MCEP
ADVANCING EMERGENCY CARE

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James Ziadeh, MD, FACEP

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Submissions to the March Newsletter should be received by the Chapter office no later than February 28, 2016.

FROM THE PRESIDENT

James Ziadeh, MD, FACEP

Having just returned from this year's MCEP winter symposium, I can declare that it was a phenomenal success. We had nearly 150 attendees from across the state that came to the Beautiful North Country of Michigan to hear what's new and cutting edge in Emergency Medicine by regional and national speakers. The year was special in that our conference coincided with ACEP's first annual Emergency Physician Wellness Week. To recognize this special first time event, all the attendees received a special "wellness" gift embossed with the MCEP logo and were automatically entered into a raffle to win a Fitbit. Conference registrants were also entitled to a 20% discount at the Grand Mountain Lodge Spa, of which several people took advantage. Physician wellness is such an important topic in today's fast-paced work and home environment and each of us needs to take the time to do a self-assessment of our own wellness. There are a number of wellness assessment tools available on the web that take only a few minutes to complete and will give you a general sense of where you stand on the wellness scale. I encourage you to give one a try! The ACEP website is also a useful resource if you are looking for more information with tips on improving physical well-being, improving emotional and social connections, as well as identifying opportunities for career enhancement.

One wonderful addition to the Winter Symposium is our medical student outreach program. This program, successfully led by Dr. Jacob Manteuffel, hosted 46 medical students from nearly every medical school in Michigan and was sponsored by the residencies of William Beaumont, Henry Ford, Central Michigan University, and Sparrow medical centers with EMRA being the financial sponsor. The students received an overview of ACEP, MCEP, and EMRA and also broke up into small advisory groups with one faculty member to four students. Dr. David Overton gave two fantastic lectures including the pros and cons of EM and tips on comparing EM residency programs. The program also included a skills session introducing the students to airway management, ultrasound, and intraosseous access. The program concluded with a Medical Student Council Leadership Meeting which took place during the Board Meeting. I would like to extend a special thank you to Dr. Manteuffel for implementing this fantastic program. Work like this helps provide the fertile soil to grow the future practitioners and leaders in Emergency Medicine.

In addition to great faculty and a fantastic lecture series, we were fortunate to have a special guest from national ACEP, Dr. John Rogers. Dr. Rogers comes from Georgia and currently serves on the ACEP Board of Directors as Vice-President. One of the great strengths of our Chapter is the ability to attract national figures to our conferences because these individuals know and understand the strength of our Chapter. Having national leaders come to our conferences also provides a great opportunity for all of you to let your national leadership know what's on your mind. Dr. Rogers was kind enough to provide an update at our board meeting on some top issues that national ACEP is focusing on. One such issue is the balance-billing dilemma. Under balance billing, a provider seeks to recoup the difference between what is billed and what the insurance provider pays. In many states where this practice is banned by state law, insurance providers have opted to aggressively drive down reimbursement for emergency services knowing that their enrollee will not be obligated to cover the difference. Reimbursement in many cases does not even cover the cost of care. This issue also extends to those physicians providing on-call coverage for our departments. Providing access to care, including specialty coverage is already a challenge due to liability issues. Unfair reimbursement practices by insurance providers only adds to the problem. Emergency Departments serve as the true safety net for our health care system and being fairly reimbursed for the services we are mandated to provide under EMTALA is critical to our survival. While balance billing in our own state of Michigan is much less of an issue, we have our own challenges related to reimbursement. For example, we haven't seen a rate adjustment in the two-tiered Medicaid reimbursement structure in nearly a decade. Over the last two years, we have been involved in multiple meetings in Lansing which have finally paid off with an impressive twenty percent increase in treat and release payment. This is all due to the hard work of several members including Drs. Antonio Bonfiglio, Brad Uren, Rami Khoury, and Kevin Monfette along with Diane Bollman, our executive director, and Bret Marr, our lobbyist. Victories like this truly represent the value proposition for membership. With our membership's continued support, our chapter will have the resources to address the important issues we need to tackle, even if it takes years to accomplish our goals.

Our Chapter is blessed to have an incredible group of engaged physicians who contribute their time to advance the issues important to all of us. These individuals continue to contribute year after year because they truly understand that if we don't advocate on behalf of our needs and our patient's needs, no one else will. I would encourage all of you to consider participating in the great work our Chapter is doing. The first step is the hardest but it is simple, and I guarantee it will be rewarding. We have a number of committees that are always in search of new members with unique points of view and ideas. With committees ranging from education and health finance to EMS and advocacy, we have opportunities that will suit many interests. Starting this year, we have created a new committee related to quality. Health care is in the midst of a change from volume based care to value based care and Emergency Medicine is not exempt. As these changes begin to impact us at a greater level, we need to be an integral part of the conversation. If you have an interest in being a member of this newly formed committee, which will be co•chaired by Drs. Gregory Gafni-Pappas and Emily Mills, please contact our office for details. We need broad representation from around our state to make this a success. Consider taking the first step and see how MCEP can be part of a long term strategy for your own success and wellness! §

www.mcep.org

FROM THE EDITOR

The Midwest Winter Symposium at Boyne was again a success. A major theme of the conference was wellness as ACEP embarked on its first Wellness Week initiative. This was certainly evident as attendees jumped on the slopes for some great skiing with their families while others enjoyed the Avalanche Bay indoor water park. Some took time to enjoy the spa, while others enjoyed cross-country skiing and snowshoeing in the crisp northern Michigan outdoors. The Friday night reception was a nice place for colleagues and families to catch up, have a great meal, and for kids to run around and enjoy the piñatas, always a crowd favorite.

The point is that we as physicians, as emergency physicians especially, need to take care of ourselves, mentally and physically. A recent report from the AMA showed

that emergency physicians have the highest burnout rate in medicine. It's not a surprise to me considering our ED volume is only getting higher with more paperwork, cumbersome EHRs, difficult patients, and many other stressors. Dr. Kathleen Cowling gave a great lecture on second victims highlighting the stress providers can endure when involved in an unanticipated adverse event or medical error. She stressed the importance of creating a culture of support for these events and teaching coping skills when the incidents occur. In the setting of a recent resident suicide that shook the emergency medicine community, we need to take ownership of our own health and teach our aspiring emergency physicians the same tools to allow them a long and fulfilling career. Here are a few of the tips I received from ACEP emails during Wellness Week that I thought were worth sharing.

1. "Part of the secret is making it easy for ourselves and incorporating exercise into our daily routine. Commit to always taking the stairs. Bike to work. Spend your time with your kids outdoors playing soccer, basketball, etc. Go on a family hike. Play basketball with your friends. The point here is to bring exercise into your daily life."
2. "Limiting your food intake to 12 hours a day may be all that is needed to maintain a healthy weight and even decrease body weight."
3. "Luck is what happens when preparation meets opportunity. Can you set small goals such as waking and taking 5 minutes to breath or meditate today, ensuring you exercise, guaranteeing the opportunity to get enough sleep, not necessarily changing your diet but avoiding unhealthy snacks at work, or not letting yourself get overextended with new requests on your time?"
4. "Music calms, de-stresses or invigorates. Pick music for stressful moods from your favorite venues."
5. "Mindfulness: Start a gratitude list. Be grateful for each day, list or list mentally all the positives at this time."
6. "All too often, we cloud our schedules with entirely long to-do lists, projects and choices. One way to reduce stress and anxiety is to limit the number of choice and lists that you focus on daily. This allows more time for you to engage in activities that provide the greatest pleasure and stress reduction."

Gregory Gafni-Pappas, DO, FACEP

Please make wellness a priority in your personal life and in your department. Talk about it at your department meetings and make sure that your colleagues have the support they need. For more information on wellness, please visit http://www.acep.org/EMWellnessWeek/. §

MCEP Calendar of Events

February 25, 2016
Critical Care Practice in the ED
Somerset Inn
Troy, Michigan

March 2, 2016
Board of Directors
Chapter Office
Lansing, Michigan

April 19, 2016
EMRAM Research Forum/ SIMWARS
CMU Education Bldg.
Saginaw, Michigan

April 23, 2016
Mock Oral Boards
Sinai-Grace Hospital
Detroit, MI

April 25, 2016
SaveMIHeart
Livingston County
Howell, MI

April 29-30, 2016
APLS
Munson Medical Center
Traverse City, Michigan

May 4, 2016
Board of Directors
Chapter Office
Lansing, Michigan

May 15-18, 2016
ACEP Leadership Conference
Washington, DC

July 31 – August 3, 2016
Michigan EM Assembly
Grand Hotel
Mackinac Island, Michigan

August 1, 2016
Board of Directors
Grand Hotel
Mackinac Island, Michigan

August 16, 2016
Residents' Assembly
The Johnson Center
Howell, Michigan

August 18, 2016
ED Directors Course
The Johnson Center
Howell, Michigan

September 7, 2016
Board of Directors
Chapter Office
Lansing, Michigan

September 12-13, 2016
EM Ultrasound Course
Chapter Office
Lansing, Michigan

REIMBURSEMENT CORNER

Warren Lanphear, MD, FACEP

I am going to kick off the rebirth of the time-honored reimbursement column with some advice about scribe documentation. Many of you are already using scribes and get direction on their documentation from the various scribe companies doing business in our state. Some groups and individual providers may be using home-grown scribes. Hopefully the following information will be a helpful reminder for most and a needed warning for some. This information will not increase your revenue but it will keep you from hearing a whistle blow.

Scribes cannot act independently, i.e. they cannot document information that the provider has not stated or the patient verbalized. The exception is recording *Review of Systems* or *Past Medical/Surgical History* that is obtained from prior records or recorded by the patient on a form. The scribe cannot ask patients questions to obtain history for charting.

Problems arise if the scribe stays behind in a room and documents information not directly witnessed or heard by the provider. Ed Gaines, the ACEP reimbursement compliance expert, refers to this as "mutation." It is more likely to occur when PA students, NP students, or medical students work as scribes. It is less likely to happen with pre-medical students.

Scribes cannot document something they did not witness. They cannot enter your "normal exam" if it includes something they did not see you perform. This includes using a *macro* if the provider did not do that same exam. There is great risk if the scribe does not feel comfortable challenging the provider when asked to document something not witnessed. Providers and scribes must be educated about the problems with this type of interaction.

Here are five more important things to remember –

1. There must be an attestation statement from the scribe naming the provider.
2. The provider must attest that the record was scribed and the provider agrees with the scribed note.
3. Caution with use of macros as they can appear cloned. The scribe needs to edit the macro to make each chart look specific to the individual patient.
4. The Joint Commission requires the provider to sign off on the scribed chart prior to the scribe's end of shift. §

I welcome any questions or comments.

Warren Lanphear MD, FACEP
Lanphear@msu.edu

MCEP RESIDENT CASE REPORT

By: Riley Jakob, MD and Dilnaz Panjwani, MD, FACEP of the St. John Hospital and Medical Center, Emergency Medicine Residency Program, Detroit, MI.

Introduction: A 38-year old male presents to the emergency department with right sided flank pain radiating to the right lower quadrant for the last 11 hours. The pain awakened him at 10:30am. The pain is dull, 10/10, intermittent but getting progressively worse over the last few hours. He admits to subjective fevers and chills but denies any vomiting, diarrhea, hematuria, or dysuria. The patient has no history of nephrolithiasis. The patient does have chronic back pain, however this pain feels different. Past medical history is positive for chronic back pain, hypertension, bipolar disease, and seasonal allergies. Past surgical history includes a cyst removal and wisdom tooth extraction. The patient is single, has no children, lives alone, and is employed as a waiter. He quit smoking 1 year ago and drinks at least 6 shots of liquor per day. He has a remote history of marijuana use but denies IVDA. He has NKDA. The patient takes loratidine PRN. Both parents are alive. His mother has thyroid cancer and his father has skin cancer. ROS is negative.

ED/ Hospital Course: Vital signs are as follows: Temperature 97.8F, heart rate 87 bpm, blood pressure 163/107, SpO2 100% on room air, respiratory rate 20 breaths/min, POC glucose – 119. In general the patient appears comfortable in bed, is in no acute distress, is pleasant, and is A&O x 3. Skin, HEENT, Neck, LN, Chest, Cardiac, Neuro, MSK and Vascular exams are completely normal. On abdominal exam, the patient's abdomen is noted to be soft, non-distended, tender to deep palpation in the RUQ, right CVA tenderness to palpation, and no aortic bruit. On rectal exam there are no masses and the patient is Guaiac negative. The CBC is within normal limits except for WBC of 15.6. The CMP and UA are within normal limits. A CT abdomen/pelvis without contrast was ordered initially which showed no renal stones, however the right kidney appeared to have 3 areas of lucency, possibly consistent with renal infarcts. A CT angiogram of the abdomen/pelvis was ordered which showed a focal dissection of a segmental branch of the right renal artery, accounting for the visualized right renal infarcts. Vascular surgery and urology were both consulted and the patient was admitted to the hospital for pain control on a dilaudid PCA. Recommendations were to begin heparin and anticoagulate for 3 months in light of the renal infarcts, with a goal INR of 2-3, and target blood pressure of less than 140 systolic. No surgical intervention was necessary. Patient remained in the hospital for 5 days, mainly secondary to intractable pain.

Discussion: Renal artery dissection is an extremely rare disease process with less than 200 cases reported in 2007 and accounting for only 1-2% of all arterial dissections. It is typically associated with arterial wall disease such as fibromuscular dyplasia or atherosclerosis and is usually observed in otherwise healthy men in the fourth to sixth decade of life, with a 4:1 predominance of males to females. Hypertension is the single most important modifiable risk factor. Some other causes include trauma, iatrogenic causes such as guidewires and catheters, and cocaine use. Interestingly, in the majority of cases the actual cause of renal artery dissection is never found.

It is commonly misdiagnosed as nephrolithiasis and pyelonephritis because of the similarities in clinical presentation. In renal artery dissection, 92% of patients will complain of flank pain radiating to the epigastrium, 33% of patients will have hematuria, and 40% will have a rise in their pre-existing hypertension. Laboratory tests are often not very helpful, as they can be completely normal, however in some cases patients will exhibit an increased WBC count, an elevated creatinine level, and urinalysis may show increased WBCs and RBCs.

The diagnosis is often made after visualizing renal infarcts on CT abdomen without contrast. The gold standard imaging modality for diagnosis is selective renal angiography.

Due to the rare nature of the disease, the treatment recommendations are not evidence-based and are based upon expert opinions. Treatment is dependent on stability of the lesion and amount of kidney injury, if any. Anecdotally, treatment of patients with anticoagulation for 1-6 months with serial creatinine level checks seems to be the consensus. If patients have no renal injury, some experts recommend follow up only. If a patient has an unstable lesion, surgical or endovascular intervention is necessary. Overall, the disease process is minimally studied and accordingly, treatment modalities and patterns are poorly understood. Close follow up and monitoring of renal function is the current mainstay of treatment. §

References

1) Kanofsky JA, Lepor H. Spontaneous Renal Artery Dissection. *Reviews in Urology*2007;9(3):156-160.

2) Guerin E, Vandueren E. Spontaneous renal artery dissection in an otherwise healthy male. Acta Chir Belg 2007; 106 (6): 703-706.

3) Karanasos A, Van Mieghem N. Serial imaging observations of vascular healing in a denervation-induced renal artery dissection. European Heart Journal 2014; DOI: 10. 1093.NATIONAL *The*

MEDICAID REIMBURSEMENT VICTORY FOR MICHIGAN EM PHYSICIANS!!

We are pleased to report that the enduring efforts of MCEP to convince State Medicaid officials to increase the rates for the Two-Tiered levels paid to emergency physicians has finally paid off!!

Effective **January 1, 2016,** the new MEDICAID rates are:

UA Rate - Treat and Admit	**$97.06**	(Previous $96.43)
UD Rate - Treat and Release	**$50.44**	(Previous $41.94)

This equates to an additional **9 Million Dollars in Medicaid reimbursement** annually for emergency physicians!! This averages about $10,000 per practicing emergency physician in the state of Michigan!!

This accomplishment could not have come to fruition without the hard work and perseverance of Drs. Antonio Bonfiglio, Kevin Monfette, James Ziadeh, Brad Uren, along with Bret Marr, our lobbyist, and Diane Kay Bollman, CEO. The discussions began two years ago with countless meetings in Lansing and spanned the course of *three* State Medicaid Directors!

It is gratifying to see that the State Medicaid officials recognize and appreciate the increasing volume of care being provided by emergency physicians across the State. We are truly the safety net providers for the state's Medicaid population.

Always remember that the Michigan College of Emergency Physicians is working diligently on a daily basis to support quality emergency medical care and promote the interests and values of YOU, our members! ***This rate increase will pay your dues for the next ten years!!***

PHYSICIANS/POSITIONS AVAILABLE

BAY CITY, MICHIGAN: MCLAREN BAY REGION, EMERGENCY MEDICINE OPPORTUNITY. Explore an excellent opportunity for a BC/BE Emergency Physician or board certified FP, IM, GS with at least 5 years contiguous Emergency Department experience, to join our group in either a full or part-time capacity at a growing, profitable hospital in Bay City. Since opening a new ED in 2007, patient volume growth has been steady with an expected 45,000+ patient visits this year. McLaren Bay Region has a supportive administration team and progressive medical staff that provides coverage for all of the major specialties. Our group offers a stable contract, sign on bonus for full-time and productivity based compensation package with potential to exceed $200/hour. Current staffing reflects 40 hours physician coverage with mid-level assistance in main ED and Fast Track. Bay City and surrounding communities offer affordable housing and a short commute to major cities and Northern Michigan. If you are interested in this opportunity, please send CV to Kenneth Parsons, M.D., M.P.H., FACEP, at kpmdmph@comcast.net or call 989-894-3145 for more information. [ufn]

CASS CITY, MI: Seeking a BC/BE Emergency Medicine Physician for a full-time position in our 5,500 visits/year, low volume Emergency Department. This is an opportunity to practice Emergency Medicine in a spacious new Emergency Department with supportive administration and outstanding ancillary staff. We work 24 hour shifts and have an on-call suite for resting at night. The hospital offers competitive compensation which includes comprehensive benefits, CME and PTO. If interested please send CV to Scott Greib, MD, FACEP at sgreib@hillsanddales.org or call 989-912-6296 for more information. [ufn]

DEARBORN, MICHIGAN/DETROIT METROPOLITAN AREA: Excellent compensation available for a clinically superior Emergency Physician to practice at BEAUMONT HOSPITAL – DEARBORN. The ED at this highly regarded facility experiences 80k patient visits annually and is a Level II trauma center. Newly remodeled for the efficient care of a higher acuity patient population, the ED provides an excellent work environment. Work with EM residents during 76 hours of daily physician coverage. Multiple shifts, staffed with capable APCs, also help manage patient flow. Considerate scheduling and EPIC EMR await EM boarded candidate. To confidentially discuss, please contact Sandy George, recruiter, at TeamHealth: 865.560.8421 or send your CV to sandy_george@teamhealth.com. [3-2]

PETOSKEY, MI: Northern Michigan Emergency Physicians, PC, a well-established democratic group providing the Emergency Services in Petoskey for 17+ years, is seeking a Full-Time BC/BE Emergency Physician. Stable contract with competitive compensation and benefit package. Excellent reputation and relationship with Administration and Medical Staff. Regional Referral Hospital with comprehensive subspecialty coverage and annual ED volume of 25,000 visits. 4 Physician shifts and 1 APC shift/day. For details contact Kal A. Attie, MD, FACEP at 231-838-2655 / kalattie@mac.com[3-3]

TAYLOR, MICHIGAN/ DETROIT METROPOLITAN AREA: Rewarding opportunity for a qualified Emergency Physician at BEAUMONT HOSPITAL - TAYLOR; excellent compensation available to a physician who is BC/BP in Emergency Medicine. Full-time preferred but part-time will be considered at this 30k patient volume ED. Friendly environment and thoughtful scheduling offered. 35 hours of EP coverage daily plus 20 hours of additional APC ED assistance. To confidentially discuss, please contact Sandy George, recruiter, at TeamHealth: 865.560.8421 or send your CV to sandy_george@teamhealth.com. [3-2]

TRENTON, MICHIGAN/DETROIT METROPOLITAN AREA: Top compensation is available for a talented and motivated board-certified Emergency Physician to care for patients at BEAUMONT HOSPITAL – TRENTON. The ED experiences 33k annual patient visits, is designated as a Level II trauma center, and hosts an Emergency Medicine residency program. With 36 hours of physician coverage, three 12-hour shifts, and an additional ten hours of APC fast track assistance, the ED offers an efficient and satisfying environment to practice in. To confidentially discuss, please contact Sandy George, recruiter at TeamHealth: 865.560.8421 or send your CV to sandy_george@teamhealth.com. [3-2]

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MCEP TO FORM NEW COMMITTEE WITH FOCUS ON QUALITY

By: Emily Mills, MD

We are thrilled to announce that in December 2015 the MCEP Board of Directors approved the formation of a new committee within the college and is actively seeking out members to join in this exciting endeavor. The committee aims to show the value of emergency medicine in the state of Michigan by improving the delivery of pediatric and adult emergency care for our membership and our patients. Objectives will include monitoring quality initiatives and policies from the Michigan Department of Health and Human Services, cultivating strategies regarding alternative payment models, and partnering with quality improvement efforts across the state focused on emergency care. If you are interested in joining the committee to impact emergency medicine practice and our patients on a statewide level, please contact the Chapter Office at (517) 327-5700 or mcep@mcep.org for more information!

NATIONAL COMMITTEE INVOLVEMENT ANNOUNCED

The following MCEP members have been appointed to ACEP positions for the 2016 year:

ACADEMIC AFFAIRS COMMITTEE
Gloria J. Kuhn, DO, FACEP
Mary Jo Wagner, MD, FACEP

AWARDS COMMITTEE
James C. Mitchiner, MD, MPH, FACEP

EDUCATION COMMITTEE
Gloria J. Kuhn, DO, FACEP
Marc S. Rosenthal, DO, FACEP
Matthew J. Stull, MD
Amrita M. Vempati, MD
Mary Jo Wagner, MD, FACEP

EMS COMMITTEE
Chris R. Engdahl, DO

FINANCE COMMITTEE
Mildred J. Willy, MD, FACEP

FEDERAL GOVERNMENT AFFAIRS COMMITTEE
Terry Kowalenko, MD, FACEP
Bradley J. Uren, MD, FACEP

QUALITY & PATIENT SAFETY COMMITTEE
Gregory Gafni-Pappas, DO, FACEP
Keith E. Kocher, MD, FACEP
Terry Kowalenko, MD, FACEP

MEMBERSHIP COMMITTEE
Diane Kay Bollman, Executive Director
Kevin Monfette, MD, FACEP

EMERGENCY MEDICINE PRACTICE
Claire Pearson, MD, MPH, FACEP

RESEARCH COMMITTEE
Anthony T. Lagina, MD, FACEP
Phillip D. Levy, MD, MPH, FACEP
Brian J. O'Neil, MD, FACEP
Claire Pearson, MD, MPH, FACEP
Jonathon M. Sullivan, MD, PhD, FACEP
J. Scott VanEpps, MD

NATIONAL/CHAPTER RELATIONS COMMITTEE
Michael Baker, MD, FACEP

BYLAWS COMMITTEE
Jessica Jewart Kirby, DO, FACEP
Paul R. Pomeroy, Jr., MD, FACEP
Larisa Traill, MD, FACEP

PUBLIC HEALTH/INJURY PREVETION COMMITTEE
Sonbol Shahid-Salles, DO

CLINICAL POLICY COMMITTEE
Michael D. Brown, MD, MSc, FACEP

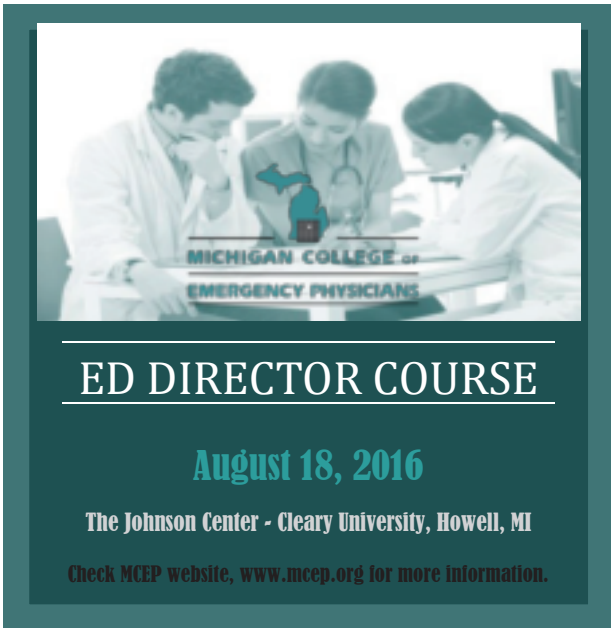
PEDIATRIC EMERGENCY MEDICINE COMMITTEE
Lee Steven Benjamin, MD, FACEP
Kurtis A. Mayz, MD, JD, MBA

WELL-BEING COMMITTEE
David Black, MD
Constance J. Doyle, MD, FACEP

MEDICAL LEGAL COMMITTEE
Geetika Gupta, MD, FACEP
Kurtis A. Mayz, MD, JD, MBA
Diana Nordlund, DO, JD, FACEP

STATE LEGISLATIVE/REGULATORY COMMITTEE
Michael Boyd, MD
Joel B. Krauss, MD
James C. Mitchiner, MD, MPH, FACEP
Larisa Traill, MD, FACEP
Bradley J. Uren, MD, FACEP
Bradford L. Walters, MD, FACEP

DISASTER PREPAREDNESS & RESPONSE COMMITTEE
Gerald Beltran, DO, FACEP
Constance J. Doyle, MD, FACEP
Ryan Kirby, MD, FACEP
Marc S. Rosenthal, DO, FACEP



THE ODD HISTORY OF INCUBATORS

Erica Walters, MD; Frank Borschke, MD, FACEP and Bradford Walters, MD, FACEP

If your emergency department is anything like mine, somewhere in a corner, often covered with some dust, is an infant incubator. They are used infrequently in our ED because we run all laboring patients up to Labor and Delivery to prevent ED deliveries. But, occasionally that is not possible and we deliver an infant and need the incubator. Of all the medical devices in the ED, the infant incubator may have the most unique and strange history. The idea of providing a protective and warm environment for newly delivered neonates, particularly those who were premature or low birth weight, would seem obvious but is actually a relatively new concept in medicine.

In order to more fully appreciate the impact the incubator has made, one has to understand the state of neonatal care in the late 19th Century. Infant mortality at that time in an urban environment was 15-20%, most of which occurred in the neonatal period. Typically premature infants were wrapped in a blanket, handed to the parents, and wished good luck. It was accepted that premature or low birth-weight children had a high mortality rate and many would die. That was the state of neonatal medical care at that time in history. The future of neonatal care changed when Dr. Stephan Tarnier went to a poultry exhibit at the Paris Zoo and saw a warming device for eggs. In a stroke of genius he began experimenting with an early style of incubator for warming premature infants similar in concept to an egg incubator. He found it reduced the mortality of 1200-2000 gram premature infants from 66% to 38%. This decrease in mortality was a monumental achievement for its time. Another French physician, Dr. Pierre Constant Boudin, took the idea even further and created *les services des deliles* (service for weaklings) that became the first neonatal intensive care unit (NICU). Even with that new medical service concentrating on the neonate and the use of Boudin's incubator mortality for this was a dismal 50% in its first year. This was due to a lack of appreciation that infections would rapidly run rampant through the immunocompromised premature infants.

These early disappointing results lead the medical community to abandon the use of incubators. But, there still remained a strong interest amongst the public as families with premature infants had few alternatives. Dr. Alexander Lion was the next physician to turn his attention to this area of medicine. He created a more sophisticated incubator, but the downside was that it was also quite expensive. One must recall that this time in history predated medical insurance by some 50 years. In order to help defray the costs and to make his incubator a more affordable option to parents Dr. Lion decided to publically display the neonates in his incubators. For a small fee anyone could view the premature infants encased in their protective cocoon. Essentially, this was an early example of crowd source funding. People found the exhibit amazing as Dr. Lion tapped into an intense public fascination with these tiny neonates. The monies from the entry fees were used to help fund this new medical treatment. The idea

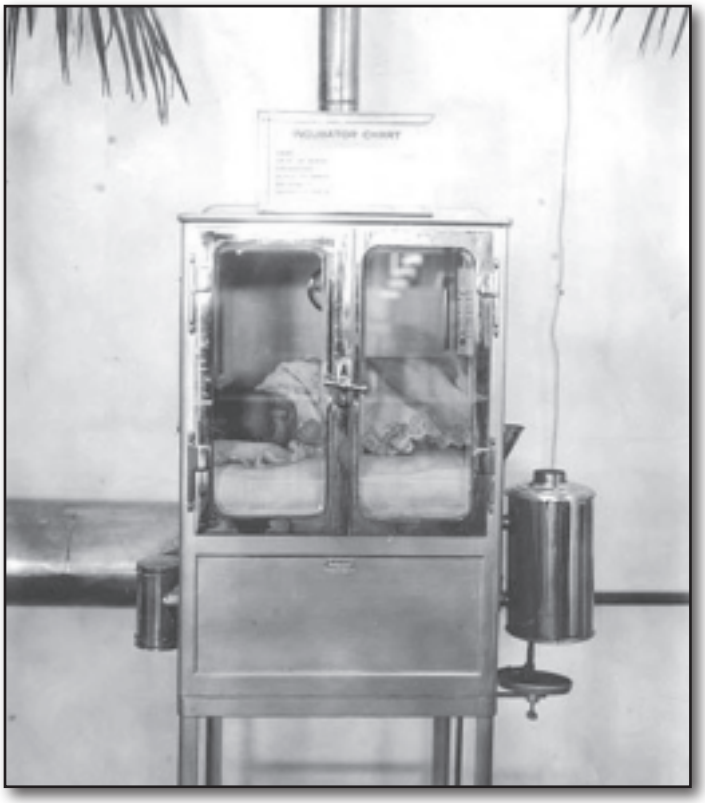
The exhibit at Coney Island in 1903.

gained additional traction in 1896 when he took his exhibit to the Berlin Exposition. Despite its popularity as an attraction the medical community still paid little attention. Without hospital or physician support incubators might have faded into obscurity. Fortunately one of Dr. Lion's associates, the enigmatic Dr. Martin A. Couney, decided to take the idea of displaying neonates inside incubators to a new location, first London and then America. He felt the ideal venue was the 1901 Pan American Exhibition in Buffalo, New York. Despite the popularity amongst the public who lined up to view living babies ensconced in a glass and metal device, the American medical establishment remained largely unimpressed. However, Dr. Couney refused to give up and searched around for another venue he could demonstrate the efficacy of neonatal incubators. He found the perfect place at an amusement park; a spot that drew thousands of people who were looking for displays merely for their entertainment value.

At the turn of the century Coney Island, NY was becoming the most popular amusement park in the nation. In addition to usual carnival rides including a historic roller coaster there were side show exhibits where the unusual was an everyday sight. So, in 1903 next to the Bearded Lady, the Rubber Man, and the Alligator Boy there was a sign with bright lights that read, *"INFANT INCUBATORS – LIVE INFANTS!"* On the street there were carnival barkers luring in the passer-bys who for a mere 10 cents could see actual, living, premature babies in this newest of medical miracles – the incubator. As an aside, one of those very carnival barkers for Dr. Couney was a young Archibald Leach who later left for Hollywood to become Cary Grant. The exhibit was a huge success and became one of the most popular on Coney Island.

One might ask where did the premature babies come from who were placed on display? Being situated just outside New York City there were a large number of premature infants born each year in the city. Most people who sought out Dr. Couney had heard about the incubators from friends, had read about the exhibit in a newspaper or magazine, or had visited the display at Coney Island. Parents of premature or low birth weight infants sought the help of the only physician to offer any hope; even if that meant becoming a sideshow exhibit at Coney Island. One such child born premature and weighing only a couple of pounds was handed over to her father with the usual admonition of her likely death. He immediately took the train out to Coney Island and handed his daughter over to Dr. Couney. She remained there on display for six months ultimately living until she was 94 years old! She was by far not the exception. Couney was so confident in his incubator that his own premature daughter became a patient at the Coney Island exhibit. He never charged a single family for the care provided. The costs were entirely covered by the entrance fees that in later years were raised to 15 cents, not actually insignificant for the time. He refused to discriminate by race, creed, color, or income – a remarkable stance in the early part of the 20th Century.

Continued on Page 10



One of the early incubators with a neonate safely ensconced.

Dr. Martin Couney holding up a premature infant.

THE ODD HISTORY OF INCUBATORS

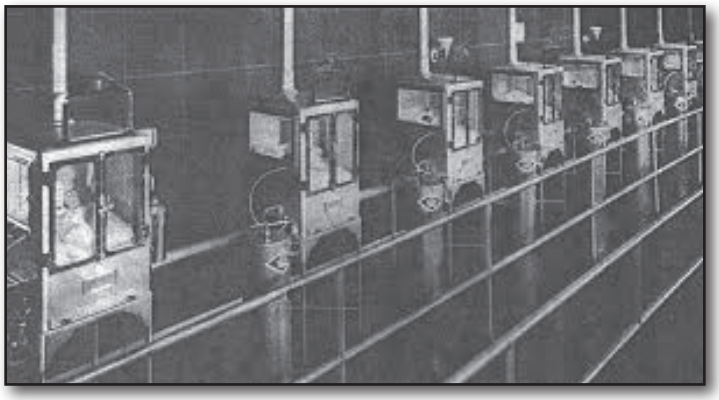
Continued from Page 9

Dr. Couney's incubator display continued for 40 years. With time more and more physicians were quietly referring their premature infants to him. Ironically hospitals were still not interested in creating similar neonatal units despite growing public interest and greater acceptance by the mainstream medical community. Over those 40 years he treated approximately 8,000 infants with 6,500 having survived. That was an 81% survival rate, unmatched by any other program in the world. Finally, in 1939 Cornell University Hospital opened up the first hospital based neonatal unit. It was largely based on Dr. Couney's work and the success of his incubator. In 1943 Couney stated, "My work is done" and quietly closed down the Coney Island sideshow.

Martin Couney himself faded off the stage of medical history and is rarely mentioned as one of the major figures in neonatology. His persistence and success of using incubators to protect fragile neonates was generally ignored by the staid and conservative medical establishment. It was largely demands from the public that finally broke the ice and within a few years of the Cornell neonatal unit similar programs were seen in most larger and even smaller hospitals. This resonates with emergency physicians because the specialty of emergency medicine was driven, not by the House of Medicine, but by the public-at-large who demanded better and more professional care in emergency departments. Medicine and the public owe a great deal to Dr. Martin A. Couney who pursued his passion of neonatal care and the development of his incubator despite tremendous skepticism from the medical community. He had to be an entrepreneur, carnival sideshow barker, in addition to a physician to keep his infant incubator therapy available to those who needed it. So, in honor of his memory I wiped the dust from our ED incubator where it patiently waits to gently warm a tiny new life. §

One of the later models of incubator around 1930, note the air filter.

Night time at Coney Island as the pedestrians on the Boardwalk rush by the exhibit of "Infant Incubators with Live Infants – Come one, Come all."



Inside the exhibit rows of babies could be seen but not touched safely protected by the most advanced neonatal program of its time.

EMRAM CORNER

EMRAM – CALL FOR ABSTRACTS

RESIDENT RESEARCH DAY
APRIL 19, 2016
CMU EDUCATION BUILDING, SAGINAW, MI

EMRAM is accepting abstracts for presentation at the EMRAM Research Day. This is an opportunity for residents to present their work to others across the state and to learn about what others are doing. This would be especially helpful for those who are presenting nationally to have a trial run and it will also give senior residents an opportunity to present their scholarly projects. To expand the relevance of this forum to more senior residents and highlight other scholarly work we will be expanding the program this year to solicit abstracts for scholarly activities that are not purely research.

Residents or fellows are encouraged to submit abstracts of their scholarly work. The format is as follows: those that are presenting at the national meeting would present in the same format whether it be an oral presentation or poster. This will also give them an opportunity to improve upon their presentation in front of a group other than their own program. Each oral presentation will be no longer than 10 minutes in length with 5 minutes for questions and discussion. Posters will be presented in a small group moderated poster session. Non research scholarly abstracts (e.g. case reports, quality improvement initiatives) will be considered for a limited number of poster presentation spots as well.

Abstracts must be received no later than March 7, 2016. Abstracts can be e-mailed to the Amber Meyers at amber@mcep.org. Follow-up communication will be forwarded to all who submit abstracts in late March.

All abstracts must be limited to 300 words. The format must be structured and include the following: Objectives, Methods, Results, and Conclusions. Each abstract must be accompanied by a cover letter detailing the full names and titles of authors and should indicate the presenting author. The submitted abstract should be blinded with a cover sheet identifying study title, authors, and sponsoring institution. The cover sheet should also identify whether the author will accept an opportunity to present a poster presentation, or an oral presentation or either. EMRAM offers a special award for the papers determined best by the judges.

Please contact the MCEP Chapter office should you have any questions.§

Send abstracts to:
EMRAM, 6647 West St. Joseph Highway, Lansing, MI 48917 or amber@mcep.org.

CALLING ALL INTERESTED RESIDENTS.....

IT IS TIME FOR THE ANNUAL EMRAM OFFICER ELECTIONS

The offices of President, Vice President, Secretary and Treasurer will be filled. Positions are intended for residents that have demonstrated a commitment to emergency medicine; and through this commitment are interested in furthering the programs, activities, and success of the Michigan Emergency Medicine Residents' Association.

Elections will be held during the EMRAM Research Day at the CMU Education Building in Saginaw on **Tuesday, April 19, 2016.** **Candidates interested in running for office need to submit their intent to run and the office they are interested in by noon on Friday, April 1st. Candidates should submit a personal statement and photo to be distributed prior to elections.** **Candidates running from the floor, without prior thought to the responsibilities and duties of office, are strongly discouraged.**

If you are interested in running for an office, please contact the Chapter office by phone, 517/327-5700 or by e-mail, mcep@mcep.org.§

MICHIGAN COLLEGE OF EMERGENCY PHYSICIANS

Michigan Emergency Medicine News & Views is the official publication of the Michigan College of Emergency Physicians. Deadline for publication of all letters/articles is the 5th of the month prior. All correspondence should be addressed to MCEP News & Views, 6647 West St. Joseph Hwy., Lansing, MI 48917. Telephone (517) 327-5700, FAX (517) 327-7530, www.mcep.org. Opinions expressed within this newsletter do not necessarily reflect the College's point of view. While News & Views believes that the ads it accepts originate from reputable sources, it takes no responsibility for the consequences resulting from, or the responses generated by, any commercial or classified advertisement.

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