Fall 2010 Issue

From the President
Stephen Wolf, MD, FACEP

When the issues become real...

9:50 pm [Snooze]

10:00 pm [Snooze]

10:07 pm My coffee is made for the upcoming shift and my wife is just going to bed after studying for her final human anatomy test of her first year of medical school. Literally, we are passing in the night.

10:10 pm. As I get dressed, I wonder what the world of medicine will have in store for her when she graduates. Will there be enough Graduate Medical Education (GME) residency training slots for her. Few know that 2010 was the first year that the number of graduating seniors in US medical schools in the scramble out numbered the total number of available positions. I could not imagine being unable to procure a residency training position - let alone in the specialty I want - after four years and 200K of debt. I struggle with why the federal government does not lift the GME funding cap set in place by the Balanced Budget Act of 1997. Politicians have to understand that there are significant workforce issues. Don't they? Thirty percent of Colorado emergency departments (EDs) are staffed by non-residency trained, non-board certified emergency physicians. Seventy percent of Colorado EDs are lacking adequate subspecialty on-call coverage in at least one discipline. Is this how we want to care for our patients? Is this how the politicians what to serve their constituents? Why can't we do something to improve system?

11:03 pm. I take sign out in the ED and I am ready for my shift.

Colorado Chapter ACEP

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11:30 pm. A 30's-year-old male is brought in screaming in pain, with an obvious left ankle fracture/dislocation after laying his motorcycle down at highway speeds. It clearly requires emergent reduction with sedation. He is intoxicated, agitated, and ungodly strong. His neck is thick and of course he has a beard. I wonder what is in his stomach from his late night snack, as I assess his airway and consider medications. Unfortunately, there is no time for extensive information gathering. His foot is pulseless, and cool and he is at risk for even greater injury with his agitation. While ordering medications for sedation, I hope that no critical information has been missed in the chaos, and that no unexpected complications will occur that in the light of

the day will be judged by many and understood by few. I know the inherent risks associated with emergency care and I do everything possible to mitigate them. However, I often wonder if society understands these risks or will judgment occur with perfect hindsight? Should I be liable if this patient has an unknown allergy or an unforeseen complication in an emergency situation where care is required by law (EMTLA) if the acts were not willful or wanton?

12:27 am [Coffee]

12:50 am [More Coffee]

01:59 am. An 83-year-old female with chronic lung disease comes in with severe shortness of breath. EMS alludes to paperwork for advanced directives but none could be found. I hope my face conveys to her the same comfort I am trying to give her with my words. I believe she understands how sick she really is and that she likely will not get better. She seems to be accepting of her likely end. I wish she came with the paperwork. It would be ideal to have medical orders to guide my scope of treatment so that I could let her live and die with dignity. I wonder if she knows she could have completed a MOST form to convey here wishes. Now that Colorado recognized the legality of this form's, we now have to educate both physicians and patients as to its use.

3:12 am. A nurse informs me of a 74-year-old hypertensive, diabetic female with lower abdominal pain. The patient is clearly uncomfortable, yet apologizes for coming to the ED over a primary care physician. She has been unable to get in to see someone who accepts Medicare. After a history and physical, I know her work-up to assure medical stability will be significant. The CDC says that 92% of visits to an ED are urgent or emergent, as I believe this one to be. But, I can't help but wonder if this patient would be here if her blood pressure and diabetes were controlled over time. I don't know. Some believe that this is why society must improve coverage. However, in Massachusetts, where coverage was recently increased through legislative efforts, EDs saw a 7% rise in visits. The lesson I see here is two fold. First, coverage does not equally access, thus reform can not stop there. Secondly, fair payment for participation in governmental programs is a significant step to increasing access. Currently, few if any, providers can cover their cost when solely caring for Medicaid or Medicare enrollees. This is because of the fatally flawed sustainable growth rate (SGR) formula. This formula destines medicine to a 23% reimbursement is not addressed. However, a true fix would cost Congress over $10 billion dollars. Thus, repeated temporary, 'just-in-time' patches are used to try to preserve current reimbursement rates; effectively just postponing an inevitable Washington needs to continually be reminded of the importance of this issue.

5:58 am. In rolls the classic early morning chest pain patient. A large anterior ST-segment elevation injury pattern is seen on ECG. The patient is efficiently cared for - medications are given, labs and a chest radiograph are performed, the family counseled, and off to the cardiac cath lab the patient goes. Knowing that CMS demonstration projects right now are looking at episodes of care and bundled payments, I wonder, 'what was emergency medicines value in this patient's care?' On the surface there seems to be a significant risk that institutions and powers-to-be marginalize the value of emergency care in these settings. We as emergency physicians must make sure this does not happen. It is critical that as reform moves forward that both society and administrations understand the roll of emergency medicine from every standpoint, diagnostic, therapeutic, and preventative.

7:00 am. I give sign-out to my colleague and head home to sleep.

These are just a few of the issues facing emergency medicine. As active practitioners we can not escape them. They affect us every day.

By being a member of Colorado ACEP you support emergency medicine. By being a member, you are advocating for a more appropriate workforce, tort reform and EMTALA provider protection, quality/safety & patient integrity, fair payment, and your specialty in the future of health care.

Thank you for being a member.

Congratulations to Carol Vanetti, MD, FACEP

Congratulations to Dr. Carol Vanetti on receiving the National Association Medical Staff Services(NAMSS) Leadership Award for 2010. Dr. Vanetti is the Regional Chief Medical Officer/Vice-President of Medical Affairs for Banner Health, Western Regional, Greeley, CO. Each year this award is bestowed to a Medical Service Professional, physician or healthcare administrator who is serving or has served in a leadership position on a hospital staff or healthcare organization and who has demonstrated support for NAMSS or for the activities and role of the Medical Services Professional.

Dr. Vanetti received her award October 5th during the Annual Conference in Orlando, FL. “Receiving this award is a great honor for me and a humbling experience. Over the years I have had the opportunity to work with many wonderfully talented and dedicated medical staff professionals/quality and risk managers/medical staff leaders/administrative personnel from across the system and to be a member of this team as we strive to constantly improve the patient care that we provide has been a pleasure”.

Upcoming Colorado ACEP Events

November 17 – “2nd Annual Colorado ACEP Symposium on Emergency Medicine”
Keynote Speaker: Greg Henry, MD, FACEP
Location: Brown Palace Hotel
Register at www.coacep.org

November 30, 2010 – Deadline for Board Candidate applications.

December 13-16th, 2010 -- Shared Strategies for Homeland Security is a multidisciplinary conference in Denver scheduled for December 13-16th, 2010. A group of experts from Israel and the United States will provide information about preparedness and response to terrorism and bombings. This is hosted by the Denver Urban Area Security Initiative. The tracks include: medical, EMS, first responders, bomb squad, SWAT, critical infrastructure and public health. More information is at: www.sharedstrategiesconference.com.

December 31, 2010 – Colorado ACEP Leadership Development Program Fellowship application due. Application can be found at www.coacep.org.

2011 Colorado ACEP meeting dates:
January 26, 2011 – Annual Meeting
March 23, 2011
May 18, 2011
July 27, 2011
September 28, 2011
November 16, 2011

Meeting Time – 11:30 – 2:00
Location – COPIC/CMS, 7351 Lowry Blvd, Denver, CO (unless otherwise noted)

Congratulations New Fellows

Tracy A. Cushing, MD, FACEP
Julie K. Hall, MD, FACEP
Caleb Hernandez, DO, FACEP
DS Miner, MD, FACEP
Anna M. Olson, MD, FACEP
David E. Rosenberg, MD, FACEP
Matthew Solley, MD, FACEP

Clinical News

CME Article on Sore Throats Now Available
Originally printed in ACEP News, the “Focus On” series of articles brings the latest literature and best practices to help the busy emergency physician. This issue’s topic, “Sore Throats -- What Really Works?,” will help the emergency physician review the incidence of strep pharyngitis in different populations, understand present guidelines regarding the diagnosis of strep pharyngitis, and develop a plan of care for treating your next patient with a "sore throat."
Read the article online and then take the CME quiz.

The Effective Physician: Chest Pain in the Emergency Department

Over 8 million people seek emergency department (ED) attention every year for assessment of chest pain. The American Heart Association recently issued a scientific statement to give guidance on rapid, effective approaches to the assessment of such patients. Conclusions: Most patients who present with chest pain to ED settings do not have acute ischemia: Less than 5% have an ST segment elevation myocardial infarction, and up to 25% can have a non–ST segment elevation event. Up to 7% of patients with chest pain after cocaine exposure have infarctions. At the same time, up to 2% of patients with acute coronary syndromes (ACS) are inadvertently discharged from EDs with potentially twice the risk-adjusted mortality of patients admitted for management of acute ischemia.

Read the Entire Article

Combination of Two Oral Drugs Shows Promise for HCV in Small Study

A combination of two oral drugs for reducing viral load in hepatitis C patients had good safety and tolerability in a small, phase I study. The finding, published online Oct. 15 in the Lancet, points the way toward an alternative to the current standard of care – subcutaneous pegylated interferon-alfa plus oral ribavirin – which has limited tolerability and efficacy. The novel therapies that were tested in this study are RG7128, a nucleoside polymerase inhibitor, and danoprevir, a protease inhibitor, wrote Dr. Edward J. Gane of Auckland (New Zealand) Clinical Studies Ltd., an early-phase clinical pharmacology unit, and his colleagues.

Read the Entire Article

Members in the Spotlight

The "Retirement" of Dr. Vince Markovchick
By: David Ross, DO, FACEP

It's 2 am…. New Year's Eve… 2010… 2009… 2008…, etc. The emergency department of Denver Health…

A familiar figure walks into the ED and asks, "Can I help?" It's the voice of an emergency physician well known to all at Denver Health.

Question: Is there a shift that begins at begins at 2 am? Answer: No.

Question: Then why has this doctor shown up at 2am to work? Answer: Because he wants to and always has.

Question: Is this doctor a new resident – excited and chomping at the bit; wanting to learn as much as possible – as soon as possible? Answer: No. This doctor is the Director of the Department of Emergency Medicine at Denver Health. The one and only,Vince Markovchick, MD FACEP.

Question: Why does Dr. Markovchick come into work on the New Year's Eve holiday –unscheduled and unannounced? Answer: Because he loves what he does.

August 9, 2009: Dr. Vince Markovchick announced he was retiring as the Director of Emergency Medicine and from full-time practice.

August 2010: In one year of "retirement," Dr. Markovchick works 10 ED shifts a month – not to mention the unscheduled appearances.

November 2010: He now averages about 4 shifts a month. For Vince, "retirement" couldn't be better.

Vince Markovchick grew up the small town of Beaver Meadow PA, the son of a coal miner who later became the owner of a small tavern. Although both of his parents were only educated through the 8th grade, Vince's father always stressed the importance of a college education.

When Vince mentioned to a high school teacher and mentor that he would some day like to be a doctor, but confided that he didn't think he could do it – since none of his family had ever been to college – the reply was, "You can do it if you want."

He took a qualifying exam for a scholarship at Kings College and received an award that covered about half of his tuition cost there. In 1966, Vince entered Temple University Medical School.

While at Temple, Vince lived less than a block away from the hospital emergency room. He found that he was spending a

significant amount of his free time hanging out in the ER there because it was an exciting place and totally run by house staff.

In 1970 he graduated from medical school and heard that the skiing was really good in Colorado. So Vince was accepted into a rotating internship at Presbyterian Hospital in Denver. His first internship rotation was in the ED at the old Denver General Hospital. "Everyone we saw, it seemed, was totally whacked out on drugs – usually LSD – and the place had no air conditioning. The ER was run by nurses and residents." Vince recalls. "So needless to say it was a pretty neat place to work and I traded with other interns to get their rotations in the ED, since many of them didn't like it."

"One of the first clinical times that we worked together, and this has always stuck with me, there was this guy that came in and it looked for all the world like he had a CVA. He had left sided hemiparesis. Back then it was like pulling teeth to get a CT scan – it was like a new phenomenon. So we were doing all kinds of things. We had residents and nurses scurrying around. And Vince walked in and kind of looked over the situation and said, "Um, did you check his blood sugar?" Sure enough, the guy was hypoglycemic. We gave him some D50 and he fully recovered. It sort of epitomizes for me Vince's clinical acumen. He's sharp as a tack and one of the best clinicians I've ever encountered. He's superb that way. He also has all around great educational and teaching capabilities. He is a master bedside teacher." Ben Honigman, MD.

After Vince completed his internship, he spent three months working as a locum tenens family physician for Homestake Mining Company in South Dakota. There he managed patients while totally alone. He did emergency call and OB call. He shot, and read, his own x-rays and did his own lab work. "That was a very humbling experience," Vince says. "After trying to manage all of this on my own, having to supposedly actually do this stuff, I realized that whatever I did in medicine, I needed formal training."

In 1971, like many doctors, Vince was faced with being drafted into the army. As an alternative, he elected to join the Air Force and became a flight surgeon.

Stationed in Taiwan for 15 months at the beginning of the end of the Vietnam War, Vince says that he treated "drips from every orifice and fought a losing war against VD." In between all of this he took ER call at the small air force base hospital in Taiwan every 15-16 days, which continued to pique his interest in emergency medicine.

While he was in the service, Vince noted in some throw away journals that the University of Cincinnati was starting the first emergency medicine residency.

All of these experiences forged Vince's interest in a career in the fledgling specialty of emergency medicine. By 1973, there were only 11 residency programs in the country and he applied to all of them.

He was accepted to the University of Chicago in 1974; the third year the program had been in operation. The Director of the Emergency Medicine Residency at that time was Dr. Peter Rosen. The entire residency consisted of no more than four attending physicians and the "the residents ran the place" according to Vince.

It was a very challenging time, to say the least, as the pioneers in emergency medicine fought (sometimes literally) for a place at the table in the house of medicine. Vince says that his class dealt with the perception of other residents that "anyone can do ER." "Other specialties would usually assign the most junior house staff to the ER."

"We had a few knock out, drag 'em down sessions there," Vince recalls. "It was tough to just get patients admitted. It was an evolutionary process and really hard back then. We were blazing new trails. We had no real respect. So you had to work hard and if you provided good medical care, over time – things got better. We had no inpatient rotations at the University of Chicago. We had a few inpatient rotations at outside hospitals. About 80% of our training was in the ED. The other services just didn't have much respect for emergency medicine. That was a limitation."

Nevertheless, only 1 of the 8 residents in Vince's class left the program and the other 7 all had long careers in emergency medicine. "I don't think any of us second guessed our decision. We were close knit socially and we trained each other a lot. We realized this was exciting new specialty."

"We knew this was a pioneering time. But we took a lot of arrows – but none more than Peter Rosen. Fortunately, in Peter, we had a strong and visionary leader. We could not have done it without him."

"Vince is a self-proclaimed techno-tard. He called me when I was on shift one day and said, 'I need to send an email attachment to somebody and my secretary is out of town.'

I knew it was going to take a while. So I let everyone know I was going to kind of be out of the flow of things. So I walked him through the whole thing. Now hit "new," and find your contact. See the little paper clip on the email? – and that took him awhile – now push browse…

‘OK, OK,’ he said.
Now do you see your document?
He said, ‘what do you mean?’
Well, do you see the document that you want to attach?
There was silence.
‘No, I have it on a piece of paper right here.’
And I didn’t know what to say. I just sort of didn’t say anything.
Then he said, ‘Oh, forget it. I’ll just wait until my secretary comes back,’”
Katie Bakes MD

After completing his residency, Vince took a job in Denver in the ED at Swedish Hospital. “They had one of the first residency trained emergency medicine groups in the country,” he recalls. It was an excellent opportunity in non – academic emergency medicine.

But in 1977, Dr. Rosen came to Denver General Hospital (as Denver Health was known at the time) to take over direction of the emergency medicine program. He quickly lured Vince away from Swedish to Denver Health and, in a very short time Vince served as the Associate Director of the Emergency Medicine Residency. He essentially, ran the day – to – day operations.

“Vince was in the second full class of residents I trained at the University of Chicago.
He was a wonderful resident. He came to residency from the Air Force and was very mature. He was always a good doctor and grew rapidly in the residency.

I became Chair at Denver General and he quit his Swedish job to help me develop the residency. I was always very appreciative of that help and Vince had to accept a really significant decrease in salary. To me, that is a mark of terrific loyalty.” Peter Rosen, MD

Up until 1985, the University of Colorado did not recognize the specialty of emergency medicine and did not confer faculty status on the Denver General emergency medicine residency faculty. After that, emergency medicine became a division within the Department of Surgery and the emergency medicine faculty members were given academic appointments in the Department of Surgery.

During these years, emergency medicine “gained its spurs by working hard,” Vince says. “We recruited the highest quality residents who could stand up. We were the first academic ED to commit to 24 hour attending coverage. During the period from 1977- 82, we had 6 – 7 positions per year and received about 50 applications – with many top quality people who applied. But when emergency medicine became a specialty in 1980, the applications for a residency spot at Denver General quadrupled in number – over night. Over the next 8-9 years, we increased to 12 – 14 positions but averaged over 500 applications. Peter Rosen was our mentor for much of this growth.”

They did all of this with 6 – 8 attendings in the program. It wasn’t until 1990 that the CEO of Denver Health, Dr. Patty Gabow, added funding for four more attendings. Vince thought he was in heaven.

The EMS biophone at Denver General Hospital rings.
“Paramedic” Jody Richter is on the line. = JR
Dr. Vince Markovchick, serving as Medical Control that day. = VJM

VJM: Vince Markovchick, go ahead.
JR: Yes, Dr. Markovchick, this is Jody Richter on Reed Med 21. I’m calling into you because we were enroute on an interhospital transfer when we came across an auto pedestrian accident about 17th and Madison. We’ve gone ahead and evaluated the pedestrian. She’s a 55 year old female who was in a wheelchair crossing the street when she was struck by a car traveling about 30 miles per hour. She was knocked out of the wheelchair. She’s paraplegic evidently from a spinal cord tumor that she has had in the past. Her only complaints now are some right wrist pain and an inability to feel her lower extremities. She’s really not complaining of anything else. She’s a little bit confused but I smelled some alcohol so I think she’s probably intoxicated. She has a history of hypertension and is on some antihypertensive meds but can’t remember what they are right now. On physical exam she’s a bit confused. Her vital signs are stable. Her head, there’s no obvious injury. Pupils equal, round and reactive. No obvious trauma there. Her neck is restrained at this time. She has some mid c-spine tenderness. Chest is stable and clear and her abdomen is basically non-tender. Pelvis is stable. On extremity exam, she has some swelling and marked tenderness over her right wrist and the pulses are intact. We thought that she had some deformity of her right proximal femur with some swelling associated with it, but we think that is probably old because she has absolutely no tenderness whatsoever on palpation of it. And, um, that’s about it for physical exam-“
VJM: What are her vital signs?

JR: She has a blood pressure of 100/60, a pulse of 117 and a respiratory rate of about 24.
VJM: Alright, and you're bringing her here?
JR: Well, what we planned on doing was – we're at 17th and Madison and only one block from Mercy , so –"
VJM: That's a negative. Uh, this is not a DG overload call is it? You're calling us for advice. Mercy's not a trauma center. Given the mechanism of injury, she needs to come to either University or to here.
JR: Umm. OK…. Let me check with my partner on that… What's an overload call?
VJM: That's if our dispatch called you. But you're calling me as if it's a DG call and I'm telling you what your destination is for trauma. Given this mechanism and her confusion, she needs to go to one of the trauma centers.
JR: I see.
VJM: OK?
JR: Umm, the other thing we wanted to ask for was an order for – see she's in considerable pain with her wrist – and actually she's refusing right now but I think we can talk her into transport – we were hoping that… she says if we could give her something for her wrist – we were hoping to give her 2 mg of morphine IV.
VJM: Ahhh, I guess that's OK to give her 2 mg. But, uh, as I said – why don't you let us know what hospital you're going to take her to – but Mercy's not appropriate.
JR: OK... Umm, would you hold one second, Dr. Markovchick, while I speak with my partner?
VJM: Alright.
Long pause in the patch.
JR: Umm, Dr. Markovchick, Umm, apparently my partner says he's having a hard time getting a pressure now; it's down to about 80 now.
VJM: Well then she needs to come either here to University – Code 10. She can't run away from you. Put her in an ambulance and take her.
JR: OK her respiratory rate is about 24 right now umm do, you think -.
VJM: Hold on the morphine. I don't want any morphine if she's hypotensive!
JR: She's already gotten it, sir.
VJM: How'd she get it so soon?
JR: Well, actually my partner –
VJM: Gave it before he got the order. OK. Umm, alright.
JR: Um, anyway, do you think we should intubate her?
VJM: Well, is she awake and talking to you?
JR: Well, she's kind of confused and she's –
VJM: Well I think you ought to get her in the ambulance and get her to University or here. That's the first thing to do. If her level of consciousness goes down – she's got c-spine tenderness right?
JR: Uhh-
VJM: So I would just supplement her respirations with bag valve mask and get her to one of the two trauma centers. Where ya gonna go?
JR: OK, well, I think that since we're only one block from Mercy, umm maybe –
VJM: I said I don't want you to go to Mercy! Now you called me for some orders. If you want to call your own physician and let him take all the responsibility, go ahead and do it. We're wasting time.
JR: Ummm... OK, Dr. Marko. I guess the ….. here is that we accidentally gave 10 mg of morphine

VJM: 10 mg of morphine? Oh, geez! You've got to give her IV fluids, alright?
JR: Ok, Uh – uh, ok –
VJM: And if her respirations are depressed give her narcan.
JR: Ohhh, OK.
VJM: Alright? Go ahead and give her narcan. Open up her IV fluids. You got an IV in?
JR: Well…. We had one –
VJM: And you lost it.
JR: We lost it.
VJM: Alright. Get her in an ambulance. Are you closer to here or University?
JR: Well we're closer to Mercy but we're –
VJM: Well, uh, are you closer to here or University? Forget Mercy.
JR: Umm, probably, probably DG.
VJM: Alright, bring her here, OK? What's your ETA?
JR: Umm, probably, uh, 20 minutes?
VJM: 20 minutes?
JR: OK. Well, ya we got –
VJM: Yeah, sure. OK, why don't ya do that? Give her narcan. Give her fluids if you get the IV reestablished. If you don't, just put her in an ambulance and bring her here. OK?
JR: OK my partner's trying to intubate her now. He's, he's having some difficulty..…. with epistaxis.

VJM: Alright, well if he's having difficulty – Give her narcan! Now he has difficulty with epistaxis – Joanne is this you?
JR: Yes. (sound of laughter in the background)

Indeed, hapless "paramedic" Jody Richter was none other than Joanne Edney, MD, graduating resident at the time that call was made – and recorded – for posterity. She was ably assisted by another senior resident, Dr. Jeff Schaider. Dr. Peter Rosen was also an accomplice in the scam. He was stationed near the biophone just in case Vince launched himself into orbit over the call and had an MI. According to Dr. Edney, the audio for the call was played for the next 18 years at residency graduation and also when incoming residents were introduced to the biophone.

"I could see Vince getting madder and madder. His face was turning red and his blood pressure was hardly measurable. But Vince remained very professional and very courteous to the paramedic. Finally, I have no idea what triggered it – other than Vince's great instincts – he finally said, "OK, Joanne very funny – that's enough."

I don't know how he does it but he has the ability to solve problems instantaneously. It's very hard to fool Vince. You can con a lot of people in this world, but I don't think he's one of them. How he recognized her voice I don't know, because she had very successfully disguised it. Joanne did a masterful job of playing a paramedic. One of the funnier parts was how she mispronounced his name." Peter Rosen, MD

In 1989, Dr. Rosen left Denver General. Vince was selected to replace him as the Director of Emergency Medicine." Peter was my mentor and gave me every opportunity to what I have been able to do. He is just an incredible person. And I have seen him again and again take a resident who didn't have a lot of self confidence in his own abilities and bring him along," Vince says.

"Early on, getting people to recognize emergency medicine as a specialty remained difficult. We very were fortunate that Dr. Gene Moore (the current Chief of Surgery at Denver Health) arrived at the same time. Gene had an enlightened view of emergency medicine and has always been a good friend. He helped us a lot from the surgical perspective."

"Vince assumed the Directorship of the Denver Health Emergency Department from Peter Rosen, and maintained a premier training program as well as outstanding emergency department. Under his capable leadership, the Denver Health Emergency Medicine Program has literally trained the first generation of emergency physicians throughout Colorado." Gene Moore, MD

Denver General was the first academic emergency medicine residency in the country to make a commitment to 24 hour attending coverage. In fact, they wrote an editorial in the 70s about why it was important to have 24 hour attending coverage. "And we got an awful lot of blowback from our colleagues across the country who didn't want to make that commitment," Vince recalls.

"He has a profound love of eating. He really loves events that have food associated with them. But because of that love, he knows a lot of great restaurants in Denver. My wife and I still go back to the New Saigon Restaurant where Vince and Leslie first took us years a go," Ben Honigman, MD

"There are lots of legendary stories about Vince's eating and food. We always knew that if we wanted a meeting to go well with Vince, that if you brought food and waited just about 15 minutes for Vince to eat, the meeting would go well and he would be happy.
It could be almost anything. He wasn't particularly picky about which food.
If you brought the right food, and let him get a first helping there, - immediately the atmosphere and mood would head in the right direction," Chris Colwell, MD

"His ability to repair a wound is matched only by his appetite and his desire to eat good food," Peter Pons, MD

"There used to be a chain of restaurants in Denver called Victoria's Station. They had good prime rib. They would give you free seconds, thirds and fourths. But the portions would get smaller each time. One time Vince and I went there for lunch. We had 8 portions! By the time we got to the 8th portion, the restaurant staff was not happy at all. They were not making any money on us," Peter Rosen, MD

Vince has made many friends at Denver Health along the way, but particularly mentioned former residents and later faculty members Drs. Steve Cantrill, Dr. Peter Pons. They've been close friends and colleagues and have been instrumental in developing bringing Denver Health to where it is now in clinical care and residency training.

Working at Denver Health, Vince could just practice emergency medicine – and did not have to worry about billing and coding. "I enjoy taking care of indigent patients. And when the intoxicated sober up they usually become very nice people," Vince says.

"What struck me about Vince when I was a resident in 1992 is his love for emergency medicine. I mean he loves to do it. You can tell when you stand next to him how much he loves doing clinical work. He's also very good at it.
As a resident one night, we had 6 asthmatics. He and I went to all of them. After that, Vince said, Room 1 and 6 will wind up getting intubated, but the others I think we can turn around. Vince was absolutely spot on. He is a clinician first and foremost."
Chris Colwell, MD

"Vince is probably one of the most amazing emergency physicians I have ever met. I first met him when I was a starting as a resident in 1977. He's a great clinician. He has probably the best suturing hands I have ever seen on anyone including any plastic surgeon you can name. The guy is just amazing when it comes to his ability to repair a wound. He takes real pride in the skill of repairing wounds. It is where the art of medicine comes into play with mechanical skill. The end result is kind of the visible part of what we do. His ability to teach how to suture and repair a wound is just remarkable."
Peter Pons, MD

"Vince has a bear trap mind. I have been very impressed over 30 years of time. You sit and talk with him and these things just pop out. It sometimes a little deceiving about how much he knows. I have always appreciated him for that." Steve Cantrill, MD

"Vince is one of the clinically instinctively best physicians I've ever met. He's just always on the money. He's a very hard worker as everyone at Denver General knows."
Peter Rosen, MD.

Of the many non-clinical achievements in Vince's career, one that stands out his service on the Board of Directors of the American Board of Emergency Medicine from 1994-2002. He also served as President of ABEM in 1999-2000.

"This (ABEM) is a first class organization in emergency medicine that I think we are very fortunate to have doing the certification process," Vince says.

"He has done a lot to shape the specialty which I think a lot of people don't appreciate.
His work on the Liaison Review Committee (before we had an RRC) and to shape the development of residencies across the country as well as ABEM and the LLSA – love it or hate it, has been very instrumental," Steve Cantrill, MD

"He's done a tremendous amount nationally with ABEM and his scholarly work,"
Ben Honigman, MD

"Vince was a crucial part of residency creation. Vince has been CO ACEP President and done many other things for our specialty and all that is important, but what defines him most is his love of patient care," Chris Colwell, MD

Vince has also had the opportunity to participate in the medical care at many major events in the Denver area throughout the years.

"What's fun about emergency medicine is that you don't always work in the ED. You can do other things," Vince says.

Covering special events in Denver has always been an exciting diversion for Vince.
One of the big ones he participated in was World Youth Day in 1993. Vince, along with others, had to provide care for the kids at the event – and also coverage for the Pope.

There were over 100 Secret Service agents involved and Vince got to meet the Pope.
"I was very moved. The man was an incredible person. I also go to meet his physician and observe many things behind the scenes. We were very busy clinically at both events," Vince recalls.

For Vince, the highlight in his storied professional life has been the opportunity to interact with almost 300 residents. "The reason I went to Denver Health in the first place was to be involved in the recruitment, selection, training and the incredible maturation of the residents and most importantly watch them go out and do great things – has been wonderful. That's the satisfaction of being in academics; to have some small part in the amazing things the residents later go out and do."

"Vince has been a really big mentor for me. You can always believe what he says and know that he will never stretch the truth. He went into academic medicine because he believes strongly in the mission of taking care of patients in a safety net hospital and of academics. He chose to work more hours for less pay because of the mission and training of new emergency physicians." Katie Bakes, MD

"About 14 residents have been academic emergency medicine directors. Approximately 20 have gone on to be private ED directors and 15 have been residency directors. We have been able to train leaders who have made a real impact on the

specialty across the country. About 30% of the practicing emergency physicians in Colorado are graduates of our program. That role has been the greatest part of my career," Vince says.

"I consider myself extremely fortunate to have trained under Vince Markovchick. He was an excellent teacher, mentor and subsequent friend. He helped build the framework of one of the best emergency medicine residencies in the country and provided an amazing training experience for me and many others. His passion for the specialty of emergency medicine was contagious. Many of our current national leaders in emergency medicine are his former residents and testimony to his success. Through example he taught hard work, accountability, and intellectual honest,"
Joanne Edney, MD

On the occasion of Vince's "last" shift he was given a catered breakfast.
"That was kind of neat. It was bittersweet. On the one hand, I sort of thought it was time to leave. I had been there for 32 years and maybe it was time to have some new people take over," Vince recalls.

"And you know I'm back. I had been averaging 10 clinical shifts a month over the past year, but I have slowed down just recently to about 4 per month. It's easy but when you don't have any administrative responsibilities. As an academic, the clinical hours are less than in private practice, but the total time is generally greater."

"I missed the residents," Vince continues. "I just wanted to have maintained contact with them and with clinical emergency medicine. And I had some free time and it's nice for Leslie to get me out of the house. And I would like to continue doing that for the next few years."

"He and I worked a shift a couple of weeks ago which is kind of funny. It was kind of the old fart shift. I think it scared some of the residents." Steve Cantrill, MD

"I think that typifies what I see in him and his clinical care. He always puts the patient first. He considers it a real vocation to take care of people and also teach residents," Katie Bakes, MD

Nevertheless Vince, and his wife, Leslie, have found enough time to much more traveling this past year. "We have been to Iceland and Scotland where I did a gig as a cruise ship doctor. We've been to Argentina, South Africa and Hawaii. We will be going to Australia and New Zealand. That's been sort of fun to have the opportunity to go off and travel."

Since Vince has been retired he gets to the gym every day. That was never possible when he was working full-time. He likes to read. And he gets to read a lot more – especially things outside of medicine that he has an interest in and never have had time for.

Their three daughters are grown. Nicole works for a church in Kansas City. Natasha is a nurse at Denver Health and Nadia is an emergency medicine resident at Temple in Philadelphia.

"We lived right around the corner from each other in Denver. Our kids played together. We used to compete over who could give the other's kids the loudest toys that would be the most irritating to the respective parents." Peter Rosen, MD

"I've been lucky because he I have had a very supportive wife and family who have understood that I have had to be gone for 5-6 days a week," Vince says.

Vince enjoys skiing and has since he first came out to Colorado. He has had an association with the Copper Mountain Ski Patrol since 1979 that has been a very satisfying diversion for him.

On April 1, 2010, Dr. Vince Markovchick was designated the first Emeritus Professor in Emergency Medicine of the Department of Emergency Medicine at the University of Colorado.
"I thought that only went to people who were dead," Vince remarks with characteristic wit.

"His sense of humor is present most of the time. Vince can see the humor in many situations which many people might not. That goes a long way towards defusing situations and adding a bit of sanity to the practice," Steve Cantrill, MD

"He's a very honest man. His seriousness is matched by his very puckish sense of humor. He's fun to get to know when you get past his seriousness," Peter Rosen, MD

"I am very optimistic for the future of emergency medicine. The exciting part of emergency medicine is that it continues to be defined. It continues to evolve. The incredible people we keep recruiting into it are taking it to different heights and different places. Emergency medicine has now evolved into a specialty that attracts the most competitive students who are the best and the brightest. And that will continue. It's going to continue to do even greater things in the future," Vince concludes.

“Vince is one the founders of emergency medicine. He was one of the developers of what we take for granted today in emergency medicine,” Chris Colwell, MD

“He does not play games with things that are important. His ability to strive for perfection and to require others do that is one of the things that makes him great,”
Peter Rosen, MD

“I am forever grateful for the foundation he provided for me and others,”
Joanne Edney, MD

He’s done a lot and emergency medicine is the better for it,” Steve Cantrill, MD

“Any time a pediatric emergency department opens, there is a lot of negotiating with the Department of Pediatrics and he really helped with that. Ultimately it is an emergency department with all the things we needed for kids. It was a lot of work that he really made happen. It wouldn’t have been done without him,” Katie Bakes, MD

“Dr. Markovchick carried on the great tradition of Dr. Peter Rosen in leading a world class Department of Emergency Medicine. He supported and developed all the components of the Department: clinical care, training of residents, fellows, paramedics and EMTs, advancing new knowledge with research in Emergency Department and pre-hospital care, and continuing to mature the medical based pre-hospital care system. In addition to his leadership, he, personally, was an excellent clinician and teacher. His shoes will be hard to fill,”
Patricia Gabow, MD

“We’d all be remiss to not recognize that he has been the heart and soul of the residency in emergency medicine in Denver for the last 32 years. He has been the one truly constant factor there from the very beginning. And this is really a passing of the baton in terms of someone who started in emergency medicine at the very beginning in one of the earliest residencies in Chicago. He, then, took the residency in its infancy and developing it into one of the best programs in the country,” Peter Pons, MD

“Vince has been a loyal companion and true colleague and a wonderful friend and an absolutely admirable physician. He is one of my heroes,” Peter Rosen, MD

Highlights in the Career of Dr. Vince Markovchick – At a Glance.

1970: Graduation from Temple University School of Medicine
1971: Family Practice, Homestake Mining Co. Hospital. Lead, SD
1971-1973: US Air Force service as a flight surgeon
1974-1976: Emergency medicine residency - University of Chicago
1976: Emergency medicine practice - Swedish Medical Center in Denver
1977: Faculty position in the emergency medicine residency - Denver General as Program Coordinator
1981-86; 1995 – present: Oral Board Examiner, American Board of Emergency Medicine
1982-83: President, Colorado Chapter ACEP
1983-87: Member ACEP Academic Affairs Committee (Chair 1985-87)
1983-92: Co-editor, Abstract Section – Annals of Emergency Medicine
1986-87: Medical Director, Denver Health Paramedic Division
1987-90: Vice President, Executive Board, Colorado Trauma Institute
1989: Appointed Director of the Department of Emergency Medicine – Denver General
1989-92: Member, Board of Directors – Council of Emergency Medicine Residency Directors
1991: Excellence in Teaching Award - Emergency Medicine Residents Association
1992: Outstanding Career Service Faculty Teaching Award – Denver Health and Hospitals
1993: Emergency physician to Pope John Paul II and World Youth Day
1994-96: Chair of the Residency Review Committee
1994-2002: Member, Board of Directors - American Board of Emergency Medicine
1995, 96, 98: Peter Rosen Leadership Award – graduating Denver Health Residents
1996-2000: Medical Director, Denver Fire Department
1998-2002: Editor, Written Board Certification Exam, American Board of Emergency Medicine
1999-2000: President - American Board of Emergency Medicine
2000: Alumni Achievement Award – Temple University School of Medicine
1997: Outstanding Contribution to Education Award – ACEP
2001: Peter Rosen Award – American Academy of Emergency Medicine
2002: Best Doctors in America List

2007: Appointed Associate Dean for Health Affairs, University of Colorado School of Medicine
2007-09: Director of Medical Education, Denver Health Medical Center
2008: Health Hero of Colorado – Health Care for All Colorado
2008: Lifetime Achievement Award - Denver Health Emergency Medicine Residency
2008: Hero of Emergency Medicine – ACEP
2009: Retirement from Director of Department of Emergency Medicine – Denver Health
2009: Denver City Council Proclamation recognizing “32 years of emergency medicine service to the citizens of Denver”
2009: Inaugural recipient of the Legacy Award – Colorado Chapter ACEP
2010: Appointed first Emeritus Professor of Emergency Medicine – University of Colorado School of Medicine

1977- 2009: Co-author of 6 textbooks in emergency medicine, 51 book chapters, 23 peer reviewed articles, 2 abstract presentations and over 160 lectures given nationally and internationally.

Town Hall Meeting Addresses ACEP’s Health Care Reform Priorities

With the nation’s health care reform law in place and no real expectation of its repeal, ACEP leaders discussed the College’s priorities for the law’s implementation process at a Town Hall session during the ACEP Council Meeting in late September.

“This is probably the most significant moment in our careers. Our Washington office is already working on all of this, but the discussions will heat up after the November elections,” said ACEP President Dr. Sandy Schneider. “We are all going to have to work together with one message. This is a time to build emergency medicine into a stronger emergency medicine.”

During the meeting, ACEP Immediate Past President Dr. Angela Gardner distributed a chart of the Patient Protection and Affordable Care Act of 2010 that matched provisions in the law with ACEP’s strategy. Some of the key priorities include:

- Extend the “prudent layperson standard” to grandfathered health plans to eliminate the need for prior authorization.
- Improve emergency department efficiencies.
- Improve the physicians’ quality reporting system.
- Recognize the important role emergency physicians play in providing the full continuum of care to Medicare beneficiaries.
- Raise concerns about new Medicare payment mechanisms, such as bundled payments.
- Distribute additional residency positions to emergency medicine residency programs.
- Highlight the education and training needs of emergency medicine as the work of the National Health Care Workforce Commission proceeds.
- Represent the emergency medicine perspective in identifying research priorities and establishing and implementing the research project agenda.
- Extend medical liability coverage and review the unique requirements of physicians who provide EMTALA-related services.
- Considered how the Federal Tort Claims Act may be applied to ensure the availability of emergency and on-call physicians.

“We will have to be diligent” as the lengthy and complex regulatory process continues, said Gordon Wheeler, ACEP’s Associate Executive Director for Public Affairs. “There will likely be attempts to slow funding for the law’s implementation, attempts to undercut and undermine its intent.

“As imperfect as the law is, there are a lot of things we would like to see happen in there,” he said.

To bolster the efforts of ACEP’s Washington, DC office, the ACEP Board of Directors approved a budget modification to provide more health care reform resources, including hiring two new staff members and contracting with a legal firm that specializes in regulatory law.

Dr. Steve Stack, an ACEP member and secretary of the AMA, said, “We need to focus on how we can work within this law. We are hopeful that there is not coverage without access. If all the uninsured (patients) have coverage, we know the ED patient volumes will go up and they are only going to get larger.”

Comments from members of the Council focused on concerns about emergency physician payments, projects that ultimately were cut from the reform package, and at what tables ACEP needs a seat now to protect and promote the interests of emergency patients and emergency physicians.

"The tables I want to be at are small tables in someone's office, the people who are actually writing the regulations," said Dean Wilkerson, ACEP Executive Director.

Mr. Wilkerson also explained that emergency physicians can and should get involved in the process, as well, by staying informed and informing ACEP of crucial issues at the state and local levels, joining the 911 network or the spokespersons network, writing concise newspaper editorials, staying active in their chapters, and donating to NEMPAC.

Nominations Accepted for ED Director of the Year

The Emergency Medicine Foundation (EMF) is now accepting nominations for the 2011Blue Jay Consulting/EMF Award for Emergency Department Director of the Year.

The award was created to identify and recognize an individual who has made significant strides in developing collaborative relationships with nursing to implement and improve operational and clinical standards in five specific areas -- quality patient care, operational effectiveness, education, community service, and a synergistic approach to leadership within the hospital or hospital system.

Because successful emergency departments have strong collegial relationships between physicians and nurses, these collaborations can make lasting improvements in quality care and patient satisfaction.

"The collaborative nature of emergency medicine is reflected in the goals of the Blue Jay award to recognize the successful ED director who demonstrates team work with the nursing leadership of their department," said Mark J. Feinberg, Managing Partner, Blue Jay Consulting. "Our hope is that this award will provide encouragement to all who work in emergency medicine to continue to seek out every opportunity to improve patient care in the ED."

To be considered, the nominee will have created and sustained a high degree of patient satisfaction with emergency care delivery and will have implemented creative and innovative strategies to improve all areas of the emergency department.

Dr. Rex G. Mathew, vice president of emergency medical clinical operations at Thomas Jefferson University Hospital in Philadelphia, was honored with the inaugural Blue Jay Consulting/EMF Award during the April 2010 Emergency Department Director's Academy (EDDA) in Dallas, Texas.

With almost 80 nominations from some of the best and brightest directors in emergency medicine, the selection process was challenging. Dr. Mathew was ultimately chosen because of his demonstrated leadership abilities and clinical knowledge in working with leaders throughout the hospital to improve care in the emergency department.

The three finalists for 2010 included Dr. Patrick J. Crocker, chief of emergency medicine at Dell Children's Medical Center of Central Texas in Austin, Texas, who was instrumental in working across disciplines to create the Comfort Zone Program addressing the comfort, anxiety, and pain perception of patients. Dr. William Dalsey, chairman of the department of emergency medicine at Kimball Medical Center in Lakewood, NJ, was also a finalist because of his collaborative approach to patient care that earned Kimball Medical Center top honors for the last 5 years in patient satisfaction scores. Dr. Paul Ernest Pepe, chief of emergency services at Parkland Health and Hospital System in Dallas, Texas, was another finalist. Dr. Pepe's strong team philosophy, work ethic, and philosophical temperament stood out in his work at one of the most visible emergency care centers in the country.

"This year the Emergency Medicine Foundation has a special desire to work with young investigators to focus on health policy and process. The medical director award provides a most appropriate extension of this goal," said EMF Chair, Dr. Alexander Rosenau. "The award process identifies and recognizes emergency directors who utilize actionable knowledge to improve the function of their emergency departments and the effectiveness of the health care delivery system of their institution."

The Emergency Medicine Foundation, founded in 1972, is dedicated to serve as a catalyst to advance education and research in emergency medicine. To date, EMF has awarded nearly $10 million in research awards to advance emergency medicine science and research. For more information on the foundation, please visit our website.

For a nomination form, visit www.emfoundation.org/directoraward. Nominations are due by February 18, 2011, and the 2011 award will be presented at the Emergency Department Directors Academy (EDDA) on May 2, 2011 in Dallas, Texas.

Emergency Medicine Foundation Expands its Funding Priorities

The Emergency Medicine Foundation (EMF) is pleased to announce an area of special emphasis for its fully funded grant categories in the 2011-2012 grant cycle. To better improve emergency patient care, illustrate value in emergency medicine research, and assist the practice of emergency physicians in a changing health care environment, the EMF Board of Trustees is emphasizing innovative health services and health policy research.

EMF has been committed to supporting emergency medicine research by helping young investigators. Grants currently fully funded by EMF are the EMF Health Policy Grant ($50,000), the EMF Fellowship ($150,000 over two years), and the EMF Career Development Grant ($50,000). For this grant cycle, EMF encourages applications with a focus on health services research, including but not limited to, health policy, practice, medical liability, regionalization, patient safety, and hospital utilization. However, it is important to note that EMF welcomes all applications, including research that is not health services-based.

"The Emergency Medicine Foundation has committed to supporting actionable research that directly impacts the care of our patients," said EMF Board Chair Alexander Rosenau, DO, FACEP. "EMF will continue to underwrite a wide variety of research. The EMF Board of Trustees believes that this new era in health care reform is not only momentous, but pivotal. It demands serious investigation by the best that emergency medicine researchers have to offer in health services and health policy research."

The Emergency Medicine Foundation also offers several co-sponsored grants, including:

EMF/SAEM Medical Student ($2,400 each, two available), due January 5, 2011

EMF/EMRA Resident Research ($5,000 each, three available), due January 5, 2011

2011EMF/ENAF Team Grant ($50,000,one available), due January 5, 2011

EMF is pleased to announce two new co-sponsored partnerships:
EMF/Medical Toxicology Foundation Resident Research ($5,000, one available), due January 5, 2011

2011EMF/Emergency Medicine Patient Safety Foundation ($10,000, one available), due January 5, 2011

Also new this year will be two directed research grants. The first is underwritten by Baxter in sub-cutaneous infusion ($50,000, one available) (due January 5, 2011) and the other is underwritten by Genentech in regionalization and stroke care ($100,000, one available) (due February 1, 2011).

Go to our website to upload your application and instructions. Grant deadline is January 5, 2011 for all grant categories except for the EMF/Genentech grant, which has been extended until February 1, 2011.

Welcome New Members

John D. Anderson, MD
Dowin Boatright
Alexander Bromfield
Paul T. Cheung
Benjamin R. Deaton
Peter J. Emiley, MD
Elena G. Ewert, MD
Nir Harish, MD
Eric A. Harvester
Michael A. Johnson, MD
Christopher D. Johnston, MD
Douglas Melzer-Diep, MD
Ashley Menne, MD
Michael P. Miller, MD
Kristy L. Rahimi, MD
Omeed Saghafi, MD
Matthew C. Taecker, MD
Estee L. Tran, MD
Liz Wasson

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