



VOLUME 8 / APRIL 2008

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# MEP *Excellence in Emergency Medicine*

## Connections

### ANGELO FALCONE, MD

Connections - our lives are full of them. I know someone who knows someone who knows someone. There is a game called "Six Degrees of Separation" where you must connect the actor Kevin Bacon and any other actor through the shows or films they have worked on. It works! It's remarkable to think of how we are all connected. Living in a major metropolitan area we tend lose this sense of connection to each other and our community. Walking past people we often hesitate to smile and say hello for fear of making that "connection".

Consider working in the ED on an average day. Take an average of 18 new patients per day, double that for family members (and double that in the pediatric ED!). Potentially we interact with 35-60 new people each time we work a shift. Working approximately 14 shifts per month means we directly touch 7500 new people every year. Over a 25 year career we will each connect with 200,000 other souls. WOW!

So what's the point? The point is each persons ability to influence other human beings is magnified as our circle expands. Just as a small investment over time pays

huge dividends, the impact each of us has on our world cannot be overestimated.

The current edition of our newsletter addresses the impact we have as individual practitioners in the ED as we try to improve the care we provide. With concepts such as the "triage doc," to raising our quality of standards by knowing the latest literature in pediatric emergency medicine we acknowledge this impact. It also speaks to the community impact we have as we respond to larger issues such as smoking cessation. We even touch people around the world as we have done through the connection to the medical Support Battalion, 1<sup>st</sup> Brigade Combat Team of the 3<sup>rd</sup> Infantry Division in Iraq.

We live and connect in the communities we serve. We see the patients and families we have treated at Safeway and Home Depot, in our places of worship and our kids' soccer games. Our intent should be to make the world a smaller more intimate place instead of less personal and more removed. Each of us can decide to do that the next time we are walking down the street. Perhaps it will be just the human connection that people need to get through the day.

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## MEP "Excellence in Emergency Medicine"

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

## IF WAITERS CAN DO IT...

### DAVID KLEIN, MD

Introductions, first impressions. The first part of the encounter is very important.

Last summer, Michele and I ate in an upscale restaurant in Beaver Creek. They had an interesting service system using a team approach. A waiter took our order and we did not see him again until payment time. Between the order and payment, there were many different servers who brought our drinks, appetizers, main course and dessert. It appeared to work well but when we wanted something during the meal, there didn't seem to be any one person fully responsible for us and we were hesitant to ask.

Most restaurants utilize the man to man approach, one waiter assigned to your table for the duration of your visit.

"Hi, my name is Brad." I will be your waiter. "Good evening. I am Tiffany, your server." "Hi .my name is Jack. Did you get a chance to look at the menu?", "Hi. My name is Jessica .Let me tell you about our specials."

"Hi. I am Dr.Klein. What seems to be the problem?", "I am Dr. Klein. Can you tell me a little bit about your chest pain?", "I am Dr. Klein. What brings you here today?"

All of the above are adequate introductions. However, there is a better way.

Yesterday I ate at a Cheesecake factory and the waiter introduced himself the following way: "Hi. My name is Joe. I will be taking care of all you while you are here. Before I tell you our specials and give you time to look at our menu, is there anything that you need right now?"

Wow! I can tell you that they also had a different person bring out the order but I knew that JOE was responsible for taking care of ME, not just my food.

Let's put ourselves in the patients' shoes, better yet put your self in their gurney. You are scared, anxious, in pain and you want to be comforted but most of all you want to have confidence that you will be taken care of.

"Hi. My name is Dr. Klein. I will be taking care of you while you are in the ED. Before we get into the details of your illness, is there anything that you need now?" Much better. A little extra thoughtfulness goes a long way. It says a lot more and doesn't take any longer.

## Care Packages For Our Troops

### ERIK SCHOBITZ, MD

Have you ever wondered what one group of people over here could do to help some of our troops in Iraq? Soon after starting my employment with MEP this past summer I was contacted by a

US Army medic in Iraq with a request for help – not so much for clinical expertise but for things to make life easier for him and his men. It was a simple request, for little things like coffee, freezer pops, toothbrushes, good razors, socks, and the like; but for the 20 medics as well as the docs, PA's , and staff of the Support Battalion, 1st Brigade Combat Team of the 3<sup>rd</sup> Infantry Division in Ramadi, Iraq - these "luxuries" were few and far between.



For those not intimately familiar with the geography of the Middle East, Ramadi is west of Baghdad and just northwest of Fallujah across the Euphrates River. It is part of the so called "Sunni triangle" in the Anbar province. Staff Sergeant Jason Yurek – my friend over there – is on his second 15 month tour, some of his medics are on their third. His first email was the day they arrived after a suicide bomber had sent them 61 civilian casualties – welcome to the desert! At the time of his arrival this was considered a hotbed of the resistance and Al Qaeda.

After talking with a few of our colleagues I sent out an email to enlist help from the group to send one small package. This however was not to be the case – for as Scott Freedman told me "I think you'll be amazed at the response". Now after three shipments, at least 5 large crates of supplies, and well over \$2000 in donations from MEP as well as several of our nurses and their families, I have seen what one group of people can do! So many people have donated that I cannot begin to name names so take this as a blanket – THANK YOU and a big way to go for MEP and also for the nursing staff at Shady Grove, you have all helped bring a little comfort and normalcy to those who fight for our country in a dangerous part of the world.

## Triage, A New Frontier

### THE DOC IN TRIAGE CONCEPT

DAVID SROUR, MD

If you're anything like me, what goes on in triage is a bit of a black box. Somehow the triage Nurses are able to get a lot of information in a short period of time and accurately determine the priority of the patient. In a perfect world patients would go right back to an appropriate treatment area after triage. Since this is usually not the case, patients sit in the waiting room, sometimes for hours. Obviously this is a suboptimal situation that has many factors both intrinsic and extrinsic. Some of them are fixable i.e. improving and streamlining other ED processes, particularly length of stay of admitted patients, and others do not have ready solutions. A novel approach that has been successful in many ED's around the country has been to place a provider in triage. The doctor or MLP in triage works closely with the triage RN and is able to begin evaluation and treatment in the Waiting Room. This has several important benefits:

#### **Parallel processing:**

Leveraging time in the Waiting Room. Most other things we do in the Emergency Department are done in parallel. Waiting Room time is usually wasted. Appropriate testing and treatment can begin while the patient is waiting for a treatment bay. Some patients can even be discharged from triage.

#### **Patient Safety:**

Subtle or unusual illnesses may be recognized earlier.

#### **Patient Satisfaction and the Upfront Wait:**

Waiting is the number one reason that patients are dissatisfied. It is a well understood concept that certain parts of waiting are perceived as longer than

they actually are. The upfront wait or time before a service is the most significant. Boredom has been defined as becoming aware of the passage of time itself. Why does it seem like a watched kettle never boils. Time in the Waiting Room is a watched kettle. This is made even worse when a patient is in pain or worried about what's wrong. The wait also colors the rest of the Emergency Room experience and things that would have otherwise been minor glitches, like the need to redraw blood, add to the frustration and are unnecessarily amplified. Since patients will be seen by a physician much sooner, often within minutes, the whole dynamic changes. Happier patients make for a much more pleasant work environment for everyone.

#### **The Left Without Being Seen**

(LWBS) rate will decrease: this is a patient safety concern as studies have shown many LWBS patients need to be seen urgently. Additionally LWBS represents a significant loss in revenue. The flip side of LWBS is that census will increase as word gets out that the Emergency Department has dramatically improved their level of service.

We have recently started a trial version of a "Doc in triage" at Shady Grove Adventist Hospital. Every hospital has its own specific needs and nuances and there is not one size that fits all. The key to success is to being flexible and patient. The Emergency Department staff needs time to get used to a new way of doing things and this takes effective communication and time. Adjustments will need to be made on the fly. The benefits of this new approach, however, will quickly be obvious to everyone.

## A NEW APPROACH

Aaron Snyder, MD

You may have noticed triage has changed recently at Shady Grove Adventist Hospital. Every day of the week, from 1pm to 9pm, a physician is in the triage area. Why are we conducting a trial, you may ask?

MEP, in conjunction with the hospital administration, is piloting a program to pair a doctor and nurse in the triage area to evaluate, assess, initiate care, and if appropriate - discharge patients from triage. This new unit is called the **RTU – Rapid Triage Unit.**

Our goal in this unit is to expedite patient care the moment they are seen in triage and to monopolize any time spent in the waiting room in the patient's care. We have already seen an increase in patient satisfaction as people are pleased to see a physician so early in their ED visit. By having a physician in triage, we have also made early diagnosis of life threatening conditions in patients who present in subtle manners. A ruptured ectopic pregnancy and spinal cord compression were recognized in the RTU in the first week of its existence.

In the RTU, patients can receive IV fluids, medications, antibiotics, laboratory testing, and diagnostic imaging. It is particularly effective during high census times or high ED acuity, when patients normally may have to wait in the waiting room. The RTU has decreased patient waiting room times and "door to doctor" times.

MEP would like to thank everyone for their support in this trial to improve the care of our patients. We hope the RTU will continue to make a positive impact in the lives of the patients and community we serve.



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# Three Articles to Refine Your Pediatric Practice

SCOTT FREEDMAN, MD

As we welcome 2008, I thought I would invoke my academic privileges as our PEM director by providing a review of three practical articles in Pediatrics and Pediatric Emergency Medicine that may likely impact your daily practice. As I scoured the literature and considered the vast breadth of information and studies conducted and reviewed, I realize how challenging it is to remain current in our practice. I am sure I overlooked some very worthwhile original studies and reviews and I do apologize in advance. Heck, should that be the case, there is always the next newsletter. Well here goes...

### Article 1

**Pneumococcal Bacteremia in Febrile Infants Presenting to the Emergency Department Before and after the Introduction of the Heptavalent Pneumococcal Vaccine.** Carstairs KL et al. *Annals of EM.* 43 (6) 772-777. The objective of this study was to compare the proportion of febrile children <3yo with pneumococcal bacteremia who received at least one heptavalent pneumococcal (Pneumovax) vaccine to those who received none. In the study, conducted over a 24 month period, 1428 infants had blood cultures obtained. 4.2% of infants had a positive culture (including those positive due to likely contaminated cultures). Out of 833 patients who received at least 1 Pneumovax vaccine, none of these children had a case of pneumococcal bacteremia while 2.4% of young infants who were unvaccinated to *Strep pneumoniae* had pneumococcal bacteremia.

For sometime I have been advocating significantly limiting blood draws (for CBC and blood cultures) as part of the evaluation of healthy young infants (3-

36mos) with acute fever without a source ( $T > 38.5C$ ). There are published studies similar to this one that helped prove efficacy of the Hib vaccine in providing protection against invasive *Hemophilus influenzae Type B* bacteremia. Though this study demonstrated the apparent benefit of only 1 immunization (usually given at 2 month of age) until there is more evidence based research and consensus statements issued, I suggest a cutoff equivalent to 6 months of age when most young infants have received 3 sets of Prevnar and Hib vaccines. Beyond that age, you should think twice about the merit of sending "routine" CBC / blood cultures as a part of the workup for immunized, well-appearing, febrile infants and young children. Further good practice would be to not simply accept "immunizations are up to date" as part of the history of these young infants. Rather either ask specifically if the baby has received 3 sets of Hib and Prevnar vaccines or review the shot record yourself.

### Article 2

**Dexamethasone and First Time Wheezers with Bronchiolitis.** Cornell HM, Zorc JJ Mahajan P A. *PECARN NEJM* 2007; 357; 331-339. This represents the largest pediatric study examining the question whether steroids have efficacy in the treatment of infants with bronchiolitis. Published in the acclaimed New England Journal, this multicenter, randomized controlled trial was conducted in EDs at 20 medical centers from 2004-2006. This study found no improvement in outcome in first time wheezers with bronchiolitis treated with Dexamethasone @ 1mg/kg compared to those infants who did not, There was

no statistically significant difference found in those bronchiolitis who required hospitalization as well as in the length of hospital stay.

When it comes to treating bronchiolitis and wheezing, other than a trial of inhaled beta-agonists such as albuterol there is still little evidence to support any other therapeutic modality. At that, even inhaled bronchodilators have been shown to statistically offer very little benefit if at all. Steroid use should therefore be generally limited to those infants with recurrent wheezing.

### Article 3

**Antibiotic Treatment for Pyelonephritis in children: Multicenter randomized controlled non-inferiority trial.** Monin G et al. *BMJ.* 2007; 335-386.

The objective of this study was to compare the efficacy of oral Augmentin for 10 days vs. Ceftriaxone for 3 days followed by 7 days of po Augmentin in the treatment of children 1 mo of age-7 years of age with a first episode of acute pyelonephritis. No difference was found in either study group when looking at the rate of subsequent renal scarring, time to defervescence, percentage with sterile urine along with other variables evaluated. As the title infers, this large, multicentered, randomized study was conducted in 28 pediatric centers in Italy from June 2000-July 2005. The results of this study support the use of oral antibiotics alone in the outpatient treatment of pyelo in infants and children as young as one month of age. I think as long as the child looks well, without vomiting or dehydration and with good close follow up, there is no reason we shouldn't be treating younger children

**Continued on next page-**

### Three Articles.. Continued from page 4

with first time pyelonephritis as outpatients. For really no "good" reason, until this study is repeated or accepted as the standard of care, I would be still be reluctant to treat febrile infants with pyelonephritis < 2-3 months of age as outpatients and do admit those in this young age bracket.

I look forward to an exciting 2008 for all of us and wish each of you health and happiness for this year. ... Look for more reviews in subsequent newsletters.

## We would love to hear from you!

Please submit  
your photos or  
article for our  
next newsletter  
to:

Patti Tam  
[ptam@ahm.com](mailto:ptam@ahm.com)

# SAVING LIVES

## JEREMY TUCKER, DO

As of February 1<sup>st</sup>, Maryland will go smoke-free in public places. Montgomery County may already be smoke free but this is a big change for Southern Maryland where tobacco has long been grown. It has generated much debate locally about personal freedoms. I realize the dangers of smoking have been widely publicized over the last twenty years including numerous lawsuits. The dangers of second hand smoking have not had as much press or attention. When was the last time you have asked a patient about second hand smoke in your social history? I can't remember that I have.

There was a great study done to attempt to determine the cost of second hand smoke in Maryland. This report by Hugh Waters of Johns Hopkins Bloomberg School of Public Health dated February 11, 2006 is available online and presents the calculated costs of second hand smoke exposure in the state of Maryland for 2005. The conservative cost estimates from second hand smoke exposure for childhood illness and death were \$73.8 million. For adults the figure was \$523.8 million. To emphasize, that totals nearly \$600 million for the year 2005 and that is just for second hand smoke!

Quoting this study, conditions in children related to second hand smoke include Respiratory Syncytial Virus (RSV), bronchiolitis, otitis media, asthma, and burns. Adults may suffer from lung cancer, nasal sinus cancer, cervical cancer, heart attacks, arteriosclerosis, stroke, and asthma. The statistics from this study show that bar or tavern employees had the highest rate of exposure at 97.8% of employees exposed. Restaurants with liquor licenses and restaurants without liquor licenses were second and third respectively.

The conclusion of this study estimated 1,577 adult and 24 child deaths in Maryland in 2005 were attributable to second hand smoke. This study presents very strong arguments on the dangers, and costs of second hand smoking for Maryland. Studies have been done for decades on the ill effects of smoking and second hand smoke, and this report cites many other studies that are available for review. The purpose of this report, in addition to directing lawmakers, is to educate the public on the consequences and costs of second hand smoke. As emergency medicine providers, we see these consequences daily. The pain and suffering of smoking related illnesses is enormous.

I am pleased that the State of Maryland passed a measure that will improve the health of the nonsmokers in the state, and frankly save lives. Please remember to educate your patients on the dangers of second hand smoke.



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# Learning Points From Recent Documentation Sessions

**BRETT GAMMA, MD**

- 1 As of 2008, Infusion/hydration codes are no longer able to be billed in emergency medicine. It is important to remember that both oral and iv hydration still do add to your medical decision making and re-assessment notes are helpful. You may still use the add-on progress T-sheet if you do not have adequate room for documentation in the space on the back of the original T-sheet.
- 2 You can use up to 4 diagnoses so list the most important ones. Be as specific as possible, ie rlq pain rather than abdominal pain. They do not pay more on their own, however they support higher level E and M codes that may.
- 3 You may also use presenting signs and symptoms as diagnoses. Recall the frequently used example of pharyngitis or URI, versus Febrile illness, difficulty swallowing, dyspnea. Abdominal pain may turn out to be constipation, and don't forget to list abdominal pain in the diagnosis.
- 4 In EM, it is difficult to justify non-acute care. Think of why the patient is presenting. When applicable, acute is a helpful modifier. For example, a rash for 6 months may be an "acute exacerbation of a chronic dermatitis". Other examples are "acute exacerbation of chronic abdominal pain", "acute bronchitis," "acute vomiting," "acute dyspnea," "acute dysphagia," etc.
- 5 In Peds, "worried well" is not the best diagnosis to use. Again, think of why the patient is there. Is it "observation after a MVC/fall" or a "Crying infant," or "acute febrile illness" even though only documented fever at home.
- 6 For now on, think of 2 pertinent positive or negative ROS instead of 1 and "the box" (all sys reviewed and neg). This way, if you forget to check the box it can still be a level 4 not level 3.
- 7 Recall the difference of level 4 vs 5 H & P is in the ROS (2-9 vs 10 or more), PFSH (1/3 vs 2/3 past, family and social hx), and exam elements (5-7 vs 8 or more). For pediatrics, good social questions are whether or not the child is exposed to second hand smoke, and who caretakers are (babysitter, parents, day-care, etc).
- 8 Recall the definition of critical care as a critical injury or illness that impairs one or more vital organ systems such that there is high probability of imminent or life threatening deterioration in the patient's condition. The chart should reflect this and the provider should circle the appropriate amount of cc time. Many examples were discussed (chf, acute chest pain/acs, croup, asthma, copd, arrhythmias, cva, gi bleeds, etc).
- 9 For MDM, backslash pertinent and appropriate diagnoses that you considered in your differential. For example, you did a head ct/lp and you ruled out SAH and meningitis so backslash them. Also be sure to document re-assessments (also time of), lab studies (nl or nl except or pertinent pos/neg all acceptable), radiology studies, discussions with family, pt, consultants and pmd's, review of records. They all add to your medical decision making and it is just good medicine.
- 10 Remember there is a caveat when history or physical are limited for a particular reason. Examples are pt too ill, pt intubated, pt with dementia, provider for child unavailable, etc. There are appropriate areas for these on both the T's and Bart charts.
- 11 Remember to do your neurovascular checks after splints are applied for all cases. This is also important to do and may be reimbursed.

## MOM

### JULIAN ORENSTEIN, MD

A couple of months ago I went through one of those important stages in life when my mother died. Although, at age 84, she had lost much of her memory and the intelligence that made her, *her*, Mom was still Mom. For the last year and a half, she lived near us at the Sunrise on Rockville Pike, which was great for two reasons: she was nearby (after living in New York and Stamford) and she received unexpectedly sweet loving care.

But we knew the end was getting near: she increasingly found it harder and harder to remember Dad's name, the man she had been married to for almost 50 years, and then me, my wife, brothers and kids names began to escape her. She stopped walking. She didn't even want to shop for her grandkids.

Every time something happened to her we were away. Once, she slipped and fell while I was taking my Board re-certification exam and, incommunicado for 3 hours, Mike Cetta and Vanessa took care of her with no way to get hold of me. Another time she was dehydrated and disoriented after an outpatient procedure and had to stay overnight. Dawn was her doc at that time. After that, clear sailing for a full year.

Most recently, while our family was in New York City for a long weekend, she fell and broke her proximal humerus. Thanks that time to Aaron and Brad -- especially having to deal with a poor, frail elderly woman with no idea where she was and no family within 200 miles. We got back

that night and she was back at home at Sunrise. The next day we had her over for a family dinner, her last. As fortune would have it, her sister had come down from Stamford to be with her.

Mom just wasn't right. She was not in pain, and not really any more disoriented than usual, but we could all tell she wasn't herself. My aunt and uncle made plans to meet me for breakfast the next morning and then visit mom.

In the morning, the call came from Sunrise. Mom wasn't responding well, the ambulance had been called. She died en route. The crew of medics knew to not resuscitate, and respected that directive. When I came through the front door, I saw right away -- in David's eyes, in Nicole's eyes, in Lisa's eyes.

Following that I'm sorry to say, I don't remember much of what you all said or did for me. I remember calling my Aunt Lee, my wife, my brothers, and I remember having time alone with Mom and our gathering family in room 6. I remember the chaplain showing up -- but not really anyone else who came by with their words of sorrow or sympathy. I do know that they were the right things because I remember appreciating the warmth, respect and caring -- even if now the details are vague. Whatever you said or did, you all deserve thanks because all of us -- my wife, aunt, uncle, kids included -- will always think back to the crisp, pretty morning when Mom died and remember the loving kindness, respect and dignity you showed us.

## A CHANCE TO BRAG

### Scott Freedman, MD

I would like to start a new column with this newsletter affectionately called, "A Chance to Brag" The concept is rather simple. We all lead busy lives and many of us have the fortune of having family members who have received special awards or recognition or have done something that has made you proud. It could be anything from a grade school performance to a sports achievement to a graduation.



*Jacqueline Whang Peng*

So, I will lead off by taking tremendous pride in telling you briefly about my mother-in-law, Jacqueline Whang Peng. She recently was recognized for her lifetime of achievements in international cancer research and contributions in Taiwan by being named a L'Oreal laureate. This prestigious L'Oreal Award is an international award

granted annually and is considered on par with the Nobel Prize in Science designed to recognize women, who have traditionally been under-represented by Nobel. Ma (to my family and me) has been a pioneer in cancer research. First, at the NIH for 33 years prior to moving to Taiwan. She then served as the Director of their National Health Research Institutes' Division of Cancer Research.

For all her worldly accomplishments, she remains one of the most modest people I know. She deserves every bit of praise and recognition she is finally receiving. I am blessed to have her lineage in my life.

So brag a little, you deserve to be proud.



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# Honduras-Medical Mission

**Debbie Folden, PA-C**

For over a year MEP has been trying to organize a medical mission to Central America. As some of you may know, our first attempt to Nicaragua fell through due to political unrest within the country. This time, I am happy to say, we have a confirmed destination: El Rosario, Honduras.

Our mission to Honduras will be coordinated through St. Paul's Catholic Church in Damascus, Maryland. Our facilitator, Mrs. Sherrie Wade, organizes two trips a year to El Rosario, bringing medical supplies, medications and health care professionals to the town.

St. Paul's Clinic, in El Rosario, opened in 1999 to serve the needy after the devastation of Hurricane Mitch. It is open 6 days a week, Monday through Saturday, from 8am-4pm. The clinic staffs one full time physician and one part time physician, plus a full time nurse and one full time dentist. The church works in conjunction with the Mayor's office in El Rosario. When a trip is planned, the Mayor sends out an announcement to the people in the community to let them know when the American doctors and health care professionals will arrive. People from all over the region come to the clinic, some traveling for days, to be seen by the American doctors. On a recent trip to El Rosario, 989 patients were seen in 5 days!

Since a variety of people have shown interest in joining our mission, many different opportunities to serve are available. Work can be done in the clinic or by home visits, working at the university hospital in

certain specialties (OB/Gyn, surgery, neurology, etc.), or setting up brigades (tents) within the town. The Mayor's office provides security for all health care professionals wherever they may be working.

Dates planned for this trip are July 7 - 14, 2008. The cost is between \$1200-\$1500, which includes round trip airfare, hotel, and breakfast each morning. We will be staying at the Hotel Excelsior, located in Tegucigalpa which is approximately 30 minutes from the clinic. The hotel has air conditioning and a casino. MEP has generously offered to donate \$500 toward each employee's expenses, plus Dr. Mike Cetta has offered to sponsor one MEP MLP wishing to participate, by covering airfare and hotel expenses over \$500.

If you are interested in joining us, the following is required:

- Hepatitis A and B
- Tetanus
- Typhoid vaccines
- Medications for Malaria
- A copy of your medical license
- A copy of your medical school degree
- Valid passport with at least 6 months remaining before expiration
- Insect propellant

Our mission is to help the poor and needy people of Honduras. To join our group please contact me at [deb-fold@aol.com](mailto:deb-fold@aol.com) or call (301) 221-6798 / (240) 826-7550.

# WE HAVE RELOCATED

**MEP / SGAH offices have moved.**

Our new numbers are:

<b>Main Number</b>	<b>240 826.7550</b>
<b>David Srour, MD</b>	<b>240 826.7578</b>
<b>Brett Gamma, MD</b>	<b>240 826.7524</b>
<b>Scott Freedman, MD</b>	<b>240 826.7017</b>
<b>MEP Office Fax</b>	<b>240 826.5107</b>

## AND THE WINNER IS... Renaming the RTU

MEP ran a contest in March of this year asking the staff at SGAH emergency department to help come up with a new fun name for the RTU (Rapid Triage Unit).

Many wonderful, clever and very entertaining ideas were submitted. Thank you to all who made contributions.

And the winner is.....

**Roseanne Powell, RN**  
HERO – Helping "ER" Overcrowding

Congratulations! You have won a \$50 Starbucks card. Please come to the MEP offices to receive your prize.

## Sometimes No Plan at all is the Best

Angelo Falcone, MD



This past summer, as I was driving across South Dakota and Wyoming for our family's first ever RV trip I was thinking about a lot of things. 1800 miles of solo driving in 10 days will do that to you. One thought that kept rearing its ugly head was how little planning I had done for this vacation. So little so that the first night was spent at a rest stop on Interstate 90 with the 18-wheelers while we caught a few hours of sleep.

We try and plan a lot in our lives. We plan where to go to dinner, where to go to school, where to go for our first "real" job, when to leave it, when to settle down and many other less and more significant "plans". We also plan a lot at MEP. We have strategic planning goals, multiple interviews before we hire a new provider, detailed discussions on rolling out a new benefit. We want to make sure we

"get it right". So we plan.

Then there are situations when, despite our best planning, events dictate the path we take. This is a skill we use constantly as emergency specialists. A patient's condition suddenly changes or new patient appears and we have to respond appropriately. Similarly circumstances happen in our personal lives, which determines the road we take at times.

On our trip I planned a few stops; Badlands National Park, Mount Rushmore and Wyoming. I didn't "plan" on finding a Native American store and speaking to a woman who spent most of her life on a reservation. I



I didn't plan on seeing herds of buffalo in Custer State Park. I didn't plan on witnessing 150 (out of 1500 people there) of my fellow Americans stand on a stage at Rushmore at closing ceremonies to honor them for serving our country or because they lost a loved one in battle while we all sung "America the Beautiful". I certainly didn't expect to meet a blacksmith along the street in Keystone who engraved (only) girl's names on reclaimed horseshoes as a memento for free.



These, however, are the memories that will stay with me, and my girls, forever. I wonder how often those types of "unplanned" encounters occur to each of us everyday. A patient with whom we linger at the bedside just a little bit longer to finish a story or find a common link. Perhaps we have a conversation with a colleague who needed us to listen for a few minutes. Do we take the time to allow for the unexpected and unplanned?

***We want your news! Please submit your articles , photos and new baby information for next quarters newsletter. [ptam@ahm.com](mailto:ptam@ahm.com)***



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

### MEP/Shady Grove Adventist Hospital Annual Dinner, January 2008



### MEP/St. Mary's Hospital Holiday Party, December 2007



**MEP Welcomes Georgetown University/WHC  
The Class of 2011  
Emergency Medicine Interns**



**Matthew Borloz**

*University of Virginia  
School of Medicine*



**Liz Delasobera**

*Stanford University  
School of Medicine*



**Tress Goodwin**

*Stanford University  
School of Medicine*



**Robert Katzer**

*Temple University  
School of Medicine*



**Melat Lemma**

*University of Virginia  
School of Medicine*



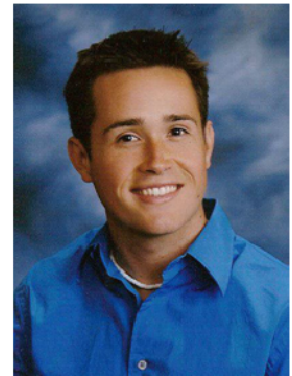
**Danielle Silverman**

*Tufts University  
School of Medicine*



**Jennifer Sreniawski**

*Stony Brook University  
Health Sciences Center  
School of Medicine*



**Michael Ybarra**

*Georgetown University  
School of Medicine*

## NEW BABY CONGRATULATIONS!



Noah was born into the Snyder family on January 13, 2008 at 2:01 p.m. He weighed in at a healthy 6 pounds, 4 ounces and measured 20 3/4 inches! Congratulations to Dr. Aaron Snyder and his wife Jennifer!



Kate Hawk was born on December 20, 2007 at 5:21p.m. She weighed in at a healthy 8 pounds, 6 ounces and measured 20 inches! Congratulations to Dr. Matthew Grzegozewski his wife Stephanie!



Mila Jaramillo was born into the Bakhtiari on October 10th, 2007 at 1:03 p.m. She weighed in at a healthy 7 pounds, 5 ounces and measured 19 1/2 inches! Congratulations to Dr. Poopak Bakhtiari and her husband Sergio.



Simon Harris Ashkin was born into the Schiffman family on October 22, 2007. He weighed in at a healthy 7 pounds and measured 19 inches! Congratulations Dr. Amy Schiffman and her husband Eric.



*"Excellence in Emergency Medicine"*



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Suite 130  
Germantown, MD 20874

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Rockville, Maryland 20850

St. Mary's Hospital  
25500 Point Lookout Road  
Leonardtown, Maryland 20650

Shady Grove Adventist  
Emergency Center  
19731 Germantown Road  
Germantown, MD 20874