference on Responding to Child Maltreatment in Baltimore on April 29th.

## Spring Update

- On April 24<sup>th</sup>, we held our 2<sup>nd</sup> annual Pediatric Roundtable for which a group of 12 local community Pediatricians participated. The goals and direction of the Hospitalist program were explored.
- Annie Soriano MD will be spearheading a new Pediatric Mock Code Program along with Susie Kline PA-C, Karen Chung RN and Debbie Pingpank RN. The four of

them are developing a program with plans to conduct two mock codes monthly (one in-patient, one in the ER) using our new high-tech Pediatric Mega Code Kid. The resuscitation mannequin was purchased with SGAH Foundation support and can be used to simulate intubations, IV line placements and cardio versions. Formal competency measures will be used to gauge the process and improvement of our entire staff.

- Adrienne Suggs MD will be coordinating a Pediatric Emergency Department Education program. Plans are to provide the staff with monthly didactic talks, timely for the season. In May, Dr. Suggs is scheduling a lecture on Pediatric Trauma; In June Drowning/near drowning. A full schedule will be posted online and in the department.

## BIO-TERRORISM TRAINING FOR SHADY GROVE ADVENTIST HOSPITAL

On Thursday, March 13, 2003, twenty-one eager Shady Grove Adventist Hospital employees met at the Montgomery County Public Service Training Center for eight hours of an Operations Level course in Managing Hazardous Material Emergencies.

This timely training program included sessions on current hazardous materials emergency laws and regulations, hazardous material recognition and detection, hazard and risk evaluation, worker protection, decontamination and terrorism awareness.

*David Klein,  
MD participates  
in  
Bio-Terrorism  
Training,  
photograph at  
right*



"Be afraid, be very afraid..."

## Mark Madness: Mark Kline, PA

### LIZ HALE

Selected as one of  
100

EXTRAORDINARY  
NURSES FOR 2003

Congratulations to

Liz! Gamma Beta  
Chapter of Sigma  
Theta Tau

International, the  
Honor Society of

Nursing at Howard  
University is pleased  
to announce that Liz

Hale has been  
selected as one of  
the 100

Extraordinary nurses  
in the Washington  
Metropolitan Area.

Okay race fans, I'm trying out a new idea for our quarterly newsletter. My idea this time involves some possibly helpful hints for simple problems. A few of the ideas are my own, others I have obtained from reading. So sit back, relax and enjoy, and as always, your comments are appreciated. Not that I could stop any of you.

- Ticks Are For Kids - when removing ticks from other homo sapiens, I gently pull up on the parasite and turn over clock-wise which eventually releases the mouth from the skin. This is a tried and true technique. In fact, I believe that I am 57 for 57 using the above method. Remember if you are below the equator you must turn clock-wise or the technique will not work. In cases where the mouth is buried in the flesh, it becomes more difficult to remove. A whorl of anesthesia should be made under the tick. Next stick a 27 gauge needle through the skin just underneath the foreign body, lift up slightly and cut the skin away just underneath the

needle. Make sure no part of the parasite's body remains. Use the ophthalmoscope to look at the site.



You can magnify the area up to 40 times with these instruments making sure no part of the piece of the pesky critter remains.

- Do You Mind Seeing That Nose Bleed.....Not any more.....well I would not go that far. How hard is it to get anyone to pinch his or her nose for 10 minutes, much less an elderly person! How often have I said to myself, "Mark you are a mas macho". No wait, that was a different conversation. Anyway, I always thought wouldn't it

be great if someone would invent something to pinch a nose for me. Well in the February issue of Emergency Medicine, a Dr. Pau Gild sent in a kit where he takes 2 tongue depressors and tapes them together one third of their length. He then slips the un-taped end over the nose and leaves it in place for 10 to 20 minutes. Dr. Gild states that this stops most new pathological bleeds. Why didn't I think of that?

Squeeze Me??? It's not rocket science people..... If you have a dirty wound as the old adage goes, "Dilution is the Solution to Pollution". Instead of getting a liter bag of normal saline, IV tubing and some type of plunger mechanism, I take scissors and poke a hole in an un-opened liter of normal saline. Careful not to drive the scissors into your other hand!! After you have placed a hole in the cap simply tip the bottle upside down and irrigate away. It's cheaper; you save a ton of time and you get plenty of pressure to properly irrigate dirty wounds. Have fun gang!

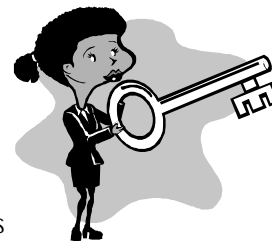
## Meet your Support Staff: Patti Tam, Administrative Assistant

Patti Tam joined Montgomery Emergency Physicians in January, accepting the position of Administrative Assistant. Patti was born a mid-westerner in Ohio. She received her education in physical education and art appreciation. Patti moved east with her family 16 years ago. Her first job in the area was in a teaching program. Later, Patti moved into retail business management and then to Shady Grove Adventist Hospital.

Patti has worked in hospital administration at Shady Grove for ten years initially supporting the nursing department and then the hospital's chief financial officer. Her extensive awareness of the hospital and its processes is an asset in her position; she seems to always be able to answer an inquiry or knows where to get the requested information.

Fondly referred to as Bat Girl by a MEP partner, you will need to make

inquiries to understand the moniker; Patti combines affability and ability with a professional and polished carriage daily. Her primary responsibilities include managing the professional schedules of both Drs. Srour and Falcone and coordinating the day-to-day activities in the management offices for MEP. Patti has a grown son and lives in Gaithersburg.



## Recent Patient Satisfaction Survey Results: Susan Boch, Practice Administrator

The Jackson Organization: Survey and Research Consultants, SGAH's Patient Satisfaction Organization, recently published the Dec. 2002 – February 2003 patient satisfaction survey results for the Emergency Department. The Emergency Department has received exceptional satisfaction ratings. Both the Adult and Pediatric treatment areas received a "Celebrate" for every area of satisfaction measured by the survey. Both the Adult and Peds ED rated above the 85<sup>th</sup> percentile nationally.



One hundred and forty three patients were sampled for the survey, with over 75% indicating a "completely satisfied" or "very satisfied" response to their ED experience.

Based on patient feedback obtained during December 2001 through November 2002, the following attributes are found to be most highly correlated to overall. Emergency Department patient satisfaction at Shady Grove Adventist Hospital:

How safe you felt that the patient would receive the proper care (r=.72)

How well the hospital did at meeting its mission during the emergency visit (r=.71)

The total amount of time spent in the facility from arrival to discharge or admission to the hospital (r=.63)

How well the staff kept the patient informed of any delays in care and/or treatment (r=.62)

How well the staff kept the patient and family informed about the patient's care and condition (r=.59)

This kind of overwhelming patient satisfaction can only come from an ED team that is committed to being the best; every day and with every patient encounter. The coordination of efforts between the physician, nursing and support staff shines through given these recent survey results. Thank you to each individual who approaches their work every day with the dedication and the desire creating an environment of continuous improvement. Let's keep building on our successes by continuing to help our patients learn what we already know: that Shady Grove Adventist Hospital's ED is the emergency department of choice.... the best care provided by the most skilled and compassionate staff available!

**Remember!**  
You can find us  
on the web at:  
[www.meped.net](http://www.meped.net)



## AHMA NEWS: The Paper Chase, Tynia Sites

Just about everyone knows that E.R. records at Shady Grove are scanned, but not many people know the process behind it. Here's a description of the scanning project as it is now.

Charts that are scanned today are records for the prior days' patients. Kim or Ann (Potteiger) use the ED "log" to alphabetically match charts to the names on the log. If a chart is missing, the disposition of the patient is checked, eliminating elopements and direct admits. Missing chart data, such as patient name, MR#, etc. is recorded and the chase is underway! While Kim begins her search, Ann takes half the charts and starts her job functions. Once Kim has located the missing chart (s), they are

assimilated into the rest of the days' records and Kim starts scanning, swapping charts with Anne. When the entire days' charts are scanned, the original medical records go to the medical records department. The chart "files" or images are "burned" to a CD named the date of service (i.e., the CD for April 1<sup>st</sup> charts is named 04-01-03). The CD is picked up by AHMA's courier and delivered to our Germantown office where the TIF images are converted to PDFs. The images are "batch printed", a paper chart is generated and the images are indexed into a medical records database. The paper charts are again matched to the E.R. log for accountability and then given to one of AHMA's Certified Coders for coding. Any chart that needs additional documentation is set aside for return to the provider. The MR#, provider name and

reason for the return are entered into a database for record keeping purposes and the charts are returned to the provider for completion. Once done, they are scanned to an "R" file CD and the paper charts are returned to the coder for completion of the coding and billing process.

Despite everyone's best efforts, sometimes charts just seem to disappear but with the scanning process described above, the number has dramatically decreased; to less than ten per month. Soon AHMA will join forces with Adventist Healthcare to share scanning responsibilities, allowing further enhancements to the scanning project at Shady Grove Hospital...Stay tuned!

## Coaching: David Klein, MD

Last year MEP launched and began to implement a “coaching program.” “Coaching” is more than just an evaluation process. The idea is to ascertain how we can all improve at what we do. Through this process, we will continue to improve our strategic plan for the coming months or years. It is a way to build a road map to success. This is a “strategic plan” for the individual and the goal is to learn from each other and continuously strive for excellence.

We have been working on the criteria to look at and what our benchmarks should be during this past year. I’ll share the idea as well as the methods we devised, but first, one must always be cognizant of the expectations and desires of the true customer: the patient. MEP in conjunction with PSR has been working on creating a method to accomplish this task in as an objective way as possible taking into the customer’s expectations. It goes without saying that the actual clinical care must be excellent, but it must all be provided in a timely fashion, be recognized as such by the patient and do so in a team approach taking into consideration all that is occurring in the

Emergency Department at the time. It is easiest to break this down into broad categories and state how they are measured.

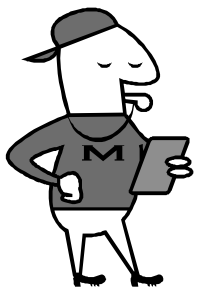
- I. Medical Management
  - ⇒ Bad outcomes
  - ⇒ Return visits within 72 hours
  - ⇒ Any cases reviewed at QI committee
  - ⇒ Internal chart review using a WEB based QI system
- II. Delivering the clinical care in a timely fashion
  - ⇒ We measure patients seen per hour
- III. Documentation
  - ⇒ RVU per hour
  - ⇒ Percentage of unsigned charts
- IV. Customer Service
  - ⇒ Performance on patient satisfaction scores from the PSR survey
- V. Team Management
  - ⇒ Performance on peer and staff surveys

All of the above data is gathered and collated so each individual can see their standing as compared to the rest of the group. I meet with each MEP provider

(NO EXCEPTIONS) three times a year to review the data during a one-hour session. In categories scored high, I ask the “coachee” advice we can share with others on how they achieved this success. In the categories where the individual scores low, we discuss potential reasons for the low scores as well as discuss methods to improve. At the end of each session, we reach conclusions with action plans to implement. I’d like to emphasize that coaching is not solely addressing negative performance. It provides the team with the information they need to be successful at their job. A coaching session is an opportunity to create a positive winning climate by clarifying goals, prioritizing tasks, listening to ideas and providing recognition.

Please send me any comments on the coaching process or any suggestions to improve it.

I want to conclude with a quote from probably the greatest coach of all time, John Wooden. *“Success is a peace of mind which is a direct result of self-satisfaction in knowing you did your best to become the best you are capable of becoming.”*



## Coaching– A Personal Reflection: Angelo Falcone, MD

One of the most powerful processes anyone can undertake is that of setting personal goals. As an organization, the process of goal setting provides focus and clarity as we react to the day to day crises and challenges.

One of the commitments our leadership has made is for each of us to be coached. This is important for two reasons.

1. We all have areas of strength and ones to improve as clinicians. We need to honestly evaluate and recognize these areas.
2. It is important for everyone in our organization to be measured by the same standards.

I am happy to say many of us have been through coaching this year. Those

that have not will do so in the next several months.

What have I learned? Primarily this is a powerful process. Seeing how you compare to your peers is a strong motivator for change. In an effort at full disclosure, it may be helpful to list my three areas to improve over the next year.

1. Sign Outs – I will make an effort to be more complete and concise during sign out. I also need to fight end of shift “fatigue factor” and keep energy up until the end of my shift.
2. Focus on increasing RVU per patient by paying more attention to documentation and charting.
3. Make an effort to increase visibility in the department during administrative days.

My areas of strength are patient and staff satisfaction. High scores on the

peer survey.

Why am I sharing the above information? One of the great things about MEP is that each of us is willing to be measured and challenged to improve the quality of care we deliver. Part of the intent of this process is to stimulate a dialogue and exchange of information. I’m very good at A and B, but need to improve X and Y. Your strengths are in these areas. How do we transfer this knowledge whether improving TAT’s, patients per hour or staff satisfaction? We have a responsibility as a community to share these practices to improve the overall quality of care we deliver.

Part of our mission statement is that we “improve the individuals and organizations we serve”. Coaching is integral to this process. I invite each of you to embrace it and provide specific feedback on how we can improve.



## Monthly ED Review Committee and PI Committee Letter: Brett A. Gamma, MD

I would like to take the time to explain some of the procedures our ED review and PI committees go through each month and some of the markers that we follow. This will also be a helpful refresher for everyone else as well.

First, I would like to explain the ED peer review process. We meet every other month to discuss cases. All are invited to attend. The entire year's schedule has been set; dates and times are available in Shahana's office.

### Cases are reviewed for the following reasons:

- All return visits within 72 hours that require admission or transfer, or death.
- Unexpected death within 24 hours of admission to the hospital from the ED.
- Case is referred from the admitting, primary or consulting physician regarding care.
- Case is referred from hospital PI or hospital QI.
- Patient complaint that is significant enough that ED review is required.
- A member of the nursing staff or anyone in the department refers case.
- Case is referred by our billing company.
- Case is referred by another department or floor (i.e. Radiology, Med/Surg, ICU, etc.) regarding care of a patient
- Transfer to a higher level of care shortly after admission to the hospital.
- Other

The reviewer first screens the cases and interesting cases are presented in the meeting. Cases are discussed and then given a standard of care score (I-IV) and an outcome score (A-D).

### Standards of care scores are as follows:

- I. *Standard of care met no problem with process or documentation.*
- II. *Standard of care met but documentation inadequate to support standard of care.*
- III. *Controversy among physician reviewers whether standard of care was met.*
- IV. *Standard of care not met.*

### Outcome scores are as follows:

- A. *No effect on outcome.*
- B. *Minor effect on outcome: problem allowed disease or symptoms to progress temporary or reversible.*
- C. *Major adverse outcome: problem resulted in reduction of longevity, functional quality of life, or adverse reaction by medical action or inaction.*
- D. *Major adverse outcome: death at tributable to acts of omission or commission.*

A causal analysis is subsequently performed on outcome scores of B, C, or D. A variety of actions may or may not then be taken by the committee. The most common type of actions taken are either none or a letter of explanation is requested from the physician of record. Letters are then reviewed and scores may or may not be changed. Other actions can be taken such as independent chart reviews of practitioners, in-service presentations on specific topics, or the case may be presented in the department meeting.

Second, I would like to discuss some of what we do in the PI meeting. I like to break it down into three areas: required MHA data, required hospital PI information, and ED PI yearly markers.

The Maryland Hospital Association (MHA) requests a certain list of information from all hospitals. They use this data to compare ourselves to other Maryland hospitals and to compare ourselves to similar volume facilities. It is difficult to do however because there are very few hospitals with a large number of ED visits with a small number of inpatient beds. The data currently

being compared is:

- length of ED stay greater than 6 hours
- number of return visits within 72 hours
- number of return visits within 72 admitted divided by the number of return visits within 72 hours,
- number of x-ray discrepancies that require a change in treatment
- the number of patients who either leave AMA or without being seen

PI Committee supplies the hospital with the data for the above 5 markers as well as three others; conscious sedation cases, completion percent of AMA charts, and completion percent of restraint sheets. All the conscious sedation charts are reviewed, but a case "falls out" when there is a need for anesthesia intervention, a need for a reversal agent, a marked deviation of the patient's pre-procedure vital signs, a cardinal event occurs, a patient is subsequently transferred to a higher level of care, or recommended medication doses are exceeded. AMA charts are reviewed for percent completion of the AMA form and that discharge instructions were given to patient. We also report the percent of completed restraint forms including the areas of deficiencies (i.e. no MD signature, no nurse signature, type of restraint, not completed at all).

The third component is the yearly ED PI markers. During the first quarter of 2003, you all heard me speak intensively about repeating vital signs. Vital signs should be repeated by nursing when initially abnormal, after a visit in the ED exceeds 4 hours, or after narcotic pain medications are given. This was our PI marker for the first quarter. We were able to reduce the deficiency rate from more than 30 percent to less than 5 percent. It remains an area of importance and will be intermittently checked with audits of charts. For the second quarter, we will concentrate on door to EKG time. Pediatric markers will be coming. I welcome any input for future markers that any of you may feel are important.

## MEP's Philosophy: The Responsibility to Market Ourselves: Julia LaJoie, MD

When most people think of marketing they think of newspaper ads or radio spots. These are useful methods to inform the community we are here at SGAH and are the best ED in Montgomery County. We want marketing to be a more global goal than that at MEP. Every patient we care for is evaluating the way they are treated and how they perceive the quality of their care. Every nurse, medical technician, and secretary that we work with is evaluating not only our quality of care but our compassion for the patients we care for and the way we treat the team with whom we are working. When the medical staff send us their patients they are not only trusting us to give the highest quality care they are trusting us to make them look good for referring to a place where their patients are treated with care and compassion. When you look at marketing this way, it becomes a goal loftier than smiling faces in a print ad; it becomes a philosophy of how we work. Every patient encounter becomes an opportunity to "market" MEP. Every interaction with a team member; be they nurse, technician, secretary, or any other ancillary staff in the hospital becomes an opportunity to let them feel that MEP employees are the best (and most fun) with whom to work.

One source of information of seeing how you are perceived as a practitioner is to read the comments in the patient satisfaction surveys which can be found on the PSR website. Here are a few things I learned about how patients perceive my care and others' by reading these patient comments.

- Patients don't like to wait and will tolerate the wait if you do two things:
  1. Apologize for their wait and thank them for their patience.
  2. Let them know you are there for them, i.e. avoid looking rushed, sit down, make

eye contact.

- Communication is key: A good explanation up front and at the end of the visit really helps with the patient's perception of the quality of care. Explain what you think their diagnosis might be and what tests you are going to do to confirm this. Explain how long you think they might be waiting, where the bathroom is, and that they can use the telephone. The most important information may be to find out what they think the diagnosis is or what concerns them the most.
- Think what you think. Patients know when your opinion is unfavorable of them even if you don't say anything negative. Much of what we "say" is non-verbal so try to catch yourself making a value judgment about people. Put yourself in their shoes. A personal example; a mother came up to the secretary in pediatrics and implied that we had forgotten about her son and that if she had not reminded us about him she would have still been waiting. After initially feeling defensive, I explained nicely that we had a sophisticated computer tracking system and that we knew where all the patients were in the department at all times. I then watched her aggression melt away as I recognized that she was worried about her son's chest pain. I reassured her that I would make sure that the pain was

nothing serious. In my mind I went from thinking of her as a "jerk" to thinking of her as "a loving mother who was advocating for her kid". By the time the family left they were smiling and thanking me. I also felt much better about the encounter and my whole shift wasn't ruined by a negative encounter. The moral of the story is that focusing on this patient's customer satisfaction ultimately benefited me.

Another marketing goal is the formation of an informational brochure for our patients explaining who we are and what we do as emergency care providers. Stay tuned!

### You're Invited....

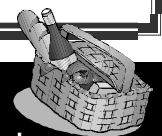
Pediatric & Emergency  
Department Personnel,

Please bring your family and join us for an  
afternoon of fun!

**Annual MEP picnic**  
**Sunday, August 10th, 2003**  
**Noon**  
**Bohrer Park, Gaithersburg**

The picnic facilities include a pool, a goofy  
golf course, a playground,  
and ball field.

\*RSVP required by June 20  
to Shahana Chaudry  
at 301-279-6578.



### SAAC UPDATE

When patient is listed as a SANE evaluation in the EMSTAT list please make sure they don't also need a medical screening exam. SANE nurses can help even in pediatric cases by assisting with any photo or video documentation of the examination.



## Meet The MD: Leslie Mitchell, MD

Leslie Mitchell has been a pediatrician with MEP for since 1997. She has seen

our Pediatric Program grow from a small unit to the 24/7 operation it is today. Dr. Mitchell is considered one of MEP's pediatric resources and recently earned her board certification in Pediatric Emergency Medicine.

Dr. Mitchell completed her residency in 1986. She was working at Henry Ford Hospital in Detroit, Michigan when a series of family illnesses required her to return to the east coast to assist as the family caretaker. Her family

has since recovered and we have the good fortune of having her remain in our area.

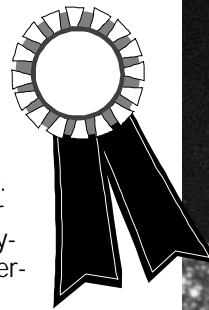
Dr. Mitchell finds pediatrics a rewarding specialty; managing the fears and expectations of frantic parents is her greatest challenge. Relieving parental guilt over a sick child, helping them understand illness and teaching them so that they are comfortable with their child's illness at discharge are some of the issues she manages daily.

She credits her calm demeanor with her ability to function so well with parents and children. and finds working with small children particularly rewarding. "They seem to still like you" .... after you have caused them the natural distress of having a stranger approach, examine and maybe even cause additional discomfort during their ED evaluation. A happy child leaving the department with their parents is her most rewarding experience.

## Pam Fox Named "Emergency Nurse of the Year by ACEP

The Maryland Chapter of the American College of Emergency Physicians has chosen Pamela Fox as their 2003 Emergency Nurse of the Year. Pam has been an emergency department nurse for 30 years, 24 of them at Shady Grove Adventist Hospital. In addition to regular nursing duties in the Pediatric ED at SGAH, she currently shares the role of interim Pediatric Coordinator for the Emergency Department and serves as a nurse preceptor. Pam received her RN diploma from the Washington Hospital Center School of Nursing in 1973 and her BSN from the University of Maryland in 1996. Pam has also received specialty certification as a Certified Emergency Nurse (CEN).

Congratulations Pam!



PAM FOX  
"EMERGENCY NURSE OF THE YEAR"



### Montgomery Emergency Physicians

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Anywhere"**

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