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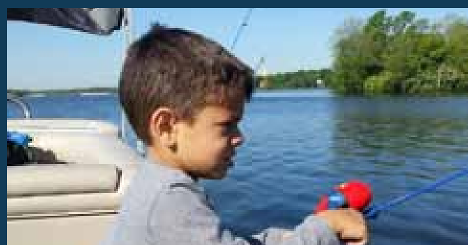

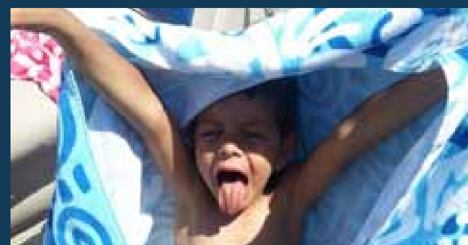

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We like to feature photographs or other artwork shared by IMS members on the cover of *The Bulletin.* Submit photographs, artwork, etc., to Beverly Hurt at the Society Office, bhurt@imsonline.org.

The Bulletin is your magazine. Share your views by submitting reprints of your published articles; articles written expressly for *The Bulletin*; quips; short stories; brief comments; ideas; cartoons, etc.

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about our cover

On our cover:
Let's Celebrate America!
Independence Day of the United States, also referred to as Fourth of July or July Fourth in the USA, is our holiday commemorating the adoption of the Declaration of Independence on July 4, 1776, by the Continental Congress declaring that the thirteen American colonies became an independent country.

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President's Page

Stephen W. Perkins, MD

Flying the "Friendly Skies:" Are You Prepared for an In-Flight Medical Emergency?

Dear Colleagues,

We are all physicians and, no matter where we are, there is an assumed and reasonable expectation that we are trained, capable and even experienced in managing sudden medical emergencies. Many of us, as we specialize and even sub-specialize in various fields of medicine, become much less knowledgeable and certainly less experienced in managing a medical emergency with respect to a potential life-threatening event. Most of the time, we are in environments where the basics of life support, i.e. BCLS are known to us and, with our own reasonable expectation, emergency medical and life support systems are within a few minutes to several minutes of taking over and treating the imperiled patient. You may be able to think of several situations or locations where you are the only medical or paramedical person within an hour or more of handling the medical emergency crisis and treating the now newly afflicted patient before you. One very common place you might find yourself is on an airplane. These may be short domestic flights within a short radius and close to being able to land fairly quickly near a known medical facility. Or they may be longer flights across the country over areas where the plane is unable to land immediately or the medical facility is located far away.

Not uncommonly, on longer flights, such as flying overseas, someone may need emergency medical attention, possibly even resuscitation, and you may well be the only physician or even allied medical person on a plane of over two to three hundred persons. You may fly infrequently or frequently for recreational purposes, for professional reasons and continuing medical education, to locations further from home. If you are a speaker in your field, you may find yourself traveling even more and for longer distances, to other countries, to lecture and teach about your medical specialty. I, personally, fly frequently for these reasons and the stories I am going to share with you are real and are almost inevitably going to happen to you the more time you spend flying the 'friendly skies.'

Are you personally prepared to manage an in-flight medical emergency? More importantly, are you aware of the medical supplies available on typical airplanes that you normally would expect to have to assist you in diagnosing, stabilizing and treating the patient's medical emergency before an appropriate landing site can be found and a medical facility awaiting transfer of care? An interesting article was written by Brian J. Secemsky, MD, an Internal Medicine resident, in *Physician* (July 16, 2015). Brian wrote about why physicians should be trained for in-flight emergencies and how he finds the training provided in medical school woefully inadequate. He found himself on a long flight from Chicago to San Francisco and could not help but feel a little bit on edge thinking about the possibility of hearing the announcement, "Is there a doctor on this flight?" If you have never heard this announcement on a long flight while you were working, reading, or even dozing off to sleep, it can be a heart rate raising announcement. My first reaction has been to think, "Hmmm. Are there any other doctors on this flight? And what is the problem they need a physician to attend to? Am I, as a specialty facial plastic surgeon, even trained and qualified, and the proper one to respond to this request?"

Brian Secemsky, MD, feels that new physicians who go through plenty of training throughout their years in medical school and residency, spend countless hours doing things that will not be used in their field of expertise and are not pertinent to the long term need to handle a medical emergency. A commercial airline medical emergency is a real possibility and, he feels that our medical schools and residency programs should train medical students and new physicians on how to confidently handle an emergency while aboard a commercial flight. One big issue a physician faces during an in-flight medical emergency is just setting up the proper medical equipment – Where is it? How do I access it? And, is anyone helping me assess and treat the patient? While airline attendants are trained as to where their medical equipment is, they are not at all trained to actually provide any kind of assisted medical care. We are often very used to having nurses, paramedical personnel and/or medical assistants, all of whom may or may not be present at the time of an emergency you are managing on an air flight- most likely not. Most clinical physicians prescribe a great deal of medications every day to treat a full spectrum of patient ailments. Most of us, as physicians, have the basic knowledge of what are life-saving medications that should be available during a medical emergency but knowing how and if these are available on any given flight up in the friendly skies is quite a different story.

To share my personal experience, I have had four different in-flight medical emergencies. On two occasions, I was the only physician on board. On the other two flights, I had the assistance of a physician in a different specialty. One of the most serious of these medical emergencies required performing life-saving resuscitation, including starting an intravenous line, establishing an airway, and administering medications. Fortunately, there was at least a nurse available to assist me at the time, as the patient was lying on the floor of the galley where the medical attendants had taken him. This particular situation occurred on a flight home from Amsterdam. We had already flown from Ireland and were within two to three hours of being able to land in Canada near a medical facility. Of course, as physicians, our first thought should be, "Is this person having an acute cardiac event?" Or, "Why have they become at least temporarily unresponsive, unconscious and pulse-less?" Fortunately, this particular emergency had

Continued on page 15.

 – Kevin Tolliver, MD; Theresa Rohr-Kirchgraber, MD

A Novel Approach to an Old Problem

A hospital discharge follow-up clinic to decrease readmission rates.

The Development of an Internal Medicine Transitional Care Clinic

Traditionally, the primary care physician (PCP) cared for their patients in both the inpatient and outpatient setting with morning rounds in the hospital, a full day at the office and often returning to the hospital again in the evening. As this method of care has proven increasingly difficult as hospitalized patients have become sicker and inpatient length of stay grown shorter, the handoff to the outpatient primary care physician (PCP) is even more important. Pending test results, complex medication regimens to reconcile, and inpatient discussions that have not involved the primary care physician have made the handoff more complicated and time-intensive. When a discharged patient can't get in to see the PCP in a timely manner, has no established PCP, or if information isn't appropriately relayed to the PCP, the potential for delayed treatment and readmission increases. PCPs are under significant time constraints with productivity measures, thereby making complicated hospital follow-up visits difficult. According to published data, as many as one in five Medicare patients are readmitted within 30 days of hospital discharge, with 6 percent readmitted within seven days.[1] The Dartmouth Atlas of Health Care reported that readmission rates across the country progressively increased between 2004 and 2009.[2] These adverse post-discharge events cost the U.S. health care system an estimated $12 to $44 billion annually.

An Internal Medicine Transitional Care Clinic (TCC) was designed at Eskenazi Health, a large public hospital system in Indianapolis, IN, to decrease readmission rates and improve continuity of care for recently hospitalized patients with no PCP or those at high risk for readmission, as defined by a LACE score of ≥10. LACE is a validated scoring tool utilized to predict risk of 30-day readmission.[3] The TCC strives to effectively implement evidence-based treatment plans, arrange subspecialist follow-up, and troubleshoot unanticipated barriers while helping to ensure there is safe and effective transition to the PCP. The clinic is located in the Outpatient Care Center located in the same building as the hospital and is staffed by the Transitional Care Physician (TCP), an internist who has worked formerly as a hospitalist and now oversees the TCC.

Initially, an outreach was made to the inpatient providers via flyers, brochures, and a meeting was arranged with the hospitalist group, surgeons and medicine housestaff to explain the new program. The intervention begins before the patient leaves the hospital with the Transitional Care Physician (TCP) or inpatient case manager making a visit to the inpatient ward to explain the rationale for hospital follow-up and the importance of being seen in the Transitional Clinic. Eligible patients are then scheduled with the TCP within 7 days after discharge in the Transitional Care Clinic.

Thirty-minute patient visits at the TCC allow increased time with each patient to customize the visit to their individual post-discharge needs. Ancillary support (e.g. pharmacy, SW, diabetes educators) are located on-site to see the patient the same day. Once stable, patients with high LACE scores are referred back to their PCP, or if they have no PCP, the TCP temporarily serves as a "bridge" after discharge from the TCC until the initial PCP visit. The majority of patients seen in the TCC require only one visit but there is capability of seeing patients as many times as is necessary to ensure stability. The primary method of communication between the TCP and PCPs is the medical record and email correspondence.

In the first four months that the TCC existed, 743 patients were scheduled and 459 patients were seen. This translated to a no-show rate of 38.2% and the 30-day readmission rate for those seen was 13.9%. The cohort of 284 patients qualifying for the TCC but who did not keep their appointment demonstrated a 30-day readmission rate of 21.8%. For comparison, the global 30-day readmission rate at our institution was approximately 14.8% over the same period. There was also a 50% reduction in the no-show rate for those inpatients visited by the TCP, compared to those patients visited by the case manager.

Our hospital follow-up clinic demonstrated decreased 30-day readmission rates for a high risk population. We also observed patients were twice as likely to attend their initial hospital follow-up appointment if visited by the outpatient physician before discharge. Our data certainly have limitations; notably, this was a single center study and we were unable to account for hospital readmissions to institutions other than our own. Furthermore, there could be potential unadjusted confounding variables in the cohort that qualified but no-showed, thereby making their risk of readmission naturally higher.

Hospital readmission and transitions of care remain a major point of emphasis in healthcare. In 1996, Weinberger et al described a robust program for the VA system in which the intervention actually increased hospital readmissions.[4] Our TCC targeted a high risk group of patients and was able to reduce the incidence of 30-day readmission. We also found that inpatients visited by their outpatient physician were twice as likely to keep their initial follow-up appointment. Interventions such as ours are a novel way of looking at an old problem. The silos of inpatient and outpatient care are here to stay so we must be open-minded to effective ways to improve transitions of care for hospitalized patients.

Notes:

1. Payment Policy for Inpatient Readmissions. In: Report to the Congress: Promoting Greater Efficiency in Medicare. Medicare Payment Advisory Commission. Washington DC; June, 2007:103-20.
2. Goodman DC, Fisher ES, Chang C-H. After Hospitalization: A Dartmouth Atlas Report on Post-Acute Care for Medicare Beneficiaries. The Dartmouth Institute for Health Policy & Clinical Practice; September, 2011:1-52.
3. van Walraven C, Dhalla IA, Bell C, Etchells E, Stiell IG, Zarnke K, Austin PC, Forster AJ. Derivation and validation of an index to predict early death or unplanned readmission after discharge from hospital to the community. CMAJ. 2010;182:551–557
4. Weinberger M, Oddone EZ, Henderson WG, Does increased access to primary care reduce hospital admissions? NEJM 1996;vol 334: No. 22: 1441-1447

IMS

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Bulletin Board

Rick C. Sasso, MD, Indiana Spine Group, presented a co-authored paper "Long-term Clinical Outcomes of Cervical Disc Arthroplasty: A Prospective, Randomized, Controlled Trail," at the 32nd Annual Meeting of the European Section of the Cervical Spine Research Society (CSSRS-ES) held in Prague, Czech Republic in May 2106. Also in May, he was the visiting guest International Professor at the South African Spine Society annual meeting in Pretoria, South Africa where he lectured on "Treatment of C1-C2 instability due to inflammatory etiology" and "Avoiding and treating post-operative cervical spine complications." And, Dr. Sasso, served as a faculty member of the Annual Spine Trauma Summit held in Seattle, Washington where he lectured on "Challenges in Cervical Spine Fractures" with the a specific emphasis on Complex C1 and C2 fractures. At the event he performed a live broadcast from the Bioskills lab on "Occiput to C2 Fixation" and taught a hands-on module, "Posterior Occipito-Cervical-Thoracic Instrumentation."

Stephen W. Perkins, MD, Meridian Plastic Surgeons, was a Key Invited Faculty member at the 8th World Congress of Facial Plastic Surgery 2016 in Rio de Janeiro, Brazil. Dr. Perkins gave the Keynote address on the topic of Photo Damaged and Aged Skin of the Face and Neck. He also conducted an instructional course about Facelifting, conducted a Rhinoplasty video presentation and moderated a panel talk on the topic of Fat Transfer.

Theresa M. Rohr-Kirchgraber, MD, spoke to the women of NOW Courier company as part of their Women's Health Week promotion. Her talk, titled, "News You Can Use: Issues in Women's Health" was well received.

She also spoke to the Indy 500 Festival Princesses as they toured Eskenazi Health System, as part of the INDY 500 celebration.

Jeffrey M. Rothenberg, MD, has accepted the position of executive director of Medical Education, at St. Vincent Indianapolis effective Friday, July 1. In addition to serving in this role, he plans to continue his gynecologic surgical practice upon arrival at St. Vincent.

Dr. Rothenberg joins St Vincent's following a distinguished career at Indiana University School of Medicine (IUSM) and Indiana University Health.

He is currently the vice chair of District V of the American College of Obstetrics & Gynecology, and is one of two examiners in the state for the American Board of Obstetrics & Gynecology, for whom he also serves on the examination writing committee. He has long been a proud member of IMS, serving in leadership positions.

In his new role, Dr. Rothenberg will work to ensure quality medical education, service and adherence to best practices, spearheading medical education and research initiatives aimed at enhancing quality, patient safety and clinical integration. This includes working with leadership at various medical schools, including Marian University, to fully implement clinical training affiliation agreements for medical students, residents and fellows.

In May 2016, Dr. Rothenberg was the Invited Silver Badge lecturer at the ACOG Annual meeting in Washington, DC, and taught a six hour course, as well, at the meeting titled: "How to Boost Your Office Productivity and Be Happier Doing It."

Tod C. Huntley, MD, the Center for Ear Nose Throat & Allergy (CENTA) was invited by the department of Otolaryngology-Head & Neck Surgery at Michigan State University in May 2016 to lecture on total and partial laryngectomy techniques. He also supervised resident cadaver dissections. Dr. Huntley was also an invited guest lecture at the 100th annual Clinical Congress of the American Osteopathic Colleges of Ophthalmology and Otolaryngology-Head and Neck Surgery Foundation on May 6, 2016. He spoke on the work-up and evaluation of obstructive sleep apnea, and was part of a panel discussion on the surgical treatment of OSA. Dr. Huntley was also the course director for St. Louis University's hands-on cadaver course, Advanced Surgical Techniques for Obstructive Sleep Apnea and Snoring, held June 23-June 25, 2016.

Aaron A. Cohen-Gadol, MD

Daniel H. Fulkerson, MD

Tod C. Huntley, MD

Jean-Pierre Mobasser, MD

Stephen W. Perkins, MD

Theresa M. Rohr-Kirchgraber, MD

Jeffrey M. Rothenberg, MD

Rick C. Sasso, MD

Mitesh V. Shah, MD

News from Goodman Campbell Brain and Spine ...

The Indiana University Department of Neurological Surgery and Goodman Campbell Brain and Spine hosted the 2016 Mealey Lecture featuring an address focused on "The Future of Brain Tumor Radiosurgery." The annual "John Mealey Lecture" focuses attention on neurosurgical oncology and brings nationally prominent neurosurgeons to the IU campus.

Daniel H. Fulkerson, MD, and his co-authors have published their research, "Efficacy of phosphorus-32 brachytherapy without external-beam radiation for long-term tumor control in patients with craniopharyngioma." While brachytherapy with external-beam radiation (EBR) has shown tumor control rates as high as 70% at 10 years after treatment, EBR is linked to long-term risks, including visual deficits, endocrine dysfunction, and cognitive decline. The researchers did a retrospective review of pediatric patients treated for craniopharyngioma between 1997 and 2004 to evaluate whether P32 brachytherapy as the primary treatment without EBR effectively controls tumor growth, thus avoiding the need for further surgery or EBR. Their results appeared in the April 16 issue of the *Journal of Neurosurgery: Pediatrics*.

Mitesh V. Shah, MD, was a featured presenter during the Resident-Fellow Training course titled, "Comprehensive Management of Subcortical Lesions Using the BrainPath Approach." The course was held at the Simulation Center at Fairbanks Hall at Indiana University Health on April 16.

Jean-Pierre Mobasser, MD, recently served as chairman of the course, "Decisions in Spine: Transitioning into Practice," which was hosted by Medtronic in Denver, Colorado, on May 20–21. The course was offered as continuing education for clinicians about Medtronic therapies.

Aaron A. Cohen-Gadol, MD, and his fellow researchers recently published their paper, "Resection of pituitary tumors: endoscopic versus microscopic." In this literature review, the authors discussed the advantages and disadvantages of transsphenoidal microscopic pituitary surgery—long considered the gold standard in surgical treatment of pituitary tumors—versus endonasal endoscopic pituitary surgery. Endonasal endoscopic pituitary surgery has come into prominence the last 20 years as an alternative to microscopic surgery. Their conclusions were published in the *Journal of Neurooncology* on May 9 ahead of print.

Additionally, Dr. Cohen-Gadol also joined a team of researchers who reported on their work, "Combination therapy in a xenograft model of glioblastoma: enhancement of the antitumor activity of temozolomide by an MDM2 antagonist." The paper investigates the impact of modulating murine double minute 2 (MDM2) function in combination with front-line temozolomide therapy in glioblastoma multiforme. Read their complete study in the *Journal of Neurosurgery* (May 13 ahead of print). IMS

CME & Conferences

Community Hospital East

First Wednesday	Critical Care Conference Ste. 420, 12:00 - 1:00 p.m.
Second Tuesday	Medical Grand Rounds Ste. 420, 12:30 - 1:30 p.m.

Community Hospital North

First Friday	North Forum Reilly Board Room; 12:00 - 1:00 p.m.
Every Other Month 4th Thursday	Psychiatry Grand Rounds 7250 Clearvista Dr. Multi-Service Rms. 1 & 2, 7:30 - 8:30 a.m.

Community Heart & Vascular Hospital

First Wednesday	Imaging Conference: rotates Cath & Echo Case Presentations CHVH MCV Boardroom Videoconference to HVC Anderson Office, HVC East Office BR (Ste. 420) HVC South Office CR (Suite 2400) HVC Kokomo, 7:00 - 8:00 a.m.
Third Wednesday	Ken Stanley CV Conference CHVH MCV Boardroom Videoconference to HVC Anderson Office, HVC East Office BR (Ste. 420) HVC South Office CR (Suite 2400) HVC Kokomo, 7:00 - 8:00 a.m.
Fourth Wednesday	Disease Management Conference: rotates CHF & EP Case Presentations CHVH MCV Boardroom Videoconference to HVC Anderson Office, HVC East Office BR (Ste. 420) HVC South Office CR (Suite 2400) HVC Kokomo, 7:00 - 8:00 a.m.

2016 Cancer Conferences
Community Hospital East

Third Thursday	East General Cancer Conference - CHE Ste. 420, 12:00 noon to 1:00, lunch provided
Fourth Tuesday	East Multidisciplinary Breast Cancer Conference - CHE Ste. 420, 7:00 to 8:00 a.m.

Community Hospital North

First & Third Tuesdays	North Multidisciplinary Breast Cancer Conference - CHN 8040 Clearvista Parkway, Suite 550 7:00 to 8:00 a.m.
Second & Fourth Wednesdays	North Multidisciplinary GI/Colorectal Oncology Conference - CHN 8040 Clearvista parkway, Suite 550 7:00 to 8:00 a.m.
First Friday	North Multidisciplinary Gynecologic Surgical Oncology Conference - CHN 8040 Clearvista Parkway, Suite 550 7:30 to 8:30 a.m.
First Wednesday	North Chest Cancer Conference - CHN 8040 Clearvista Parkway, Suite 550 7:00 to 8:00 a.m.
Third Wednesday	Melanoma Cancer Conference - CHN 8040 Clearvista Parkway, Suite 550 7:30 to 8:30 a.m.

Community Hospital South

Second Wednesdays	South Multidisciplinary Breast Cancer Conference - CHS Community Cancer Center South 1440 E. County Line Rd., Community Room 8:00 to 9:00 a.m.
Third Wednesday	South GYN Community Cancer Center South, 1440 E. County Line Rd., Community Room 12:00 to 1:00 p.m.
Fourth Wednesday	South Thoracic Community Cancer Center South, 1440 E. County Line Rd., Community Room 7:00 to 8:00 a.m.
First Tuesday	South Multidisciplinary GI/Colorectal Oncology Conference 1440 E. County Line Rd. Community Cancer Care, Community Room 12:00 to 1:00 p.m.

For more information, contact Valerie Brown, (317) 355-5381.

Indiana University School of Medicine/ Indiana University Health

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July 10-15	101st Annual Anatomy & Histopathology of the Head Neck & Bone Glick Eye Institute
July 15	Review & Interpretation of the 2016 ASCO Review The Tower
July 16	Transgender Health 2016 University of Indianapolis, Schwitzer Center
Oct. 13-14	Building a Comprehensive Home Dialysis Program JW Marriott Indianapolis
Nov. 15-17	Biostatistics for Health Care Researchers: A Short Course Health Information & Translational Science Building (HITS)

Course dates and locations are subject to change. For more information, please visit http://cme.medicine.iu.edu or call 317-274-0104.

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IMS Events/Meetings

July 19	IMS Board, 6:00 PM, Social; 6:30 PM, Dnr/Mtg., Holiday Inn, 251 E/Pennsylvania Pkwy., Indpls., IN 46280. 574-4600
Aug. 16	Executive Committee, 6:00 PM, Sandwiches
Sept. 13	Senior/Inactive Luncheon Meeting, 11:30 AM, Knights of Columbus, 2100 E. 71st St., Indpls.
Sept. 20	IMS Board, 6:00 PM, Social; 6:30 PM, Dnr/Mtg. Dr. Susan K. Maisel will be installed as 143rd IMS President, Holiday Inn, 251 E. Pennsylvania Pkwy.
Sept. 23	IMS Advisory Breakfast (Le Peep's), 7:30 AM; ISMA BOT, 9:00 AM @ Headquarters
Sept. 24-25	ISMA Convention, Sheraton Indianapolis Hotel, Keystone at the Crossing
Oct. TBD	ISMA's Fall Legislative Dinner, Downtown Marriott
Oct. 18	Executive Committee, Society, 6:00 PM, Sandwiches
Nov. 15	IMS Board, Society, 6:00 PM, Social; 6:30 PM, Dnr/Mtg., Holiday Inn, 251 E. Pennsylvania Pkwy.
Nov. TBD	IMS Advisory Breakfast (Le Peep's), 7:30 AM, ISMA BOT, 9:00 AM, @ Headquarters
Dec. 13	Senior/Inactive Luncheon Meeting, 11:30 AM, Knights of Columbus, 2100 E. 71st St.
Dec. 20	Executive Committee, Society, 6:00 PM, Sandwiches

To submit articles, Bulletin Board items, CME & events, opinions or information, email ims@imsoline.org. Deadline is the first of the month preceding publication.

Air Travel Group Insurance

A Continuing Free Benefit to Members

By action of the Society Board of Directors, Society members are being given free coverage by an air travel group insurance plan. The policy will pay $100,000 to your estate or beneficiaries in the event of your death in an airplane crash; or pay $100,000 to you in the event of serious personal injury resulting in the complete loss of both hands, or both feet, or the entire sight in both eyes; or will pay $50,000 to you in the event of personal injury involving the loss of one foot, or one hand, or the entire sight in one eye, with a maximum overall benefit of $500,000 aggregate per accident, subject to terms of the policy. Reduced benefits apply for those over age 70. This benefit will cover all Society members, regardless of employment situation.

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In Memoriam

Jose "Dr. Joe" Thomas Vieira, MD
1923 - 2016

Jose "Dr. Joe" Thomas Vieira, 93, passed away on Sunday, May 29, 2016, surrounded by his family. Dr. Vieira was born in Divisa Nova, MG, Brazil, South America, on March 21, 1923.

He attended medical school in Rio de Janeiro, came to the United States in 1949 to do his internship in West Virginia, followed by his residency at Methodist Hospital in Peoria, Illinois. Dr. Vieira returned to Pocos de Caldas, MG, Brazil, where he began his surgery and family medical practice.

Dr. Vieira returned to the United States in July of 1964 to open his Family Practice Clinic in Coatesville, Indiana. He was on staff at Putnam County Hospital in Greencastle, Indiana until 1990. From 1990 until his retirement in 2006, he was on staff for Community East Hospital in Indianapolis.

New Members

Keller, Emily C., MD
IndyDerm, LLC
8782 Madison Ave.
46227-7202
Ofc – 882-2882
Dermatology, 2013
Indiana University, 2009

Tolliver, Kevin A., MD
Eskenazi Health
Outpatient Care Center
720 Eskenazi Ave., Fl. #2
46202-5189
Ofc – 880-7000
Internal Medicine, 2009
Indiana University, 2005

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a positive outcome, primarily because I had access to an intravenous line and an AED as well, and the patient responded rapidly, without the need for intubation.

I would suggest that every physician take the time to have some awareness of even using the AED. What I did not know ahead of time was that I was going to be the main person responsible for making the decision as to where we were going to land and to prepare the patient for transference to awaiting medical personnel. They moved the patient next to me for the next 2-1/2 – 3 hours until we landed, and I was filling out paperwork with the appropriate medical documentation the entire time. The purpose of saying this is not to laud myself, but just to bring out that this is a reality any one of us as physicians may well experience; so, even if it is not our primary specialty, we need to learn and keep our training up-to-date on these potential medical emergencies.

"It's important to scare yourself to do the things you don't think you are capable of doing." Reese Witherspoon

I had the fortune of voluntarily working in the St. Vincent's Emergency Room for the last two years of medical school and worked in multiple emergency rooms as the sole physician throughout the years of my otherwise specialty training. This provided invaluable ongoing utilization of what I had learned in medical school and internship, as well as improvement in my knowledge base of treating acute medical emergencies. Initially having managed and run an office-based medical facility, I took it upon myself to personally receive and routinely have my staff receive ACLS (advanced cardiac life support) training. This at least keeps me and my staff current with the proper medications used and the techniques recommended for basic and advanced cardiac life support, etc. However, I am accustomed to having anesthesiologists and other physicians available at a moment's notice.

One other experience that was extremely stressful was on a similar flight pattern. We had almost arrived on the coast of northern Canada in Labrador, when they announced the emergency landing at a remote town with at least some medical facility and asked for the help of a physician on board. There was a woman pregnant with twins, 20-weeks gestational, who was having a spontaneous abortion. Between a nurse on board capable of assisting with I.V.s and a pediatrician on board, we were able to assure that the patient was awake and stable until we landed and she was taken away by emergency personnel. That was another "wake-up call" for me to learn about which medical supplies are, and sometimes are not, on any given commercial airliner. Brian Secemsky, MD, refers to a detailed list of medications stocked on most commercial airplanes, called the Emergency Medical Kit with equipment. Rather than list all of these in this article, I refer you to this article, (*New England Journal of Medicine* in 2002; 346:1067.73), and also a source from the Aerospace Medical Association. In my experience, although they had a rudimentary airway, intubation equipment was not readily available on one of my flights. Getting an I.V. fluid system established is not an easy task if you do not have help but most of the emergency medications, including epinephrine, antihistamines, dextrose, nitroglycerine tablets, bronchial dilators, atropine, steroids and beta blockers, are generally available.

"Before anything else, preparation is the key to success."- Alexander Graham Bell

"One important key to success is self-confidence. An important key to self-confidence is preparation." – Arthur Ashe

Some recommendations/advice for in-flight volunteering docs:

My first caveat is that, occasionally, my first reaction was to wait to hear whether any other physician was responding; but we all know that, given the need, each of us will respond in whatever manner we are able.

1) Introduce yourself to the cabin crew and state your qualifications and your field of specialty.
2) Ask them what they know about the problem and then, hopefully, ask the patient for permission before you start a thorough history and physical exam. This, of course, may not be possible based on the state of the patient at the time.
3) If the patient's condition is critical, request diversion to the nearest appropriate airport. You have the ability and the authority to do this.
4) Cooperate with the medical response center and coordinate the airport medical staff.
5) Do keep a written medical record of your patient encounter or ask for paperwork and definitely fill out as much of the medical record you are able to.
6) Perform only treatments you are qualified to administer. This is where it becomes more difficult, given a situation that requires emergency life-saving measures. The more aware you are that this might happen, so you can possibly train yourself, the better off, hopefully, the patient will be and the safety assured on our airline flights.

While Brian Secemsky, MD, states that he thinks clinical physicians completing residency should be formally trained in commercial airline emergency medicine and this should involve real time emergency simulations and repeated certification of handling basic medical equipment, I agree that this should be a part of medical school curriculum. I think we would all like to see that government regulations and the aerospace industry would require a certain level of equipment, medications and basic training by someone on the airplane to handle in-flight emergencies, especially when hours from the nearest landing spot or acute medical care.

As a Medical Society representing the physicians in Central Indiana, we can encourage, propose and request that our State Medical Association suggest this to our medical school(s) and the state legislature for future, more specific, action and education of all of our physicians.

Sincerely,

Stephen W. Perkins, M.D.

Stephen W. Perkins, M.D.
President, Indianapolis Medical Society

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