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## **From the President** **Fernando L. Soto-Torres, MD, FACEP**

### ***Patients: Treat them like Family***

This year, I took my first re-certification as an ABEM diplomat. It's funny how time flies. I don't feel that old but in some aspects I still feel like an intern. I started reflecting on how I have been doing this for quite some time now and I remembered something I learned right after graduating, which I still tell my residents: "It is after you know 'everything' that you truly start learning". We all keep growing and learning every day. And so, for this newsletter I humbly wish to share with you a list of a few suggestions that I have found useful after 13 years since I first walked into the ED as an intern and fell in love with this specialty.

Patients are anxious and have no idea what they are getting into when they visit us in the ED. They might think they have an idea because of something someone said or because they watched an episode of "House" or "Grey's Anatomy", but they don't. The first thing I consciously

do is look them in the eye and avoid writing anything as they speak to me or as I examine them. To gain their trust, the first thing I try to do is show them I care. I know, this sounds like one of those medical school clichés, you know, the poster you read someplace: "Patients don't care how much you know until they know how much you care". But hey, it's still true. How do you think clichés are started in the first place?

As far as their expectations go, they need to be addressed. Sometimes, we feel awkward asking the young male with dysuria, why he chose to come to the ED at 2 am, or inquiring to the grandmother whose been hovering over our cubicle what she was really expecting "had to be done" to her granddaughter for her fever. I have come to understand that unless these specific expectations are disclosed there will never be a satisfied patient. We may think we know what they want and we most likely know what they need but even the most Zen of people already has an idea of what the doctor should and should not do for their condition. These expectations may range from subtle and sensible to completely unattainable. Address them. Treat them as you would a member of your family. This may sound particularly simple and obvious, but, I don't just do this as a code of ethics or practice. I also do it to justify whatever interventions I would or would not do to patients visiting the emergency department. I make an effort of letting them know this. I have found that this sincerity wins my patients over even when I don't end up doing what they were expecting. That head CT they were requesting for a mild head bump or those labs (or antibiotics) they were requesting for the "run of the mill" viral illness suddenly becomes less useful when you share sincerely that you are offering exactly what you would your wife or daughters. And tell them this. In fact...

Discuss the whole mental process you have gone through. While avoiding clichés like: "you should be fine" or "you have nothing serious". Instead, explain to them in simple words what you thought they had and what you excluded through your work up or exam. It is not unusual for some professionals to have a hard time justifying their hard work. People can't see what we are thinking, such as how much we had to read to not send this test or that test. They don't appreciate the long list of potential diagnoses we excluded just by checking the vitals and speaking to them. They don't understand that we just excluded a PE by applying the PERC rule or that we have risk stratified their chest pains to predict how safe (or not) they will be for the next few weeks. Let them know how hard it is and how sure you are. Especially let them know that nothing is certain and let them have the numbers, the percentages, the outcomes and what to watch for in the future.

Assume that all mild presentations will evolve as they can do sometimes. That baby with the "sniffles" may just be three or four days away from a moderate bronchiolitis, dehydration, or admission. That female with epigastric pain with the negative labs and ultrasound might just be 48 hours away from becoming appendicitis or a PID. Again, inform them of how hard it is to fully exclude or anticipate outcomes and what to do if they occur. I remember this case where a concerned mother came in with her 8 month old. She had a very mild upper respiratory infection. I did not send any labs or tests. I sat down with the mother and explained to her that if her child's condition was to worsen, she would develop increasing respiratory symptoms and would likely choose to eat and drink less. In four days, she was back and was admitted for

bronchiolitis. As concerned as the mother was, she was pleased that I had anticipated this and thanked me for it. Of course, I documented all this in the chart...

My final suggestion is document with the lawyer in mind. The medical chart has been the bane of the medical establishment's existence since it was first used to sue us for medical malpractice. The natural history of a medical chart is pretty boring. In fact, it is pretty much a meaningless existence once we finish documenting on it and it is filed and submitted to insurance companies. Unless...there is a bad outcome! So, in reality, when we write a chart we should have a lawyer in mind. Not just any lawyer but one that has bad intentions (not necessarily so but I try to visualize it as such). This professional has more time than you had, has an expert witness who dissects every corner of the chart, and more importantly knows what the final outcome is. They have the benefit of the hindsight, which we never do and all they have to do is wait. So I tend to think up of most (if not all) possible bad outcomes and specifically tailor the chart to show I have thought about it and excluded it to a satisfactory level.

This is just a short list and I do not presume to have all the experience in the world. I am sure you all practice medicine in a similar fashion but the best way to grow is to share our experiences and knowledge. I hope this small essay has inspired you to share your thoughts and perhaps - more optimistically - even provided you new ideas on how to gain your patients' trust and improve your doctor-patient relationship. I personally believe that patient satisfaction, quality of care, and best evidence in practice can truly co-exist. I hope this short list provides a few tools on how to make it so.



Colegio de Emergenciólogos Assembly • June 8, 2017

**We hope you can join us!**

**If there is a particular topic you'd like for the Puerto Rico ACEP Chapter to discuss at this upcoming event, please send the chapter an [email](#). We'd be happy to address the topic!**

## Adriana's Corner

[Wellness Week](#) came and went. I hope that all of you were able to take some time from your busy schedules to do something specific to take care of your health. If not, it's never too late.

Here at the national office, every day, we were sent various health tips. A particular one that caught my attention was the following:

### **HAVE A GOOD LAUGH**

Maintaining a sense of humor can relieve stress in several ways. First, there are specific benefits that you get from laughter that can help you relieve stress and even stay healthier in your life. Also, laughter connects people, and social support is good for stress relief. It's hard to stay stressed when you're laughing. And maintaining a sense of humor reminds us that our stressors may not be as menacing as they seem, and probably have solutions, too. For these reasons, laughing in the face of stress can help you feel better in a matter of minutes. Learn more about the benefits of laughter and how to maintain a sense of humor in the face of stress by clicking [here](#).

If you have a health tip you feel has helped you and would like to share it with the members of the chapter, please send it via [email](#). I'd be happy to send it to the members of the chapter for you.

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## Clinical News

### **CT Can Indicate Mortality Risk in Elderly with Trauma**

**NEW YORK (Reuters Health)** – Opportunistic CT screening for osteopenia and sarcopenia in older adults with traumatic injury can provide insight into frailty and one-year mortality, according to Seattle-based researchers.

[Read More](#)

### **HCV Infections Less Prevalent than Previously Estimated**

**NEW YORK (Reuters Health)** – The global estimate of hepatitis C virus infection (HCV) is lower than previously thought, making World Health Organization targets for reducing infections and HCV-related deaths more attainable, researchers suggest.

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### **Free CME for Reading Annals of Emergency Medicine's Practice and Clinical Updates**

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**Diversity and Inclusion: Our Chapters, Our Duty**  
**Ryan P. Adame, MPA, CAE**  
**Deputy Executive Director, California ACEP**  
**Chair, ACEP Chapter Executives Forum**  
**Member, ACEP Diversity & Inclusion Task Force**

Diversity. Inclusion. Worthy goals or buzzwords? What do they mean to you? What is your reaction when you hear them being discussed? How much have you reflected on the diversity of your leadership, or the opportunities for inclusion in your organization? I hope you will take a moment to consider your answers to these questions, as well as to whatever feelings or emotions you experienced when you read “diversity” and “inclusion” because acknowledging our successes and shortcomings is, I believe, the first step to building organizations that better serve our physicians and, in turn, their patients.

Here are some statistics to consider about ACEP membership: women comprise 26% of total membership, 28% of committee membership, are 26% of committee chairs, and 27% of the Council. In senior leadership, women represent just 12.5% of the ACEP Board of Directors, and just 19% of Chapter presidents are female. Approximately 1% of ACEP members are African-American and another 1.5% are Hispanic. While this is just a sample of membership attributes, there are many, many other aspects of diversity to consider: other ethnic groups to be sure, but also LGBT members, religious cross-sections, as well as generational considerations.

Why does this matter? To me, this matters because we have the opportunity and the duty to help build more diverse organizations that are reflective of the memberships we serve. Beyond diversity, inclusion matters because without meaningful participation by a diverse group of people, diversity can be reduced to a demographic check-box exercise. Our task, in my view, is to assist and, when necessary, lead our physician members in meaningfully integrating voices and perspectives that are as different as the millions of patients they treat every year.

As the staff leaders within our family of organizations, we have unique access to and influence over our programs, our communications, and, most importantly, our leadership. I urge you to examine what your Chapter currently does to ensure better diversity and inclusion in leadership. Maybe right now the answer to that is “nothing.” We all have to start somewhere. Perhaps that means making inroads in your educational conference faculty’s diversity. Perhaps it means that you have to cultivate younger leaders differently, or help connect members from underrepresented groups with current leadership. Many Chapters already have resident members of their Boards of Directors but if you do not, there is another opportunity. Check that your meetings and conferences do not conflict with major religious holidays. Consider programming aimed at unconscious bias and/or health care disparity.

There are many avenues by which our family of organizations – ACEP, Chapters, and EMRA – can build better, more diverse, more inclusive organizations for our members. But first, like our members do each and every day, we have to triage. We have to look honestly and soberly at

our organizations as they are today and ask ourselves how we can make them more diverse, more inclusive for the members of today and tomorrow.

## New Congress, New Administration, New Challenges

Now is not the time to sit on the sidelines. Wondering how can you influence health care policy on the national level?

Join the [ACEP 911 Grassroots Legislative Network](#) today to help emergency medicine convey our principles and priorities to legislators in Washington DC and their home districts.

Already a member of the Network? Take your advocacy to the next level. Host an emergency department visit for your legislator or invite them to meet with a group of local emergency physicians from your chapter.

Newly elected and veteran legislators are hiring key staff, getting up to speed on important issues, and setting priorities for the new Congress. Now is the perfect time to reach out on the local level to educate the member about the specialty and offer to serve as a local resource on issues relating to the delivery of health care.

**ACEP 911 Legislative Network**

Host a Member of Congress in your Emergency Department



**Congress is shaping the nation's delivery of health care**

CONTACT JEANNE SLADE IN THE  
DC OFFICE: [JSLADE@ACEP.ORG](mailto:JSLADE@ACEP.ORG)

ACEP will work with your schedule & provide visit materials.

[www.ACEPAdvocacy.org](http://www.ACEPAdvocacy.org)

Go to the [ACEP Grassroots Advocacy Center](#) for detailed information on how to join the

program and start engaging with legislators today!

## **Emergency Department to Hospital Admission and Discharge, Developed and Provided by ACEP, SHM and Our Educational Partner**

### **EARN FREE CME - Heart Failure Management: From the Emergency Department to Hospital Admission and Discharge**

Emergency medicine clinicians and hospitalists have a unique, collaborative relationship in the continuum of care of acute heart failure (AHF) treatment- providing optimal patient care from first point of access through hospitalization to discharge.

Click [here](#) to take this free CME course and get up-to-date, evidence-based information on the clinical presentation of AHF, the importance of an accurate and timely diagnosis, and more! This program developed and presented by ACEP in collaboration with Haymarket and is made possible through an educational grant from Novartis.

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