The Big Tent of Emergency Medicine

ACEP is facing a choice in how we will define ourselves and who we will count as members in the future. Should we open the tent of emergency medicine to those physicians who work by our side in the ED but are not EM certified? Or should we save our tent for those who have dedicated time and effort to EM certification and maintain the current membership policies? Two ACEP members share their opinions on the issue. What do you think? Send your comments to acepnw@acep.org.

PRO
OPEN ACEP TO ALL EMERGENCY PHYSICIANS
Allowing ED physicians not certified in EM to join will fulfill our mission—and ultimately help patients
by SULLIVAN SMITH, MD, FACEP, CHAIR OF THE ACEP CAREERS SECTION

CON
HOLD THE LINE IN DEFENSE OF OUR SPECIALTY
The case for maintaining strict membership requirements for ACEP
by RUSSELL RADTKE, MD, FACEP, CHAIR OF THE ACEP YOUNG PHYSICIANS SECTION

Welcome to the Hot Seat
BODY LANGUAGE TIPS FOR THE EMERGENCY PHYSICIAN ABOUT TO TESTIFY
by PATTI WOOD MA, CSP, AND DOUGLAS SEGAN MD, JD, FACEP
SEE PAGE 19
Timing is everything in the emergency room. But for women of childbearing age, many medical procedures must wait until these patients have been tested for pregnancy.

The Siemens CLINITEST® hCG pregnancy test helps ED clinicians quickly clear women for further procedures. Paired with a CLINITEK Status® Connect analyzer, the CLINITEST® hCG test provides the only truly connected, CLIA-waived solution. Since no manual documentation or visual interpretation is required, the chance for error is greatly reduced.

Test results take just two to five minutes and can be transferred to electronic health records, enabling hospitals to quickly move ahead with X-rays or other routine procedures. Less time spent on pregnancy tests leaves more time for critical patient care.

Want to streamline your emergency department with more efficient pregnancy testing? Take our online product tour and learn how Siemens can help. Visit www.usa.siemens.com/clinitesthcg

Pregnancy testing when every moment counts.

Siemens answers give emergency departments more time for patient care.

www.usa.siemens.com/clinitesthcg
every moment counts.
Pregnancy testing when Siemens answers give emergency departments more time for patient care.
The Siemens CLINITEST® hCG pregnancy test helps ED clinicians quickly clear
Timing is everything in the emergency room. But for women of childbearing age, many medical procedures must wait until these patients have been tested for pregnancy.
Test results take just two to five minutes and can be transferred to electronic other routine procedures. Less time spent on pregnancy tests leaves more
can help. Visit www.usa.siemens.com/clinitesthcg
Want to streamline your emergency department with more efficient time for critical patient care.
THE BREAK ROOM

Don’t Underestimate the Physician Exam

I am writing in response to the article “The Death of the Physical Exam” by Shari Welch, MD, FACEP (Feb. 2014). I note, with dismay, the continued justification for the present-day lowering of the standard of care expected of physicians. The physical exam is required to assist in diagnosis and not because it is needed for full reimbursement. I will not defend the yearly physical exam as an effective screening test. In the emergency department, the focused physical exam is necessary for the experienced practitioner to use this skill and the patient’s history to render unnecessary many laboratory tests.

The suggestion that the vaginal exam in someone with first-trimester bleeding lacks value is a good example of the disturbing trend to no longer emphasize physical diagnosis in some medical schools. The vaginal exam may show an abortion in progress, a bleeding endocervical polyp, a septic abortion, or an incompetent cervix. A normal exam (with the history of vaginal bleeding) might suggest a bloody cytosis or unsuspected bleeding from the rectum. Those who “could make it through their shift without a stethoscope” have not been trained properly, and Laennec and Ausenbrugger would roll over in the graves, as would Osler.

Physicians without stethoscopes will not hear the rales of heart failure or the gallop rhythm, or feel the palpable thyroid and hear the irregular rhythm in the patient complaining of weakness. The contention that the urinalysis is superior to the physical exam is poor thinking: the history, physical exam, and urinalysis are complementary. When there is no fever and no costovertebral angle tenderness, pyelonephritis is less likely, and it points to the lower urinary tract. However, when abdominal tenderness is found, one may be looking at a gynecological infection soiling the urine or an inflamed appendix resting on the bladder causing white cells to be present in the urine. The Advanced Trauma Life Support course has eliminated the digital rectal exam from the pelvic protocol because the floating prostate or the prostatic hematoma will rarely be the main clue to a pelvic fracture or a transected urethra. The yield was almost zero.

The focused physical exam gives assurance to both the physician and patient. It is critical and should justify the laboratory test that is ordered. It has not, indeed, gone the way of the dinosaurs.

—Orzie Henderson, MD, FACEP
Saline, Michigan

NEWS FROM THE COLLEGE

Section of Medical Humanities Writing and Visual Arts Awards Deadline Sept. 1

The Section of Medical Humanities is soliciting submissions for its eighth annual Writing Award. Eligible pieces are creative works published in print or online between November 2013 and August 2014. Blog entries are only eligible if reconstructed and submitted as an independently publishable piece of creative writing. Self-nominations or nominations of someone else’s writing are both welcome. Limit two pieces per person.

The Section of Medical Humanities is also soliciting submissions for its second annual Visual Arts Award. This is an opportunity for artists to show off their paintings, photography, etc. Submit a digital image or file of the visual art (photograph, sculpture, textile, pottery, painting, etc.). Limit two pieces per person.

Submissions for both awards are accepted.
ADASUVE® (loxapine) inhalation powder

HELP DEFUSE THE SITUATION BEFORE AGITATION ESCALATES FURTHER

ORAL INHALATION
Breath-actuated, single-use, ready-to-use inhaler

FAST ONSET
Statistically significant reduction in agitation at 2 hours, with improvement rapidly achieved at 10 minutes post-dose

ENDPOINT SCHIZOPHRENIA BIPOLAR DISORDER
ADASUVE PLACEBO ADASUVE PLACEBO
AT 2 HOURS (PRIMARY)
49% 33% 53% 27%
AT 10 MINUTES (SECONDARY)
19% 10% 23% 10%

The mean baseline PEC scores in all treatment groups were 17.3 to 17.7.

IMPORTANT SAFETY INFORMATION (continued)

- After ADASUVE administration, patients must be monitored for signs and symptoms of bronchospasm at least every 15 minutes for at least 1 hour
- ADASUVE can cause sedation, which can mask the symptoms of bronchospasm
- Antipsychotic drugs can cause a potentially fatal symptom complex called Neuroleptic Malignant Syndrome (NMS), manifested by hyperpyrexia, muscle rigidity, altered mental state, irregular pulse or blood pressure, tachycardia, diaphoresis, and cardiac dysrhythmia. Associated features can include elevated serum creatinine phosphokinase (CPK) concentration, rhabdomyolysis, elevated serum and urine myoglobin concentration, and renal failure. If NMS occurs, immediately discontinue antipsychotic drugs and other drugs that may contribute to the underlying disorder, monitor and treat symptoms, and treat any concomitant serious medical problems
- ADASUVE can cause hypotension, orthostatic hypotension, and syncope. Use caution with patients in whom known cardiovascular disease, cerebrovascular disease, or conditions that would predispose patients to hypotension. In the presence of severe hypotension requiring vasopressor therapy, epinephrine should not be used
- Use ADASUVE with caution in patients with a history of seizures or with conditions that lower the seizure threshold. ADASUVE lowers the seizure threshold. Seizures have occurred in patients treated with oral loxapine and can also occur in epileptic patients
- Use caution when driving or operating machinery. ADASUVE can impair judgment, thinking, and motor skills
- The potential for cognitive and motor impairment is increased when ADASUVE is administered concurrently with other CNS depressants
- Treatment with antipsychotic drugs can cause an increased incidence of stroke and transient ischemic attack in elderly patients with dementia-related psychosis; ADASUVE is not approved for the treatment of patients with dementia-related psychosis
- Use of ADASUVE may exacerbate glaucoma or cause urinary retention
- The most common adverse reactions (incidence ≥2% and greater than placebo) in clinical studies in patients with agitation treated with ADASUVE were dysgeusia, sedation, and throat irritation
- Pregnancy Category C. Neonates exposed to antipsychotic drugs during the third trimester of pregnancy are at risk of extrapyramidal and/or withdrawal symptoms after delivery. ADASUVE should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus
- Nursing mothers: Discontinue drug or nursing, taking into account the importance of the drug to the mother


Please see Brief Summary of Prescribing Information, including Boxed Warnings, on following pages.

The Official Voice of Emergency Medicine

ACEPNOW.COM

AUGUST 2014

ACEP

NOW

The Official Voice of Emergency Medicine
Mnnesota is a “no-fault” auto insurance state, providing that auto insurance policies include first-dollar medical coverage, up to $20,000, for an individual injured in a motor vehicle accident. No-fault auto coverage serves as critical reimbursement for auto-related EMS response and trauma care services. Advocated by billers of a new trend in which law firms were interfering in the reimbursement of medical claims, Minnesota’s ACEP worked to pass an amendment in the final hours of the legislative session to fix the emerging issue. A growing number of law firms, encouraged by seminars advising on the practice of filing liens and notices of representation to auto insurance carriers in order to intercept the medical claim reimbursement to the provider for treatment provided to an accident victim. This was done prior to any legitimate arbitration decision or denial.

Most often, EMS and trauma providers would learn of the interception of the payment upon receipt of an explanation of benefits (EOB) from the insurance company showing the claim as paid. However, rather than reimburse the provider for services rendered, the insurer redirected payment to the lawyer due to a notice to the insurer of a lien or certificate of representation. The law firm might make reduced payments to providers out of the $20,000 benefit or, in some cases, suggest partners file for a charity case or bill the claim to the injured patient’s health insurance, despite an EOB clearly showing payment of the medical claim.

Approached about the issue, the trial attorney association, Minnesota Association for Justice, and insurance industry representatives denounced the practice and joined MNACEP in the pursuit of a legislative solution. The bill, signed by Governor Dayton on May 21, 2014, clearly states that firms are prohibited from placing liens on no-fault awards to providers if an insurer had not denied the no-fault claim. This represents preserving millions of dollars in first-dollar coverage for the health care provider and EMS community.

— Ms. Augustin is the Minnesota ACEP executive director.
Enthusiasm for Patient Satisfaction Scores Is Unjustified
by JOSHUA J. FENTON, MD, MPH, ANDREW N. FENTON, MD, FACEP

A NEW SPIN

The Official Voice of Emergency Medicine

Y

ne Kaplan MD, FACEP, recently argued in ACEP Now (April 2014) that emergency physicians should embrace patient experience metrics because patient satisfaction has been linked to patient adherence to evidence-based recommendations and improved clinical outcomes. However, Dr. Kaplan was selective in his review of the literature and, at times, erroneous. We believe that emergency physicians have legitimate concerns about the potential misuse of patient experience metrics and that Dr. Kaplan’s enthusiasm is unjustified.

In Dr. Kaplan’s review, he excluded the literature overwhelmingly supports a causal connection between patient satisfaction and clinical care quality, citing a 2013 BMJ Open review.1 However, this review included studies utilizing sophisticated patient communication measures bearing little resemblance to widely used patient experience metrics. Key negative studies were excluded from the review, including a Dartmouth Atlas analysis that found no consistent relationship between satisfaction and clinical care quality.1

Indeed, the Dartmouth Atlas study is consistent with other studies of the relationship between patient satisfaction and technical health care quality.2 While some literature supports an association between patient satisfaction and adherence, patient satisfaction has been linked to patient adherence to evidence-based guidelines.3

In the placebo-controlled trials with atypical antipsychotics in elderly patients with dementia-related psychosis, there was a higher incidence of cerebrovascular adverse reactions (stroke and transient ischemic attacks), including fatalities, compared to placebo-treated patients. ADASUVE is not approved for the treatment of patients with dementia-related psychosis. See Contraindications (4.5). See Boxed Warning and Warnings and Precautions (5.3).

Anticholinergic Reactions Including Exacerbation of Glaucoma and Urinary Retention

ADASUVE has anticholinergic activity, and it has the potential to cause anticholinergic adverse reactions including exacerbation of glaucoma or urinary retention. The concomitant use of other anticholinergic drugs (e.g., antiparkinsonian drugs) with ADASUVE could have additive effects.

6 ADVERSE REACTIONS

The following adverse reactions are discussed in more detail in other sections of the labeling:

- Hypersensitivity (serum skin reactions) [see Contraindications (4.2)]
- Bronchospasm [see Warnings and Precautions (5.1)]
- Hypersensitivity and syncope [see Warnings and Precautions (5.2)]
- Seizure [see Warnings and Precautions (5.5)]
- Potential for Cognitive and Motor Impairment [see Warnings and Precautions (5.7)]
- Cerebrovascular Reactions, Including Stroke, in Elderly Patients with Dementia-Related Psychosis [see Warnings and Precautions (5.8)]
- Anticholinergic Reactions Including Exacerbation of Glaucoma and Urinary Retention (see Contraindications [4.3])

6.1 Clinical Trials Experience

Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in the clinical trials of a drug cannot be directly compared to rates in the clinical trials of another drug and may not reflect the rates observed in clinical practice. The following findings are based on pooled data from three short-term (24-hour) randomized, placebo-controlled clinical trials (Studies 1, 2, and 3) of ADASUVE 10 mg in the treatment of patients with moderate to severe persistent asthma associated with schizophrenia or bipolar I disorder. In the 3 trials, 259 patients received ADASUVE 10 mg, and 263 received placebo [see Clinical Studies (14)].

Commonly Observed Adverse Reactions: In the 3 trials in acute agitation, the most common adverse reactions were dysphoria, sedation, and disorientation. These reactions occurred at a rate greater than 2% of the ADASUVE group and at a rate greater than in the placebo group. (Refer to Table 1.)

90 mm Hg with a decrease of 20 mm Hg occurred in 1.5% and 0.8% of the ADASUVE 10 mg and placebo groups, respectively. A diastolic blood pressure of 50 mm Hg or a decrease of 15 mm Hg occurred in 0.8% and 0.4% of the ADASUVE 10 mg and placebo groups, respectively.

In Study 1 (placebo-controlled trials with a high incidence of hypotension was 3% and 0% in ADASUVE 10 mg and the placebo groups, respectively. The incidence of syncope or presyncope in normal volunteers was 2.3% and 0% in the ADASUVE and placebo groups, respectively. In normal volunteers, a systolic blood pressure of 30 mm Hg or a decrease of 15 mm Hg occurred in 5.3% and 1.1% in the ADASUVE and placebo groups, respectively. A diastolic blood pressure of 50 mm Hg or a decrease of 15 mm Hg occurred in 7.5% and 3.3% in the ADASUVE and placebo groups, respectively.

5.3 Adverse Reactions ADASUVE lowers the seizure threshold. Seizures have occurred in patients treated with oral loxapine. Seizures can occur in epileptic patients even during antiepileptic drug withdrawal. In short term (24-hour) placebo-controlled trials of ADASUVE, there were no reports of seizures.

5.4 Hypotension and Syncope

In controlled clinical trials (Studies 1, 2, and 3), 225 patients treated with ADASUVE 10 mg, 91 patients treated with ADASUVE 5 mg, and 126 patients treated with placebo received antiepileptic drug maintenance therapy. In short term (24-hour), placebo-controlled trials, sedation and/or somnolence were reported in 12% and 10% in the ADASUVE and placebo groups, respectively. Most patients discontinued treatment because of sedation or somnolence. The potential for cognitive and motor impairment is increased when ADASUVE is administered concurrently with other CNS depressants (see Drug Interactions (7.1)). Caution patients about operating hazardous machinery, including automobiles, until they are reasonably certain that therapy with ADASUVE does not affect them adversely.

6.2 Bronchospasm and Airway Adverse Reactions in Pulmonary Safety Trials

Clinical pulmonary safety trials demonstrated that ADASUVE can cause bronchospasm as measured by FEV1, and as indicated by respiratory signs and symptoms in the trials. In addition, the trials demonstrated that patients with asthma or other pulmonary diseases, such as COPD are at increased risk of bronchospasm. The effect of ADASUVE on pulmonary function was evaluated in 3 randomized, double-blind, placebo-controlled clinical pulmonary safety trials in healthy volunteers, patients with asthma, and patients with COPD. Pulmonary function was assessed by serial FEV1 tests, and respiratory signs and symptoms were assessed. In the asthma and COPD trials, patients with respiratory symptoms or FEV1 decrease of ≥ 20% were administered rescue treatment with albuterol (metered dose inhaler or nebulizer) as required. These patients were not eligible for a second dose; however, they had continued FEV1 monitoring in the trial.

Healthy Volunteers: In the healthy volunteer crossover trial, 30 subjects received 2 doses of either ADASUVE or placebo 8 hours apart, and 2 doses of the alternate treatment for at least 4 days later. The results for maximum decrease in FEV1 are presented in Table 2. No subjects in this trial developed open-airway related adverse reactions (cough, wheezing, chest tightness, or dyspnea).

Asthma Patients: In the asthma trial, 52 patients with mild-moderate persistent asthma (with FEV1 ≥ 80% of predicted) were randomized to treatment with 2 doses of ADASUVE 10 mg or placebo. The second dose was to be administered 10 hours after the first dose. Approximately 67% of these patients had a baseline FEV1 ≥ 80% of predicted. The remaining patients had an FEV1 60-80% of predicted. Nineteen patients (17%) were former smokers. As shown in Table 2 and Figure 7, there was a marked decrease in FEV1 immediately following the first dose (maximum mean decreases in FEV1 and % predicted FEV1 were 303 mL and 9.1%, respectively). Furthermore, the effect on FEV1 was greater following the second dose (maximum mean decreases in % predicted FEV1 and % predicted FEV1 were 537 mL and 14.2%, respectively). Respiratory-related adverse reactions (bronchospasm, chest discomfort, cough, dyspnea, throat tightness, and wheezing) occurred in 54% of ADASUVE-treated patients and 12% of placebo-treated patients. There were no serious adverse events. Nine of 26 (35%) patients in the ADASUVE group, compared to one of 26 (4%) in the placebo group, did not receive a second dose of study medication, because they had a ≥ 20% decrease in FEV1 or they developed respiratory symptoms after the first dose. Rescue medication (albuterol via metered dose inhaler or nebulizer) was administered to 54% of patients in the ADASUVE group (7 patients [2%] after the first dose and 7 of the remaining 17 patients [41%] after the second dose) and 12% in the placebo group (1 patient after the first dose and 2 patients after the second dose).

ADASUVE Patients: In the COPD trial, 52 patients with mild to severe COPD (with FEV1 ≥ 60% of predicted) were randomized to treatment with 2 doses of ADASUVE 10 mg or placebo. The second dose was to be administered 10 hours after the first dose. Approximately 57% of these patients had moderate COPD (Global Initiative for Chronic Obstructive Lung Disease [GOLD] Stage II), 32% had severe disease (GOLD Stage III), and 11% had mild disease (GOLD Stage I). As illustrated in Table 2 there was a decrease in FEV1 soon after the first dose (maximum mean decreases in FEV1 and % predicted FEV1 were 96 mL and 3.5%, respectively), and the effect on FEV1 was greater following the second dose (maximum mean decreases in FEV1 and % predicted FEV1 were 125 mL and 4.5%, respectively). Respiratory-related adverse reactions occurred more frequently in the ADASUVE group (19%) than in the placebo group (11%). There were no serious adverse events. Seven of 25 (28%) patients in the ADASUVE group and 1 of 27 (4%) in the placebo group did not receive a second dose of study medication, because a ≥ 20% decrease in FEV1 or the development of respiratory symptoms after the first dose. Rescue medication (albuterol via MDI or
is affected by factors frequently unmeasured in satisfaction studies. In a nationally representative sample, unusual patient-staff associations and patient satisfaction with care and preventive care adherence were eliminated, or even reversed, with sequential adjustment for patient sociodemographics, physical and mental health status, and attitudes toward health care.

Meanwhile, Dr. Kaplan criticized a study one of us published. Within a nationally representative sample, the study found that patients in the highest patient satisfaction quartile (versus the lowest) had 8.8 percent greater total health expenditures, 9.1 percent greater prescription drug expenditures, and significantly higher mortality over a mean follow-up of 3.9 years. The study adjusted for patient sociodemographic, clinical, and other prior treatments, including physical and mental health status, chronic illness, and prior health care utilization. The results highlighted the need to better understand the potential link between patient satisfaction with health care utilization, including the use of health care that may, on balance, be harmful.

Dr. Kaplan stated the study “has no legitimacy” due to three “serious methodologic flaws”: 1) that satisfaction was only measured in 2000 and not in 2007 and 2008; and total expenditures were only measured in 2001, and 3) that mortality was assessed in 2000–2006 and never in 2007 in patients satisfaction or cost were measured. Each statement regarding the first two relationships is false. Regarding the first two, relationships between patient satisfaction and utilization were studied all years from 2000 to 2008. Regarding the third, satisfaction in 2000–2005 and mortality outcomes through 2006 were assessed in the full sample and in the subsample initially enrolled in 2000–2005. In our view, the evidence supports a conceptualization of satisfaction as a quality metric unrelated to technical health care quality. Technical care quality is often invisible to patients. Case varied in severity: in some cases, symptoms have been self-limited, but in other cases neonates have required intensive care unit support and prolonged hospitalization.

In rats, embryotoxicity (increased fetal resorptions, reduced fetal body weight, and other anticholinergic drugs can increase the risk of anticholinergic side effects). Loxapine, the active ingredient in ADASUVE, has demonstrated increased fetal body weight and reduced fetal body weight up to 12, 60, and 10 mg/kg, respectively. These doses are 12-, 32-, and 10 mg/kg higher, respectively.

Tachycardia, hypotension, hypertension, orthostatic hypotension, and syncope. Use supportive and symptomatic measures. In rats, embryotoxicity (increased fetal resorptions, reduced fetal body weight, and other anticholinergic drugs can increase the risk of anticholinergic side effects). Loxapine, the active ingredient in ADASUVE, has demonstrated increased fetal body weight and reduced fetal body weight up to 12, 60, and 10 mg/kg, respectively. These doses are 12-, 32-, and 10 mg/kg higher, respectively.

Dystonia (Antipsychotic Class Effect): Patients with a history of dystonia will be enrolled if they do not have a history of dystonia. In the 3 short-term (3-4 hour), placebo-controlled trials of ADASUVE in 259 patients with agitation associated with schizophrenia or bipolar disorder, extrapyramidal reactions were observed. In one patient (0.4%) treated with ADASUVE, a decision making the potential risk to the fetus.

It is not known whether ADASUVE is present in human milk. Loxapine is an inhibitor of the breast milk's pump and may decrease the milk's concentration of ADASUVE. The risk of making some dissatisfied. Incentives also should not discourage physicians from caring for subgroups that may be more difficult to satisfy (e.g., Medicaid patients, patients with mental illness or chronic pain). Lack of health care access may lead to fragmented care for these subgroups and an increased reliance on emergency department visits. Questions remain regarding what drives these metrics and how they relate to patient satisfaction. Dr. Fenton and colleagues found that patients at risk for making some dissatisfied. Incentives also should not discourage physicians from caring for subgroups that may be more difficult to satisfy (e.g., Medicaid patients, patients with mental illness or chronic pain). Lack of health care access may lead to fragmented care for these subgroups and an increased reliance on emergency department visits. Questions remain regarding what drives these metrics and how they relate to personal and population health, calling for a measured approach to interpreting and rewording patient satisfaction.

**References**


**ENTHUSIASM FOR PATIENT SATISFACTION SCORES IS UNJUSTIFIED**
Interview Policy for Candidates for ACEP Offices

ACEP Member Questions Campaign Policy

by LIAM YORE, MD, FACEP

ACEP is a large and diverse group of emergency care providers united around the core mission of providing the best possible care to the patients we serve. While we all share the same goals, there has rarely been unanimity in regard to the best way to accomplish them. Indeed, the spirit of emergency medicine has seemed to select the individualists and contrarians in the house of medicine. In a way, this makes sense: emergency physicians are the crazy ones who were told that there was no such thing as emergency medicine but founded the specialty anyway. We accomplish the impossible every day in the nation’s resource-starved emergency departments using nothing more than duct tape and baling wire. We are members of a specialty composed of doers and visionaries; the best way to get emergency physicians to do something is to tell them it cannot be done.

Getting 30,000 fractious and energetic emergency physicians to agree on anything has always been a challenge, and it has led to some “lively” debates throughout the history of the College. Some very vivid and larger-than-life personalities have emerged as leaders of the Council over the years. Whatever the issue, there was one thing you could be sure of: emergency physicians would not shrink from the debate.

That is why it is so disappointing that the ACEP Council, in its wisdom, decided to adopt a policy restricting the free speech rights of candidates for leadership in the College. In this novel and unusual step, the College has pronounced a rule by conducting interviews or any other activities, and no such requests are permitted to the Council Candidate Forum, which is held prior to the annual ACEP meeting. The College Steering Committee addresses Council matters while the College is not in session. However, it should not act unilaterally on matters that require broader consideration by the Council (367 Councillors representing approximately 33,000 members). The Steering Committee comprises 15 Councillors appointed by the speaker and the vice speaker. Steering the ship away from icebergs is appropriate, but setting sail for uncharted waters is not. I know we are slow to change, but that’s part of the democratic process. Although being nimble and quick to action is important in some circumstances, careful consideration before action is important in others.

First and foremost, this is an unconscionable prior restraint on the free speech rights of the candidates. Under this policy, candidates who wish to explain their policy opinions and vision for the future direction of the College to an independent outlet may do so. While the College is a private organization that may make its own rules, the principle of the First Amendment demands that any restrictions on freedom of expression be narrowly crafted to serve a compelling interest. The Committee, in its defense of this policy, intimated that independent publications might be biased in their coverage. I have seen no evidence of this actually being the case, and none is offered by the College. If it were so, however, it is selling Councillors short by implying that they are unable to discern bias when it exists and unable to weigh and evaluate the information as presented. To the contrary, the College may be better served by its candidates speaking to publications that have an independent editorial voice and a willingness to ask direct questions. For that matter, direct access to candidates likely will reduce any potential for bias in allowing the candidates to speak for themselves rather than requiring outside news organizations to infer candidates’ positions and qualifications. The leaders of ACEP will need to take on members of Congress, FOX News, and MSNBC after they have been elected; surely as candidates they can be trusted to handle the far-friendlier confines of industry journals and newspapers.

To the degree that there exists valid disagreement and criticisms of the manner in which ACEP is governed and in its policy decisions, the College is best served when it meets these directly and defends its positions in open debate. To the degree that there exists valid disagreement and criticisms of the manner in which ACEP is governed and in its policy decisions, the College is best served when it meets these directly and defends its positions in open debate.
The Big Tent of Emergency Medicine

Why must we reopen the College? Easy—it is our mission: “ACEP promotes the highest quality of emergency care and is the leading advocate for emergency physicians, their patients, and the public.”

Why must we reopen the College? Easy—it is our mission. Have you ever really considered ACEP’s mission statement? Here it is: “The American College of Emergency Physicians promotes the highest quality of emergency care and is the leading advocate for emergency physicians, their patients, and the public.”

Consider who this includes and what it says. “Promotes the highest quality of care.” Where? Everywhere. For whom? For all emergency physicians, their patients, and the public. “Advocate for emergency physicians, their patients, and the public.” The same group is addressed here. One could argue that, in order to be an emergency physician, you must be American Board of Emergency Medicine or American Osteopathic Board of Emergency Medicine certified or eligible, or members of ACEP as defined by the ACEP Board of Directors in 2011. If so, all of the patients and public who are served by the non–EM boarded physicians or physicians who aren’t ACEP members are left out, according to our mission statement. That doesn’t make sense. In order to fulfill our mission, we must embrace all emergency department physicians, their patients, and the public—not just a few, not some, not in certain places, not just EM board certified, but all the physicians who regularly provide emergency care, their patients, and the public.

All across America, 24/7/365, there are professional men and women who cannot join our College but saddle up anyway and go to work in their local, often small, rural EDs—places where resources are often few, payment for work is often wanting, and recruiting is, at best, difficult. If they do not answer the call, who will? Often, these are the very physicians who cannot join our College. Like it or not, these physicians are necessary to fill the gaps in staffing at the nation’s emergency departments. It is the world we live in today and most likely tomorrow. These physicians, patients, and public need the full resources, advocacy, and support of ACEP. They deserve to be under the umbrella of the nation’s premier emergency medicine organization, ACEP.

ACEP needs them. These physicians have unique and important perspectives.

CONTINUED on page 11

Emergency medicine training prepares us to work up complaints in a different manner. The ordering of our differential diagnosis is different. Our skill set for approaching problems is different. These differences matter—period. Just because physician shortages force us to accept non–emergency-trained physicians in emergency department roles does not mean that we should fail to recognize that emergency medicine is best practiced by emergency-trained physicians and that those who work in the emergency environment who lack our specialty training are markedly dissimilar from us. On-the-job training is no longer appropriate just as simply passing written and oral exams is insufficient to demonstrate knowledge. To state that ACEP needs to incorporate non–residency-trained physicians into emergency medicine discounts the effort, knowledge, and dedication of emergency medicine–trained residents. It also sets a dangerous standard for the care of our patients.

PRO OPEN ACEP TO ALL EMERGENCY PHYSICIANS

Allowing ED physicians not certified in EM to join will fulfill our mission—and ultimately help patients

by SULLIVAN SMITH, MD, FACEP, CHAIR OF THE ACEP CAREERS SECTION

CON HOLDING THE LINE IN DEFENSE OF OUR SPECIALTY

The case for maintaining strict membership requirements for ACEP

by RUSSELL RADTKE, MD, FACEP, CHAIR OF THE ACEP YOUNG PHYSICIANS SECTION

T he discussion on opening up ACEP membership to non–emergency medicine boarded physicians is not a new one, but it is one that is important to continue. When considering this issue, I feel it’s important to question why a non–emergency medicine boarded physician would want the ACEP affiliation in the first place. The answer is simple: the affiliation means something now more than ever.

When our specialty was in its infancy, there were no “emergency medicine” physicians. There were certainly people who worked in the emergency environment, however, who had the wisdom to recognize the need for something better. Those pioneers saw the need for specific emergency medicine training, and over time, the emergency room became the emergency department, and the specialty was born. Since that time, there has been a marked evolution of what is expected from the emergency department and of those who provide emergency care. We are now the gatekeepers to the hospital and the providers of the bulk of ambulatory care in this country. Certainly, this is a far cry from the emergency room of old.

Our founders had to “learn on the job,” as new doctors in emergency department roles, without the benefit of formal emergency medicine training, are still doing the same thing. Although this is still an unfortunate reality, I do not feel it is in the best interest of the College to support this method of meeting our patients’ needs by endorsing the individuals who did not train in emergency medicine. Emergency medicine training prepares us to work up complaints in a different manner. The ordering of our differential diagnosis is different. Our skill set for approaching problems is different. These differences matter—period. Just because physician shortages force us to accept non–emergency-trained physicians in emergency department roles does not mean that we should fail to recognize that emergency medicine is best practiced by emergency-trained physicians and that those who work in the emergency environment who lack our specialty training are markedly dissimilar from us. On-the-job training is no longer appropriate just as simply passing written and oral exams is insufficient to demonstrate knowledge. To state that ACEP needs to incorporate non–residency-trained physicians into emergency medicine discounts the effort, knowledge, and dedication of emergency medicine–trained residents. It also sets a dangerous standard for the care of our patients.
PRO CONTINUED

Without representation of the physicians who staff these smaller EDs, the perspective of the College shifts. It shifts to the experiences, opinions, and issues of the academic and larger centers and staffing groups. How about political advocacy? Who can better advocate for the patients and the public in rural and remote locations than those who work there? Often, these are the non–EM boarded physicians. These non–EM boarded physicians are well-known in their communities and to their political leaders. These physicians represent community opinions. They vote. They get heard.

So, why don’t we just send our residency-trained emergency physicians out into these places? We don’t have enough, and we won’t for a long time. The studies are compelling. Review them for yourself.1 You should check into the pay, the available resources, and the struggles of these physicians in these smaller EDs. Better still, come visit me in rural Tennessee. I’ll be happy to show you around. Visit any number of other smaller or rural EDs in the country; speak to those emergency physicians. The stories will be pretty similar.

So what do we do to promote and advocate for these non–member-eligible physicians, their patients, and the public? We should not “let” them join. No, we shouldn’t. Rather, we should “ask” them to join and participate in the College. Let’s all work together to advocate for and provide the highest quality care to all emergency physicians, patients, and the public. ACEP then best fulfills its leadership role and lives up to its mission statement. All emergency physicians, patients, and the public benefit alike. It’s hard to see much wrong with that. Sure, ACEP’s meetings, sections, and educational resources are available to members and non-members alike. Non-members are assessed additional fees for their non-membership despite a willingness to join.

ACEP’s logo represents the missing specialty within the house of medicine. Within our College, it looks like that logo could have added meaning if ACEP limits membership to only EM board-certified physicians. The missing piece is that group of emergency physicians who cannot join. They are very real, not going away, and very much missing. Let’s open the College so ACEP represents all emergency physicians, their patients, and the public. After all, it is our mission.

References

CON CONTINUED

sends the wrong message. In our department, we have physician assistants and nurse practitioners working alongside us who also do “emergency physician” work; they work under our supervision while the non–emergency medicine boarded physicians work independently. Just because I set fractures in the emergency department, deliver babies, and interpret ECGs doesn’t make me an orthopedist, obstetrician, or cardiologist. Likewise, there is a distinction between being an emergency medicine physician and being a physician who practices emergency medicine.

Fortunately, we have reached a point where the medical community at large understands this distinction. Many hospitals already require emergency medicine–trained and –boarded physicians for staffing their departments, and when it comes to good jobs for our residents completing training, they are out there. Until we reach a point where there are enough emergency physicians available to fill every emergency department across the country, it is still necessary for non–emergency physicians to fill these positions in underserved areas. So why is it important that we continue to recognize the difference between “us” and “them”? And, more important, why not embrace them into our ranks?

If we allow non–emergency physicians the benefit of membership, what is it that they would hope to gain? They are already able to come to our conferences. They can receive our publications. They can publish in our journal. They already receive the benefits of our advocacy efforts even if they are not held to our standards. They will not provide a financial windfall to the College through their membership. The only reason to invite them is that we feel we need them at the table when we make decisions about the future of our specialty. I would argue, however, that we don’t.

Where the line must be drawn is the final remaining benefit that affiliation with the College would bring: a seat at the table. ACEP is recognized as the voice of emergency medicine, and our advocacy efforts put us in a position to make our voice heard when policies affecting us are being made. The important thing for us now is to make sure “our” message is the one being heard. No one is better equipped to determine the needs of our specialty than we are. No one is better able to develop clinical guidelines that we should follow than us.

DR. RADTKE is chair of the ACEP Young Physicians Section and a pediatric emergency physician at St. Joseph’s Children’s Hospital in Tampa, Florida.

When vascular access presents a challenge

Go directly to the bone with the EZ-IO® Intraosseous Vascular Access System

Trust the EZ-IO Intraosseous Vascular Access System for immediate vascular access for your difficult vascular access (DVA) patients

With the EZ-IO System, getting immediate vascular access for DVA patients is:

> Safe: <1% serious complication rate\(^1\)
> Fast: Vascular access with anesthesia and good flow in 90 seconds\(^2\)
> Efficient: 97% first-attempt access success rate\(^3\)
> Versatile: Can be placed by any qualified healthcare provider
> Convenient: Requires no additional equipment or resources\(^4\)

Vidacare is now part of Teleflex

Visit Vidacare.com for more information.

Potential complications may include local or systemic infection, hematoma, extravasations or other complications associated with percutaneous insertion of sterile devices.

References

*Research sponsored by the Vidacare Corporation.

Teleflex and EZ-IO are trademarks or registered trademarks of Teleflex Incorporated or its affiliates. © 2014 Teleflex Incorporated. All rights reserved. 2014-3027
fever, rash, muscle pain, or joint pain. Providers in the urgent care facility diagnosed the patient with anxiety and prescribed clonazepam. No electrocardiogram (ECG) was performed.

The following day, the patient collapsed and died. Serum obtained at autopsy revealed a strong serologic response to infection with *Borrelia burgdorferi* spirochetes, the causative agent of Lyme disease. Examination of decedent heart tissue revealed characteristic histopathologic findings of Lyme carditis (see Figure 1). *B. burgdorferi* sensu lato spirochetes were seen after Warthin-Starry stain of heart tissue (see Figure 2) and confirmed by immunohistochemistry and polymerase chain reaction.

**Discussion**

On Dec. 13, 2013, the Centers for Disease Control and Prevention (CDC) published a report describing three cases of sudden cardiac death associated with Lyme carditis in otherwise healthy young adults ages 26 to 38. While two of the case-patients described in the *Morbidity and Mortality Weekly Report* did not seek care before their deaths, one did but was not diagnosed with or treated for Lyme disease.

Lyme disease is a zoonotic, multisystem illness caused by the spirochete *B. burgdorferi*, which is transmitted by certain *Ixodes* spp. ticks. Approximately 30,000 cases are reported to the CDC each year, primarily from high-incidence states located in the northeast (Connecticut, Delaware, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, and Vermont) and north central (Minnesota and Wisconsin) United States. The actual number of annual infections is estimated to be tenfold higher; Lyme disease is the most common vectorborne disease in the United States. The actual number of annual infections is estimated to be tenfold higher; Lyme disease is the most common vectorborne disease in the United States. The actual number of annual infections is estimated to be tenfold higher; Lyme disease is the most common vectorborne disease in the United States.

Acute clinical illness is usually characterized by fever and constitutional symptoms combined with a distinctive rash, erythema migrans (EM), which develops at the site of the tick bite in approximately 70 to 80 percent of patients. However, without early appropriate antibiotic therapy, infection can disseminate to other tissues, causing peripheral and central neuropathy, arthritis, and carditis.

Lyme carditis, which is most commonly manifested as atrioventricular (AV) conduc-

---

**Emergency physicians are in a unique position to recognize and diagnose Lyme disease before it progresses.**

---

emergency health care providers should investigate heart block in patients with Lyme disease if clinically indicated. Importantly, providers are advised to consider obtaining an ECG in men and young adults from, or with recent travel to, high-incidence Lyme disease areas who present with symptoms of Lyme carditis, such as chest pain, palpitations, lightheadedness, shortness of breath, and syncope, particularly during summer and fall months.

Recommended treatment algorithms for Lyme carditis have been established by the Infectious Diseases Society of America, and readers are directed there for additional therapeutic information (see Table 1). Hospitalization and continuous cardiac monitoring should be considered for symptomatic patients, any patients with second- or third-degree heart block, or those with first-degree block with a prolonged PR interval (>200 milliseconds).

Confirmatory laboratory evidence of infection should not delay supportive care in appropriate clinical scenarios. Recommended parenteral antibiotics should be administered during hospitalization. For patients with severe heart block, a supportive temporary pacemaker may be required. The prognosis is generally excellent with appropriate antibiotic therapy. Most patients will experience resolution of symptoms and ECG abnormalities within one to six weeks, depending on the degree of initial conduction disturbance.

An oral antibiotic regimen can be used to complete a course of therapy upon hospital discharge.

While Lyme carditis is an uncommon manifestation of Lyme disease, it is also one of the most serious. Emergency health care providers are in a unique position to recognize and diagnose this potential-life-threatening illness before it progresses. Additional information about the prevention, diagnosis, treatment, and epidemiology of Lyme disease can be found at www.cdc.gov/lyme.

---

**Table 1. Recommended Antimicrobial Regimens for Treatment of Patients With Lyme Disease**

<table>
<thead>
<tr>
<th>DRUG</th>
<th>DOSAGE FOR ADULTS</th>
<th>DOSAGE FOR CHILDREN</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PREFERRED ORAL REGIMENS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amoxicillin</td>
<td>500 mg 3 times per day</td>
<td>50 mg/kg per day in 3 divided doses (maximum, 500 mg per dose)</td>
</tr>
<tr>
<td>Doxycycline</td>
<td>100 mg twice per day</td>
<td>Not recommended for children aged &lt;8 years. For children aged ≥8 years, 4 mg/kg per day in 2 divided doses (maximum, 100 mg per dose)</td>
</tr>
<tr>
<td>Cefuroxime axetil</td>
<td>500 mg twice per day</td>
<td>30 mg/kg per day in 2 divided Doses (maximum, 500 mg per dose)</td>
</tr>
<tr>
<td><strong>ALTERNATIVE ORAL REGIMENS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Ceftriaxone</em></td>
<td>For recommended dosing regimens, see footnote in Table 3</td>
<td>For recommended dosing regimens, see footnote in Table 3</td>
</tr>
<tr>
<td><em>Penicillin G</em></td>
<td>18–24 million U per day intravenously, divided every 4 h</td>
<td>200,000–400,000 U/kg per day divided every 4 h (not to exceed 18–24 million U per day)</td>
</tr>
</tbody>
</table>

a Although a higher dosage given twice per day might be equally as effective, in view of the absence of data on efficacy, twice-daily administration is not recommended.

b Tetracyclines are relatively contraindicated in pregnant or lactating women and in children ≤8 years of age.

c Because of the lower efficacy of macrolides, macrolides are reserved for patients who are unable to take or who are intolerant of tetracyclines, penicillins, and cephalosporins.

d Dosage should be reduced for patients with impaired renal function.

---

WHEN TO PROVIDE PROPHYLAXIS

or prevention of Lyme disease after a recognized tick bite, routine use of antimicrobial prophylaxis or serologic testing is not recommended. A single dose of doxycycline may be offered to adult patients (200 mg) and to children ≥8 years of age (4 mg/kg, up to a maximum dose of 200 mg) when all of the following circumstances exist:

A. The attached tick can be reliably identified as an adult or nymphal I. scapularis tick that is estimated to have been attached for ≥36 hours on the basis of the degree of engorgement of the tick with blood or on certainty about the time of exposure to the tick.

B. Prophylaxis can be started within 72 hours of the time that the tick was removed.

C. Ecologic information indicates that the local rate of infection of these ticks with B. burgdorferi is ≥20 percent.

D. Doxycycline is not contraindicated.

requests have ever been received. Thus, this would be a material and substantive change for our campaign process that the Steering Committee did not feel would be appropriate to decide without further consideration and broader input. Some may ask how this differs from other campaign rule changes. An excellent example is the removal of social media restrictions. The ACEP Council candidate campaign rules have always allowed any use of social media for campaigning. This year, the ban was lifted, allowing unrestricted use of personal social media sites to promote candidacies. This sounds like a “material and substantive” change, doesn’t it? It certainly is. However, in contrast to outside publications conducting campaign interviews, the use of social media for campaigning has been discussed for the past three years (by three different Steering Committees) and has been fully evaluated, with Council consensus supporting this change reached.

To effect meaningful change as quickly as possible, the Steering Committee is discussing for the past three years (by three different Steering Committees) and has been fully evaluated, with Council consensus supporting this change reached.

To effect meaningful change as quickly as possible, the Steering Committee is discussing for the past three years (by three different Steering Committees) and has been fully evaluated, with Council consensus supporting this change reached.

To effect meaningful change as quickly as possible, the Steering Committee is discussing for the past three years (by three different Steering Committees) and has been fully evaluated, with Council consensus supporting this change reached.

To effect meaningful change as quickly as possible, the Steering Committee is discussing for the past three years (by three different Steering Committees) and has been fully evaluated, with Council consensus supporting this change reached.

To effect meaningful change as quickly as possible, the Steering Committee is discussing for the past three years (by three different Steering Committees) and has been fully evaluated, with Council consensus supporting this change reached.

To effect meaningful change as quickly as possible, the Steering Committee is discussing for the past three years (by three different Steering Committees) and has been fully evaluated, with Council consensus supporting this change reached.

To effect meaningful change as quickly as possible, the Steering Committee is discussing for the past three years (by three different Steering Committees) and has been fully evaluated, with Council consensus supporting this change reached.

To effect meaningful change as quickly as possible, the Steering Committee is discussing for the past three years (by three different Steering Committees) and has been fully evaluated, with Council consensus supporting this change reached.

To effect meaningful change as quickly as possible, the Steering Committee is discussing for the past three years (by three different Steering Committees) and has been fully evaluated, with Council consensus supporting this change reached.

To effect meaningful change as quickly as possible, the Steering Committee is discussing for the past three years (by three different Steering Committees) and has been fully evaluated, with Council consensus supporting this change reached.

To effect meaningful change as quickly as possible, the Steering Committee is discussing for the past three years (by three different Steering Committees) and has been fully evaluated, with Council consensus supporting this change reached.

To effect meaningful change as quickly as possible, the Steering Committee is discussing for the past three years (by three different Steering Committees) and has been fully evaluated, with Council consensus supporting this change reached.

To effect meaningful change as quickly as possible, the Steering Committee is discussing for the past three years (by three different Steering Committees) and has been fully evaluated, with Council consensus supporting this change reached.

To effect meaningful change as quickly as possible, the Steering Committee is discussing for the past three years (by three different Steering Committees) and has been fully evaluated, with Council consensus supporting this change reached.

To effect meaningful change as quickly as possible, the Steering Committee is discussing for the past three years (by three different Steering Committees) and has been fully evaluated, with Council consensus supporting this change reached.
ACEP to Build New Home

New ACEP headquarters means more member benefit

BY ALEXANDER M. ROSENAU, DO, CPE, FACEP, AND DEAN WILKERSON, JD, MBA, CAE

In 1983, when the current ACEP headquarters was built, emergency medicine was fairly new as a recognized specialty. Now, with more than 33,000 ACEP members, the needs of this dynamic, growing medical organization have greatly evolved. Just as many aspects of emergency medicine were different 30 years ago, our building was designed for a very different organization with different staffing and space needs as well as different technological requirements. In the 21st century, ACEP needs a headquarters that better represents the specialty and meets the needs of its members and its mission.

In advance of the June meeting of the ACEP Board of Directors, the Finance Committee provided due-diligence to make sure we could continue to advance and meet our financial benchmarks. The Board analyzed the options and decided that the best course of action is to buy land in Irving, Texas, near the Dallas/Fort Worth (DFW) International Airport, and build a new headquarters.

The ACEP headquarters plays an important role in the work of ACEP’s Board of Directors, many committees, task forces, workgroups, and the Texas College of Emergency Physicians. Important educational trainings such as the Emergency Medicine Basic Research Skills Workshop are already held at the headquarters, and we hope these can be expanded to the Emergency Department Directors Academy, Teaching Fellowship, and other small to medium educational opportunities.

The current ACEP building is dated, requiring frequent and costly maintenance, and is energy inefficient. More important, the current space is already inadequate for staff work critical to support the growing membership and mission-critical activities of ACEP. Any future growth would make it even more challenging. There are insufficient conference rooms and workrooms, and the building lacks state-of-the-art audio/visual equipment.

Out of necessity, ACEP has been leasing space across the street for some of its staff, which is not optimal for efficiency and collaborative work. ACEP expects to add four to five employees per year over the next five years and projects to have around 150 employees at its headquarters in about 10 years. After discussing the subject of a new headquarters in varying degrees for more than two years, along with a substantial amount of due diligence, considerable planning and projects to have around 150 employees at its headquarters in about 10 years. After discussing the subject of a new headquarters in varying degrees for more than two years, along with a substantial amount of due diligence, considerable planning and progress have been made.

ACEP commissioned a top-level space-needs analysis and found that at ACEP’s current staff size, we need a building of approximately 42,527 square feet; currently we have 30,474 square feet. If staff grows by 25 percent in the next five years, we would need approximately 50,000 square feet. If we were to grow by 40 percent in 10 years, we could use a building of approximately 52,000 square feet.

After an extensive request-for-proposal process, a real estate consulting firm was selected for the project. It provided a thorough lease-versus-own analysis that concluded ownership of the headquarters is financially more favorable than leasing over a 20-year time horizon. It also conducted an exhaustive analysis of buildings for sale in the area and found no building deemed to be suitable for purchase as they were in the same outdated condition as our current location.

Several tracts of land for potential build-to-suit projects were identified, and in April 2014, the ACEP Board approved pursuing this option. The preferred 5.8-acre tract of land is close to DFW International Airport and two miles from the current headquarters. For the convenience of our Board, committees, and members who visit, it is adjacent to a full-service hotel. It can hold a 5,000-60,000 square-foot office building with adequate parking.

The Board approved a plan to meet the total project cost of $14.5 million, with $7 million down and financing of $7.5 million. ACEP has healthy financial reserves, with a substantial portion in very low-yielding CDs and fixed-income investments. Additionally, when the current building is sold, ACEP can expect to net about $3.5 million.

Provided that the ongoing land-acquisition negotiations continue favorably, it will likely be spring 2015 before we can break ground, and it will be 18 months or more before we move in.

We believe value to our members and future members will be the result of this investment, and we anticipate more effective and efficient service for our Board, committees, and chapters. A newer, modern headquarters presents further opportunities for ACEP to reflect, develop, and disseminate our values and goals.

Dr. Rosenau is President of ACEP and practices emergency medicine at Lehigh Valley Health Network in Allentown and Bethlehem, Pennsylvania.

Mr. Wilkerson is Executive Director of ACEP.
The Official Voice of Emergency Medicine

Dr Steven Stack Named President-Elect of AMA

Emergency medicine plays a key role in the house of medicine

BY THE AMA SECTION COUNCIL ON EMERGENCY MEDICINE

On June 7, 2014, another glass ceiling was broken for emergency medicine. On that date, the AMA announced that Steven J. Stack, MD, FACEP, would be its 170th President, the first emergency physician to ever hold that position. When he assumes office in June 2015, Dr. Stack will be the youngest president in the past century and may, in fact, be the youngest president since the AMA’s founding in 1847. Through just one of many accomplishments made by emergency physicians, this one has special significance, tracing back to the founding of our specialty.

EM’s AMA History

Forty-five years ago, John Weigenstein, MD, one of ACEP’s founders, was accepted as the first emergency physician to represent ACEP in the AMA House of Delegates (HOD). At that time, he was most likely the only physician in the AMA HOD practicing full-time in an emergency department and his early representation in that body was one of many critical first steps to the birth and formal recognition of our specialty within the house of medicine. The road was difficult and many other physicians stood in the way, but in the end, recognition within the AMA helped pave the way for our independent standing and recognition as a distinct specialty.

How the times have changed! ACEP now has five delegates in the EM Section Council of the AMA HOD. Additionally, numerous other emergency physicians serve in the AMA HOD as delegates and alternates representing their state medical associations. Many of these leaders have distinguished our specialty as presidents of their state medical associations or in service on one of the AMA’s councils. Moreover, it has become common for numerous students, residents, and young physicians entering our specialty to hold leadership positions within AMA sections and in designated “lifecycle” seats on the AMA councils. From a challenged beginning, emergency medicine has clearly reached maturity and has enjoyed three consecutive years of increasing membership. Further, through a bold new strategic plan, the AMA has set out to catalyze audacious and necessary change to benefit patients and physicians. Just to mention a few major current AMA activities:

• In 2013, in partnership with 11 leading medical schools across the nation, the AMA launched its Accelerating Change in Medical Education initiative, an $11 million competitive grant endeavor designed to jump-start the complex process of creating the medical school of the future.
• The AMA is investing substantial resources to evaluate long-term paths to physician practice sustainability and professional satisfaction. Through research, data, and analytics, the AMA is identifying effective care delivery and payment models to improve the quality of patient care, reduce health care costs for the nation, and increase professional satisfaction.
• In partnership with the YMCA and Johns Hopkins University (and others to come), the AMA is committing its resources, expertise, and reach to preventing heart disease and type 2 diabetes and to improving outcomes for those with these diseases. The toll of these two diseases—both in dollars and human suffering—is staggering.

Join the Efforts

In the midst of this new burst of innovation and vibrancy at AMA, however, your representatives to the AMA HOD are troubled by the paucity of emergency physicians who have chosen to help “carry the water” as members of the AMA. We are certainly thankful for the outstanding job that ACEP does representing EM interests and supporting our specialty. We do not, though, exist alone in the house of medicine, and ACEP alone is not positioned to completely represent EM’s interests in Washington, D.C., and within organized medicine in general. This is where a strong EM voice within a strong and growing AMA is vital to all of us. If you are not an AMA member, now is the time to join. If you are already a member, please make certain that you have balledot on the AMA website to designate ACEP as your representative at the AMA. ACEP’s five-year membership review at the AMA is this year, and the number of delegates we get in the AMA HOD is determined by the number of AMA members we have. Sadly, at this time of so much accomplishment by our specialty and with so many challenges facing us in Washington and elsewhere, we are subject to losing one or more delegates absent an improvement in our EM membership within the AMA membership. Fewer delegates means that the future of medicine could be shaped to a greater extent by other specialties such as radiology, surgery, family practice, internal medicine, pediatrics, and many others—others that do not have the expertise of our specialty and that do not necessarily have the best interests of our specialty in mind.

With one of us about to assume the pinnacle of leadership within organized medicine, it is now time for each of us to make an additional press forward on behalf of emergency medicine by joining the AMA to ensure our voice remains strong and grows stronger still.

You can further enhance emergency medicine’s AMA influence by joining the AMA now at https://commerce.ama-assn.org/membership.

The Official Voice of Emergency Medicine

AUGUST 2014

ACEPNOW.COM
Explore Innovations in EM at ACEP14

See the newest innovative approaches, procedures, and products that can impact real-life situations during live, simulated code events in the innovatED experience at ACEP14.

Here, the best-of-the-best products and services — reviewed and vetted by a committee of emergency physicians — are showcased working together in a true-to-life environment.

Between mock drills, try out new equipment, learn about patient and staff safety improvements, download relevant content, and connect with clinical experts and industry leaders — all included as part of your ACEP14 registration.
What You Need to Know About POLST

Understanding POLST forms will better enable emergency physicians to verify patients' wishes for end-of-life care being met

BY MARILYN J. HEINE, MD, FACEP, FACP

As the front line in care, emergency physicians often approach a patient in extremis or with a dramatic change in clinical condition. We may be presented with a Physician Orders for Life-Sustaining Treatment (POLST) form for a patient who has limited or no ability to communicate. Some background and cases will illustrate relevant considerations.

What Is POLST?
The POLST form is part of a program to foster communication and shared decision making about goals of care at the end of life. The conversation is to occur between the patient and a surrogate and a health care professional when the patient is diagnosed with a serious illness or frailty where the provider “would not be surprised if the patient died within the next year,” an outcome that is difficult to predict precisely.1 The health care professional documents the patient’s preferences as medical orders when the POLST form is completed.

Forty-three states currently have a fully endorsed or developing POLST program that is designed along the paradigm with shared core principles and similar form design.2 States may differ, however, in the terminology (eg, POLST, Physician Orders for Scope of Treatment [POLST], Medical Orders for Life-Sustaining Treatment [MOLST]), Medical Orders for Scope of Treatment [MOST]); color of the form (eg, bright pink, green, white, or copies); which health care professional is authorized to sign (eg, physician, nurse practitioner, physician assistant); whether the patient or surrogate must sign; action prompted by a blank section of the form; whether the program is delineated in statute, in regulation, or by a consensus panel; how to address a conflict between a POLST form and an advance directive; the degree of immunity, duty to comply, and the level of reciprocity with other states’ POLST programs. To understand many states’ specifics, visit the National POLST Paradigm’s website at www.polst.org.

Details of the POLST Form
Not all POLST forms are identical. The POLST form (see Figure 1) should include the patient’s name and authorized signatures of the health care provider and patient or surrogate. The top section, with a selection regarding resuscitation, applies if the patient is in cardiac arrest. The next sections usually describe goals of treatment, level of medical interventions, anesthetic, artificially administered hydration, and nutrition. The lower portion includes discussion of care goals.

A patient’s POLST form should be readily accessible by caregivers and EMS to facilitate its implementation. The form should accompany the patient on transfer. In states with POLST programs, most hospitals honor the POLST form that accompanies a patient until the patient is reassessed. In an emergency where the attending physician is precluded from discussion with the patient, the orders expressed on the POLST form should be followed. Challenges include when the POLST form is unavailable, incomplete, unsigned, or with a seeming inherent contradiction (eg, DNR/full treatment, attempt cardiopulmonary resuscitation, and comfort measures only).1,2

How Does a POLST Form Differ From an Advance Directive?
The POLST form complements an advance directive (see Table 1). It is not necessarily a substitute for what is on the POLST form. This highlights the surrogate’s instrument role in ensuring the goals of the patient are implemented. While there may be instances where the view of the surrogate and the intent of the patient differ, each state can establish safeguards to help ensure that the surrogate carries out the patient’s wishes. Such steps may require consultation with the treating physician before authorizing a change to the patient’s POLST form, that the patient’s advance directive is reviewed, that good-faith efforts are made to act consistently with the patient’s known desires, and that the reason for a change in the patient’s POLST is carefully documented.

Do we have legal protection? Emergency physicians are generally protected by statutory immunity associated with a state’s laws on advance directives and surrogates. In states without a similar level of explicit immunity from criminal prosecution, civil liability, and disciplinary sanctions when POLST orders are followed in good faith, the liability climate may influence the acceptance of POLST orders.7 It is important to familiarize yourself with the protections in your state.

As POLST programs become more established, emergency physicians are increasingly likely to care for patients with POLST forms. Better understanding of these programs may enhance the end-of-life care we provide.

This highlights the surrogate’s instrument role in ensuring the goals of the patient are implemented. While there may be instances where the view of the surrogate and the intent of the patient differ, each state can establish safeguards to help ensure that the surrogate carries out the patient’s wishes. Such steps may require consultation with the treating physician before authorizing a change to the patient’s POLST form, that the patient’s advance directive is reviewed, that good-faith efforts are made to act consistently with the patient’s known desires, and that the reason for a change in the patient’s POLST is carefully documented.

Do we have legal protection? Emergency physicians are generally protected by statutory immunity associated with a state’s laws on advance directives and surrogates. In states without a similar level of explicit immunity from criminal prosecution, civil liability, and disciplinary sanctions when POLST orders are followed in good faith, the liability climate may influence the acceptance of POLST orders.7 It is important to familiarize yourself with the protections in your state.

As POLST programs become more established, emergency physicians are increasingly likely to care for patients with POLST forms. Better understanding of these programs may enhance the end-of-life care we provide.8

Table 1. Comparison of Advance Directives and POLST

<table>
<thead>
<tr>
<th>Applicable population</th>
<th>ADVANCE DIRECTIVES</th>
<th>POLST FORMS</th>
</tr>
</thead>
<tbody>
<tr>
<td>All adults</td>
<td>Adults with advanced illness or frailty</td>
<td></td>
</tr>
<tr>
<td>Time frame of care</td>
<td>Future care or condition</td>
<td>Current care and condition</td>
</tr>
<tr>
<td>Where completed</td>
<td>Any setting</td>
<td>Medical setting</td>
</tr>
<tr>
<td>Product</td>
<td>Legal document by patient, surrogate appointment, statement of preferences</td>
<td>Medical order by health care professional based on decision making shared with patient</td>
</tr>
<tr>
<td>Surrogate role</td>
<td>Cannot complete</td>
<td>Can consent if patient lacks decision-making capacity</td>
</tr>
<tr>
<td>Responsible for portability</td>
<td>Patient, family</td>
<td>Health care provider</td>
</tr>
<tr>
<td>Periodic review</td>
<td>Patient, family</td>
<td>Health care provider</td>
</tr>
<tr>
<td>Document interpretation</td>
<td>Required</td>
<td>More clearly defined</td>
</tr>
</tbody>
</table>

Figure 1. POLST form for Pennsylvania, available at http://www.polst.org/educational_resource/pennsylvania-polst-form. 

Figure 2. Online POLST electronic form.

References

DR. HEINE practices emergency medicine and hematology oncology in Pennsylvania.
Emergency physicians sign on for challenge and camaraderie of extreme obstacle races

BY GRETCHEN HENKEL

“The greater the obstacle the more glory in overcoming it.” – Molière

In May 12, emergency physician Sudip Bose, MD, FACEP, FAAEM, along with three nurses and two other physicians from his emergency department at Medical Center Hospital in Odessa, Texas, each paid a $990 entry fee to spend the day slogging across muddy streams, crawling in mud under barbed wire, running up 40-degree inclines, and jumping over fire pits, among other barriers, in a nine-mile endurance race. The occasion was the Spartan Super in Austin, Texas. For Dr. Bose, who was a state-ranked mile runner in high school and won physical fitness awards during his military service, the race was an “all-around fitness event and a great way to build camaraderie within our department.” He also pointed out that the ailments he treats as an emergency physician bring home the importance of staying fit and healthy.

Dr. Bose and his team are part of a growing trend of Americans incorporating obstacle races into their fitness goals. According to the Los Angeles Times, such events have become more popular than marathons, with an estimated 1.6 million participants in 2013 who signed on to test their physical and mental stamina. While major events such as Tough Mudder, the Warrior Dash, the Spartan races, and the Volkslauf (with the motto “Pain Is Good!”) offer different course and obstacle configurations, they share common themes of physical and mental challenge and often emulate the military training model.

Events such as Tough Mudder’s Boa Constrictor, where racers crawl through a series of pipes, and Electroshock Therapy, where participants run through an obstacle field hung with electrified wires, are designed to elicit a maximum fear factor. The Arctic Enema, for example, entails jumping into frigid water and swimming under a wooden plank before pulling oneself out of the water.

Howard Mell, MD, MPH, chair of ACEP’s EMS Section, pointed out that such events are actually “haunted house scary” and that obstacle races pose no greater risk to participants than do more standard marathons. “These types of obstacle courses have been done for years in the military and by SWAT teams as they prepare for what they do,” he noted. “[These events] are for ‘weekend warriors’ doing the same. There will be broken bones, bruises, cuts, and scrapes, and there are going to be a couple of people who give themselves angina because they’re just not in the condition to do these things. But the same can be said of a marathon.”

In fact, fatal injuries sustained during obstacle races are rare. There have been two reported deaths: a man who drowned after jumping into ice-cold muddy water at a Tough Mudder event and a cardiac event sustained by a rescue worker at another. However, some physicians have questioned the safety of these extreme racing events. In a published case series of Tough Mudder participants treated at the Lehigh Valley Hospital in Allentown, Pennsylvania, the authors summarized participants’ diverse injuries requiring transport to the emergency department. The injuries ranged from moderate dehydration to contusions and dislocations to near syncope and electrical injuries. Although the injuries were not excessive compared with other endurance competitions or military training exercises, the authors did “strongly encourage” participants to obtain sign-off from their physicians before enrolling in such competitions.

Benefits Outweigh Risks
Participants often cite the benefits of camaraderie and accomplishment that they gain from completing such courses. Trina Flores, 37, of Atascadero, California, began participating in mud runs five years ago after shedding 50 pounds. She has now completed 17 races and enjoys the fun and teamwork required to help others surmount obstacles. “I like mixing it up,” she said. “Doing marathon runs would be boring for me, and the part I like is that [mud runs] really push you out of the box.” Next spring, Dr. Mell will participate with two other emergency department colleagues from medical school in a GORUCK event, founded by a former Navy SEAL, which features running with 40 pounds of bricks in a rucksack and emphasizes team building through accomplishment of a mission. Dr. Bose said part of his motivation for participating in the Spartan Super was to raise awareness for his nonprofit foundation, The Battle Continues (www.thebattlecontinues.org), which provides aid to wounded veterans and advocates for health care issues. (Dr. Bose is also a motivational speaker, applying lessons learned from combat as a template for surmounting other life challenges. Proceeds from corporate leadership lectures also go to injured veterans.)

Teamwork and Challenges
In November, Dr. Bose and his team will tackle the Spartan Beast, a 13-mile course with different obstacles. He has added another goal to his regimen. He is seven pull-ups shy of winning a pull-up competition. “I’m gonna try to nail those pull-ups!” he says. Beyond that, though, he believes there is a psychological benefit to embracing the challenges of extreme racing. “I think it’s inspirational when people push their limits,” he said. “Whether it’s a physical race or another obstacle, you can take that same skill set and apply it to other aspects of your life. I also think what our injured veterans or patients overcome is much more difficult than any extreme race.”

Reference

GRETCHEN HENKEL is a medical journalist based in California.
Welcome to the Hot Seat

You are sitting in a hard chair on a raised platform being asked question after question by a hard-hitting attorney while a courtroom full of people watches your every move. Welcome to the hot seat! As a physician testifying as a defendant or serving as an expert witness, your experience on the stand can be daunting. Understanding how to use nonverbal communication to exude confidence and credibility will make a difference in the outcome.

Here are the keys to ensuring your nonverbal communication conveys the same message of impeccable integrity as your words.

It is important to know that how you hold your body can actually change how you feel. You can influence how you look and feel on the stand by consciously controlling your nonverbal cues.

Under stress, the limbic brain normally makes us freeze, flee, fight, faint, or give up. You may react by freezing in place, pulling your body back so you appear to be fleeing, or folding in your limbs to look small. Other reactions to stress may include becoming tense and angry or going limp and giving up. You can take steps to reduce those stress responses and improve your credibility.

You want to be aware of the dance between you and the opposing counsel and avoid being reactive to the opposing team’s attorney.

Take Up Space
You want to look powerful, like a true expert, but not appear arrogant. Instead of going still and getting small, take up space and get big. When you need a shot of confidence, put your arms on the armrest of your chair or stretch out your feet a bit. Research says that women on the stand tend to perch on the edge of the seat and arch their backs, which makes them look less powerful. Men tend to slouch and rely more on the backrest, which makes them appear disrespectful. Purposefully vary your position to be in control, but when you feel stressed, get big.

Project Openness
Imagine that there are “windows” on the front of your body: on the knees, pelvis, heart, mouth, eyes, and palms of the hands. These body windows can be open or closed. You want to keep your windows open to look honest and unafraid. The most important windows for credibility are on the palms of the hands. The limbic brain of the viewer senses danger and dishonesty when the palms of someone’s hands are hidden. Keep your hands open and in view on the table or the arms of the chair.

Get Grounded
When people are nervous, they tend to either move a lot or freeze. Here’s a trick: when you’re in the thick of the most difficult questions and want to achieve the highest levels of cognition, place both feet firmly on the ground, setting them slightly apart. This placement actually makes it easier to utilize both hemispheres of the brain—the rational and the creative/emotional. If you feel yourself freeze, move your feet apart and/or forward to feel strong.

Lean Into It
We tend to pull back when we are fearful or offended by a question. Lean forward as you listen to show you are interested and confident. You can lean forward with your head, your upper torso, or your whole body to show you are connecting to what the lawyer is saying and you are not afraid. Lean in when you are being questioned by your team to show respect, but don’t overdo it—you’re not trying to “get in their face.” So don’t lean forward quickly or aggressively; just aim for gentle timely leans.

Speak With Strength
Everyone, but especially women, should be sure that their voices stay strong until the end of each sentence. Going up in pitch at the end of your sentences makes you sound unsure of yourself. Practice answering questions with a confident voice going down in pitch, steady and strong in volume, until the end of your sentences.

Match Your Movement and Your Words
Make sure your gestures and movements match what you are saying. If you say, “That is accurate,” and shake your head “no,” the jury will believe your body language, not your words. Be careful of being too scripted or automatic. If your emotions, facial expressions and gestures do not match, you seem less genuine.

Keep Your Hands Away From Your Face
Be careful of showing “stress cues.” When we feel stressed, the nerve endings fire at the tip of the nose, edge of the ears, around the mouth, and around the eyes. You may have an urge to touch or rub your face. Don’t! It makes you look uncertain or dishonest. If you need to comfort yourself, briefly place a hand on your leg out of view, which will help you feel anchored.

Mind Your Mouth
The mouth is the source of truth and lies. Avoid licking your lips or pressing your lips tightly together. Keep hydrated, and keep your lips relaxed.

Giving a deposition or testifying in a trial is an experience that is part of being an emergency physician. Knowing the nonverbal messages that people use to ascertain whether you are telling the truth will help you ensure you are perceived as being the credible witness you are.

DR. SEGAN is an emergency physician and attorney based in Woodmere, New York. He can be reached at DougSegan@yahoo.com.

MS. WOOD is a body language consultant and professional speaker and the author of eight books. She is interviewed weekly by national media, including CNN, Fox News, Today, The History Channel, The Wall Street Journal, Forbes, and Psychology Today. You can contact her at Patti@PattiWood.net.
Eighty-seven percent of intubations were performed by emergency physicians. In more than two-thirds of cases, rapid sequence intubation was utilized. The Skeptics Guide to Emergency Medicine (SGEM) is a knowledge translation project. Its goal is to cut the knowledge translation window down from an average of 10 years to one year. The SGEM uses a validated and reliable tool to turn a skeptical eye on the literature. This information is then disseminated using social media to provide high-quality, clinically relevant, evidence-based information so that you can deliver the best care to your patients.

The Case: A 21-year-old male presents collared and boarded from a motor vehicle collision. He is combative, with an obvious head injury, several extremity fractures, and a surgical abdomen. It is clear that he needs to be intubated. You set up your equipment for intubation, and one of the nurses asks you, “Are you going to use DL [direct laryngoscopy] or the GlideScope?”

Question: Which is better for intubation in trauma patients: video or direct laryngoscopy?

Background

Emergency medicine owns the acute airway. A 2011 paper by Walls et al from the National Emergency Airways Registry showed that 87 percent of intubations were performed by emergency physicians. In more than two-thirds of cases, rapid sequence intubation (RSI) was utilized. There have been a number of advances in the last few years. Many of these advances have been in new airway management devices. There are a variety of video laryngoscopy (VL) tools that are displacing traditional DL. For an excellent discussion on the complexities of DL versus VL, check out the 2011 paper by Levitan et al in the Annals of Emergency Medicine. Another good resource is by Levitan and Weingart in the Annals of Emergency Medicine in 2012.

Relevant Article


- Population: Trauma patients at Shock Trauma in Baltimore
- Intervention: Video laryngoscopy (GlideScope)
- Comparison: Direct laryngoscopy
- Outcomes:
- Primary: Mortality
- Secondary: Survival among subgroups, duration of intubation attempt, desaturation during procedure, first-pass success rates

The strengths include that it was a randomized trial, all patients were followed up for the primary endpoint, and the study used video to record the resuscitation to avoid any bias inherent in a chart review.

The Bottom Line

VL leads to the same outcome as DL in trauma patients. VL takes longer to accomplish and may be associated with higher mortality in patients with severe head injuries. However, this relationship will require more study to confirm.

Case Resolution

You decide to use the GlideScope in this case because you feel that it might be better since the patient is in a cervical collar. Knowing that it may take a little longer to pass the tube, you make sure to properly pre-oxygenate the patient with high-flow oxygen with a non-rebreather mask at 30 to 60 liters per minute and use a nasal cannula set at 15 liters per minute kept on during your intubation attempt. You get an excellent view with the GlideScope and pass the tube on your first attempt.

Thank you to Dr. Steve Carroll from EM Basic for his help on this review.

Remember to be skeptical of anything you learn, even if you learned it from the Skeptics Guide to Emergency Medicine.

References


The Skeptics Guide to Emergency Medicine (SGEM) is a knowledge translation project. Its goal is to cut the knowledge translation window down from an average of 10 years to one year. The SGEM uses a validated and reliable tool to turn a skeptical eye on the literature. This information is then disseminated using social media to provide high-quality, clinically relevant, evidence-based information so that you can deliver the best care to your patients.

The Case: A 21-year-old male presents collared and boarded from a motor vehicle collision. He is combative, with an obvious head injury, several extremity fractures, and a surgical abdomen. It is clear that he needs to be intubated. You set up your equipment for intubation, and one of the nurses asks you, “Are you going to use DL [direct laryngoscopy] or the GlideScope?”

Question: Which is better for intubation in trauma patients: video or direct laryngoscopy?

Background

Emergency medicine owns the acute airway. A 2011 paper by Walls et al from the National Emergency Airways Registry showed that 87 percent of intubations were performed by emergency physicians. In more than two-thirds of cases, rapid sequence intubation (RSI) was utilized. There have been a number of advances in the last few years. Many of these advances have been in new airway management devices. There are a variety of video laryngoscopy (VL) tools that are displacing traditional DL. For an excellent discussion on the complexities of DL versus VL, check out the 2011 paper by Levitan et al in the Annals of Emergency Medicine. Another good resource is by Levitan and Weingart in the Annals of Emergency Medicine in 2012.

Relevant Article


- Population: Trauma patients at Shock Trauma in Baltimore
- Intervention: Video laryngoscopy (GlideScope)
- Comparison: Direct laryngoscopy
- Outcomes:
- Primary: Mortality
- Secondary: Survival among subgroups, duration of intubation attempt, desaturation during procedure, first-pass success rates

The strengths include that it was a randomized trial, all patients were followed up for the primary endpoint, and the study used video to record the resuscitation to avoid any bias inherent in a chart review.

The Bottom Line

VL leads to the same outcome as DL in trauma patients. VL takes longer to accomplish and may be associated with higher mortality in patients with severe head injuries. However, this relationship will require more study to confirm.

Case Resolution

You decide to use the GlideScope in this case because you feel that it might be better since the patient is in a cervical collar. Knowing that it may take a little longer to pass the tube, you make sure to properly pre-oxygenate the patient with high-flow oxygen with a non-rebreather mask at 30 to 60 liters per minute and use a nasal cannula set at 15 liters per minute kept on during your intubation attempt. You get an excellent view with the GlideScope and pass the tube on your first attempt.

Thank you to Dr. Steve Carroll from EM Basic for his help on this review.

Remember to be skeptical of anything you learn, even if you learned it from the Skeptics Guide to Emergency Medicine.
Shaq Shoots and Scores—So Can You

by JAMES M. DAHLE, MD, FACEP

**Question.** What are the keys to long-term financial success?

**Answer.** Achieving financial independence is remarkably simple: make a lot of money, don’t spend much of it, and make the difference between what you make and what you spend work as hard as you do. Believe it or not, a great example of this method is basketball great Shaquille O’Neal.

Shaq, like many incredible basketball talents, left college early to start playing in the NBA. Although well-known as a terrible free-throw shooter, he was a prolific scorer and won many awards, including Rookie of the Year, League MVP, and 15 invitations to the NBA All-Star Game, in addition to four championships. However, if you listened to him on TV after a game, you wouldn’t be surprised to learn that he spent a million dollars within 30 minutes of joining the league. This led to a call from his banker, chastising him and warning him he would end up broke like so many other NBA athletes if he kept it up. Shaq apparently took it to heart and decided to learn about business and finance. He went back to school, finished his bachelor’s, and then did an MBA. In 2012, he finished a doctorate degree. That’s right: he is now Dr. Shaq. More important, he applied those lessons and turned his high income into a high net worth by purchasing hundreds of businesses, including 172 restaurants, 150 car washes, 60 fitness centers, a shopping mall, a theater, and some nightclubs. I suspect he now earns far more money than he ever did as an NBA star.

Physicians have a lot in common with successful artists and athletes. All three groups enjoy a high income due to unique talents and skills rather than any significant business acumen. All three groups are also well-known to end up broke despite earning millions of dollars over their careers. This is not a coincidence.

Continuing medical education (CME) is a mandatory part of being a physician. There is another type of continuing education you should be doing: continuing financial education (CFE). This is far easier and requires much less time than CME. It can be as simple as forcing yourself to read a financial book once a year, following a financial blog, or meeting frequently with a good advisor financial expert take care of all of these financial chores. As I have previously discussed in this column, it is perfectly fine to use a financial advisor, but that does not exempt you from doing CFE. First, it requires a certain amount of financial education to pick a qualified financial planner and/or asset manager among the many salespeople out there masquerading as advisors. It also requires some knowledge to identify a fair price for those services. Second, and more important, your advisor cannot do the most important financial tasks ahead of you, like spending much less than you earn, without your help. Dr. Shaq might have blown his first million in a half hour. But after he wised up, he became quite good at converting his high income into income-producing assets. Physicians who wish to become financially independent someday must do the same. That means you cannot spend it all; you must carve out a significant portion of your income and invest (at least successfully investing) your return you achieve) for the rest of your life. The best part about investing (at least successfully investing) is that it is possible to live well and, more important, financially free. Frugality is the cornerstone of personal finance. The great thing about frugality, at least when applied both to Shaq and the typical doctor, is that it is all about relative frugality, not absolute frugality. Doctors don’t have to wear secondhand clothes or clip coupons in order to spend much less than they earn. Following a simple, reasonable budget will do. I often receive inquiries from residents wondering who they can borrow money from to meet their living expenses. I try to gently remind them that their resident salary alone is the equivalent of the average American household income. Half of the people in our country live on less than a resident salary; there is no reason they should not be able to do so for a few years, even in a high-cost-of-living area. However, they can’t expect to put their four kids into private school, own three cars, have two smart phones with expensive data plans, and still live within their means. You can live like you are rich or you can be rich, but very few will ever be able to do both.

You might not be able to learn much about shooting free throws from the example of Shaquille O’Neal, but you can certainly learn a lot about properly managing your finances. Educate yourself about personal finance, investing, business, and taxes by regularly doing CFE. Convert your high income into wealth by curbing out a portion and dedicating it to wealth-building pursuits. Minimizing financial worries will enable you to better care for your patients, your family, and yourself. As Dr. Shaq says, “It’s not about how much money you make. The question is, ‘Are you educated enough to keep it?’”

---

**THE END OF THE RAINBOW**

Dr. Dahle is the author of The White Coat Investor: A Doctor’s Guide to Personal Finance and Investing and blogs at http://whitecoatinvestor.com. He is not a licensed financial advisor, accountant, or attorney and recommends you consult with your own advisors prior to acting on any information you read here.
The design of emergency departments (EDs) is evolving with the changes in patients served, diagnostic testing utilized, and the process of managing higher volumes of patients.

The National Hospital Ambulatory Medical Care Survey has been providing insight into ED patient volume, acuity, testing, treatment, and disposition since 1992. The 2010 summary tables of this survey have been published, and the 2011 data tables will be released shortly. The survey has recorded growth in patient volumes of between 2.5 and 3 percent per year since 1992. The number of EDs has not been increasing, and this steady growth in patient volume has challenged the physical resources of many departments in the United States.

The roles of the ED as a diagnostic center, a buffer for many other hospital units, and the boarding center for admitted patients all combine to change ED design needs. Because 68 percent of inpatients are processed through the ED, boarding of admitted patients poses significant flow challenges if there is little space for patients.

The Emergency Department Benchmarking Alliance (EDBA) is now reporting on the data survey for 2013, with data from 1,100 EDs that saw 42 million patients. The results of this survey allow ED leaders to find data to support renovation and redesign projects.

The most common data parameters used to guide ED design are the number of visits per patient care space and visits per square foot. The figures in Table 1 reflect the results of the EDBA survey in the design area and the use of team triage intake processes. EDs are built (and typically expanded a few times) into a physical space that contains a gross square footage, but more functional metrics, such as visits per square foot, are often not considered. The visits per square foot is calculated by dividing the annual patient volume by the square footage. It is a crude surrogate for how space compact an ED really is. It has not been reported in any available literature.

Many hospital CEOs will insist that the ED be built for 2,000 encounters per bed because that rate is a known fact. Like many "facts" about the ED, this one is wrong.

<table>
<thead>
<tr>
<th>ED TYPE</th>
<th>PATIENTS SEEN PER SQUARE FOOT</th>
<th>PATIENTS SEEN PER ED BED</th>
<th>PHYSICIANS AND/OR APPS USED IN GREETING</th>
</tr>
</thead>
<tbody>
<tr>
<td>More than 100K volume</td>
<td>4.2</td>
<td>1,648</td>
<td>35%</td>
</tr>
<tr>
<td>80–100K</td>
<td>3.2</td>
<td>1,717</td>
<td>40%</td>
</tr>
<tr>
<td>60–80K</td>
<td>3.0</td>
<td>1,603</td>
<td>38%</td>
</tr>
<tr>
<td>40–60K</td>
<td>3.3</td>
<td>1,653</td>
<td>27%</td>
</tr>
<tr>
<td>20–40K</td>
<td>3.0</td>
<td>1,640</td>
<td>6%</td>
</tr>
<tr>
<td>Adult EDs</td>
<td>3.0</td>
<td>1,368</td>
<td>72%</td>
</tr>
<tr>
<td>Pediatric</td>
<td>3.8</td>
<td>1,836</td>
<td>12%</td>
</tr>
</tbody>
</table>

Many hospital CEOs will insist that the ED be built for 2,000 encounters per bed because that rate is a known fact. Like many “facts” about the ED, this one is wrong.

<table>
<thead>
<tr>
<th>ED TYPE</th>
<th>FAST TRACK</th>
<th>TRAUMA AREA</th>
<th>CLINICAL DECISION OR OBSERVATION UNIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>More than 100K volume</td>
<td>84%</td>
<td>77%</td>
<td>58%</td>
</tr>
<tr>
<td>80–100K</td>
<td>78%</td>
<td>71%</td>
<td>33%</td>
</tr>
<tr>
<td>60–80K</td>
<td>74%</td>
<td>57%</td>
<td>29%</td>
</tr>
<tr>
<td>40–60K</td>
<td>64%</td>
<td>30%</td>
<td>13%</td>
</tr>
<tr>
<td>20–40K</td>
<td>36%</td>
<td>18%</td>
<td>6%</td>
</tr>
<tr>
<td>Adult EDs</td>
<td>62%</td>
<td>51%</td>
<td>24%</td>
</tr>
<tr>
<td>Pediatric</td>
<td>27%</td>
<td>39%</td>
<td>0%</td>
</tr>
</tbody>
</table>

References
Other newer examples of patient segmentation include:

- Geriatric ED
- Chest pain center
- Pediatric ED
- Critical decision unit
- Observation unit
- SuperTrack

For emergency departments seeing medium to high volumes of patients, the concept of patient segmentation is becoming popular as a flow strategy. Patient segmentation means grouping patients requiring similar levels of care and having similar anticipat-ed lengths of stay (LOS) into a geographic area with dedicated staff and resources. The earliest example of patient segmentation is Fast Track, which now has a very compelling body of literature behind it. Other newer examples of patient segmentation include:

- Geriatric ED
- Chest pain center
- Pediatric ED
- Critical decision unit
- Observation unit
- SuperTrack

SuperTrack was pioneered by Jody Crane, MD, in the Mary Washington Hospital Emergency Department in Fredericksburg, Virginia, as part of a complete patient-flow makeover. The Mary Washington ED was seeing more than 100,000 visits when it opened its new doors in 2006 and was plagued with front-end waits and delays. As part of a complete overhaul of its ED patient flow, Crane and his colleagues assigned patients to different patient streams in geographic zones based on their acuity. This included a so-called SuperTrack for the lowest-acuity patients. They saw a reduction in LOS, improvement in patient and staff satisfaction, and dramatic reductions in patients leaving without being seen (LWBS).

Similarly, Parkland Urgent Care (UCED), part of the Parkland Health & Hospital System in Dallas, tackled its patient-flow issues by employing a variation of SuperTrack in December 2012. Parkland representatives presented its findings at the ED Innovations 2014 Conference held in Las Vegas in Feb. 2016. The team reported experiencing staggering arrival surges. These arrivals were overwhelming existing processes, causing high LWBS rates (58 percent) and door-to-provider times (158 minutes) in Dec. 2012. The team decided to revamp both intake processes and the streaming of patients. It created processes and designated space for focusing on the lowest-acuity patients (Emergency Severity Index Level 5). It dedicated six rooms as SuperTrack from 8 a.m. to 6 p.m., where identified patients would be seen by a patient care team consisting of nurses and technicians. Patients had already undergone a medical screening exam by an advanced practice provider in triage. SuperTrack was also populated by other low-acuity patients who had protocol-driven orders. The SuperTrack chief complaints and criteria were very specific and included:

- Cold symptoms/congestion
- Headache, under 50 years of age
- Purified protein derivative placement or reading
- Suture/staple removal
- Dental pain
- Dysuria with positive urinalysis results
- Asymptomatic hypertension
- Sore throat
- Hemorrhoids
- Medication refill (with labs resulted)
- Cough less than two weeks’ duration
- Earache
- Pink eye
- Sinus congestion

Once patients were found to meet the SuperTrack criteria, they were quickly placed in a room, and a patient care tech (PCT) would expedite this process and alert the provider. This pull-to-full system for expediting SuperTrack patients was owned by the PCT and was an important feature of the new process. Providers can always reroute a patient if they feel that other information indicates a higher level of care is required. Providers simply place additional orders and communicate with the main ED team.

One of the key aspects of the initiative was having clearly defined resources allocated to the geographic space dedicated to the SuperTrack. Increasing the PCT staffing was also critical to the success.

The results of the initiative were remarkable! By December 2013, the LWBS rate had decreased to 1.4 percent, the door-to-provider times had decreased by almost a full hour (52 minutes), and patient satisfaction scores had improved. Other improvements included more efficient bed utilization, rapid room turnover, and increased nursing time with patients.

Using a new process, space, supplies, and staff dedicated to the care of very low-acuity patients, Parkland UCED improved all of its performance metrics, improved the overall flow of the department, and improved patient and staff satisfaction. I’d say this is a successful improvement initiative and that the SuperTrack is SUPER!  

References:

The Case: A 24-year-old male presents to the emergency department sustaining the wound shown in Figure 1 from a broken beer bottle. He states that someone broke the bottle and cut him with it. What is the correct discharge diagnosis for the chart?

Answer: Incised wound or cut.

Discussion

Although emergency medicine providers commonly describe any break in the skin as a laceration, this terminology is forensically and technically incorrect. A laceration is defined as a tear in tissue caused by a shearing or crushing force.1,2 Therefore, a laceration is the result of a blunt-trauma mechanism. A laceration is further characterized by incomplete separation of stronger tissue elements, such as blood vessels and nerves. These stronger tissue elements account for “tissue bridging” which is seen in lacerations (see Figure 2). In addition, lacerations commonly occur over bony prominences and tend to be irregularly shaped with abraded or contused margins. Lacerations are typically caused by hard objects like a pipe, rock, or the ground. The crushing mechanism may have an effect on wound healing and scarring and increased risk of infection from the devitalized tissue.

A cut or incised wound is produced by a sharp edge and is usually longer than it is deep (see Figure 3).1 Because of the sharp-force mechanism of injury, incised wounds lack tissue bridging and often display very clean, sharp wound edges. Knives, box cutters, glass, and metal typically cause incised wounds. In contrast, stab wounds are sharp-force injuries produced by a pointed instrument where the depth of the wound is greater than the length of the wound on the skin. Once again, there is no tissue bridging.

An easy way to remember the difference is to think of a glass beer bottle. If someone takes the bottle and smashes it over someone’s head and the skin is opened, that is a laceration. If a person breaks the bottle on a table and uses the piece to slash someone, it is an incised wound.

References


DR. ROZZI is an emergency physician, director of the DOVE program, and vice chair of the forensic section at WellSpan York Hospital in York, Pennsylvania.
Keeping Up With Health Care on Twitter

by JEREMY SAMUEL FAUST, MD, MS, MA

LAST MONTH, I ATTENDED the Aspen Ideas Festival at the Aspen Institute (@aspenideas) in Colorado for its first-ever Spotlight: Health session. This was a three-day event, that brought together leaders in health care for discussion-based seminars and interviews. Additionally, 100 scholars were invited. As a member of this group of younger professionals and students, my only responsibility was to listen and learn. Naturally, I found this next to impossible, and I was able to ask questions of several experts who know a thing or two about American health care. As usual, I did a fair amount of live-tweeting from this event. I also added to my Twitter feed a handful of accounts that have very little overlap with my normal list and the world of #FOAMed and medical education. These accounts highlight some individuals and organizations that are focused on big-picture health care topics. Follow them if you're interested in health care policy or want to start keeping up. Alternatively, you can simply conduct a search for the topic(s) you are interested in. Try searching #ACA or #Medicare for articles about the Affordable Care Act. One of the pros (and cons) of Twitter’s search function is that it tends to curate its searches of high-volume hashtags. This feature is particularly appreciated when searching for gems among the legions of tweets with popular hashtags such as #ACA or #Medicare. On the other hand, the main con with curation is that you can’t always find a tweet that you once saw. Sometimes you have to dig to find a particular tweet. Another con is that you can’t cross search tweets (say, by searching for #ACA and #Obamacare).

In the spirit of Aspen, I’d like to start by sharing three thought-provoking tweets that appeared in my feed.

1. The first is from Atul Grover, MD, PhD (@AtulGroverMD), chief public policy officer of the Association of American Medical Colleges. At the festival, Dr. Grover tweeted a question for Princeton economist and health care expert Uwe E. Reinhardt: "How much should you ask taxpayers to pay to save a year of life for someone they don’t know? #AspenIdeas." It’s a simple question that nobody seems to want to answer despite the fact that how much taxpayers are already spending to save one life has recently been estimated. Summarizing recent data, Forbes.com health blogger Michael Cannon reports that the rollout of RomneyCare in Massachusetts had a number needed to treat of 830 to save one life; that is, 830 people had to enroll in a new insurance plan to save the life of one person age 20–64. Using an average premium of $5,000 per person, Cannon estimates that Massachusetts taxpayers paid around $4 million per life saved. The question Dr. Grover asked Mr. Reinhardt was, therefore, startlingly basic: can we save lives for less, and can we afford to save them for so much more?

2. Anne F. Weiss (@annefweiss), a director at the Robert Wood Johnson Foundation, tweeted an interesting idea from WebMD founder Jeff Arnold. Mr. Arnold proposes that we “look outside health tech for what attracts and engages users. Imagine making a doc appointment on OpenTable! #AspenIdeas." Convenience is indeed crucial for patients when choosing among qualified specialists. Apps like this could easily limit these searches to availability among specialists who accept a patient’s particular health care plan. This idea is so simple that I can’t imagine it not being part of business as usual within a few years, but remember, you heard it here first.

3. I attended a debate about Colorado’s new Right to Try law. This recently passed law gives terminally ill patients the right to try experimental drugs that have not yet received FDA approval. The law further opens access to investigational drugs even beyond the FDA’s expanded-access (compassionate-use) regulations, which were enacted in 2009. This debate was unique in that both participants appeared to be undecided on the issue. Colorado Lieutenant Governor Joe Garcia (@JoeGarcia) voiced some support for the law but seemed concerned that the law might have passed not because of careful debate but rather because of the emotional impact of the recent film Dallas Buyers Club about access to HIV/AIDS medication that predates the expanded-access law. He noted that the Right to Try law passed unanimously. Co-panelist Diane E. Meier, MD (@DianeEMeier), director of the Center to Advance Palliative Care, professor of geriatrics and palliative medicine at Icahn School of Medicine at Mount Sinai in New York City, a palliative care leader, and a MacArthur Fellow, at first seemed cautiously in favor of the law. By the end, she, too, began to express concern as tough questions from the audience poured in. I later tweeted at Dr. Meier that I had been “undecided on Right to Try law prior to [this discussion]; now I’d say I’m somewhat opposed. #AspenIdeas.” Dr. Meier later replied, “me too!” More conferences should be this way: with true debates that move opinions and where audience interaction both in person and via Twitter changes the conversation.

Finally, I added a few health care–associated Twitter accounts to my feed. From the nonprofit Kaiser Family Foundation (@KaiserFamFound) comes, “How is the Affordable Care Act impacting Medicaid enrollment? http://kaiserfam.org/q/4g/h/N/AACA.” In short, the ACA is increasing Medicaid enrollment. That’s good news if you believe in expanding such programs. The Kaiser account provides consistently high-quality health care data. I also added @NPRHealth: “Got questions about the #ACA? There’s a new @NPR app for that. http://n.pr/1LU7zcC.” And if you are having trouble just keeping it all straight, then the new venture, Vox.com (@voxdotcom), from journalist Ezra Klein (@ezraearnstein) may be perfect for you. The site uses short slide decks to explain complicated news topics, including health care. It promises “everything you need to know, in two minutes.” Its 13-slide deck explaining the nuts and bolts of the ACA by Vox senior editor Sarah Kliff (@sarahkliff) is among the best you’ll find for describing the legislation and how it is supposed to work: www.vox.com/cards/obamacare/what-is-obamacare.

DO YOU HAVE ANY FAVORITE TWEETS THAT ACEP NOW READERS SHOULD KNOW ABOUT VIA THE FEED?

TWEET AT ME @JEREMYFAUST OR EMAIL TO JSFAUST@GMAIL.COM.
We’re blessed with our unique location in the northwest corner of Vermont. It gives us great access to hiking, the lake, skiing—any number of ways you can interact with nature. Working at NMC gives you the opportunity to work at an award-winning institution while having a great quality of life. Competitive compensation, including excellent benefits (US$5,000 per year in CME plus paid time off for CME or vacation). Relocation and education reimbursement negotiable.

Northwestern Medical Center is looking for a full-time BC/BE physician to join our Emergency Department team! Our ideal candidate is BC/BE in Emergency Medicine, and will maintain ACLS certification. Our Emergency Department has 36 hours of physician and 18 hours of APP coverage daily, 7 days per week. Full-time physicians work 20 shifts per month, with some weekends and nights required. We register patients at the bedside, chart via NextGen EMR, have bedside ultrasound, and rarely board patients in the department.

We’re blessed with our unique location in the northwest corner of Vermont. It gives us great access to hiking, the lake, skiing—any number of ways you can interact with nature. Working at NMC gives you the opportunity to work at an award-winning institution while having a great quality of life. Competitive compensation, including excellent benefits (US$5,000 per year in CME plus paid time off for CME or vacation). Relocation and education reimbursement negotiable.

Northwestern Medical Center is looking for a full-time BC/BE physician to join our Emergency Department team! Our ideal candidate is BC/BE in Emergency Medicine, and will maintain ACLS certification. Our Emergency Department has 36 hours of physician and 18 hours of APP coverage daily, 7 days per week. Full-time physicians work 20 shifts per month, with some weekends and nights required. We register patients at the bedside, chart via NextGen EMR, have bedside ultrasound, and rarely board patients in the department.
Charlotte, North Carolina

Excellent Opportunity – Mid-Atlantic Emergency Medical Associates (MEMA)

• Independent, Physician Owned, Democratic Group
• Opportunity for Equal Ownership
• Community practice, no academic affiliations
• 32 bed ED, 50,000 visits annually
• Comprehensive Benefits
• Flexible Schedule
• Suburban Charlotte – easy access to Mountains, Beaches, International Airport
• Great Neighborhoods, Good Schools, Unlimited Recreational Opportunities

Send CV, Cover Letter to
Mary Lu Leatherman, Physician Recruiter
Mid-Atlantic Emergency Medical Associates (MEMA)
PO Box 30784, Charlotte, NC 28220
704-277-2404
mleatherman@memad.net www.memad.net

Texas - Texarkana

Busy, high-acuity ED, tort reform, and no state income tax!

No wonder our physicians love working at CHRISTUS St. Michael, a beautiful, award-winning hospital with a 33-bed, 55,000-volume ED offering scribe support.

Mid-sized, family-friendly community is an outdoor-lover’s dream. Partnership opportunity in as little as one year BC/BE in Emergency Medicine required. Emergency Service Partners, L.P. is a respected, Texas-based, 100% physician-owned group. Come join us!

Contact Renaldo Johnson today:
renaldo@eddocs.com for more details, and mention job #149830-11.

The Department of Emergency Medicine at Eastern Virginia Medical School is seeking candidates for a core faculty position.

We have a well-established three year EM residency program (est 1981), a one year ED US Fellowship and an International Medicine Fellowship. Candidates should be residency trained in EM and ABEM/ABEM-US board-certified or board-prepared.

The ideal candidate will have experience in graduate medical education and a strong interest in research with a track record of research success. Generous salary, benefits and protected time provided.

Please submit your letter of interest and CV to: Francis Counselman MD, Chairman (counself@evms.edu)

Texas – San Antonio Area

Opportunity for Primary Care/Family Medicine physicians with Emergency Medicine experience!

Seton Edgar B. Davis Hospital in Luling is ideal for young physicians looking to hone their skills in a single-coverage situation, or for experienced physicians looking to slow down.

Work 12- or 24-hour shifts just a short drive from the exciting Alamo City.

Democratic group offering full benefits including generous 401(k) plan and partnership opportunity in as little as one year.

Contact Lisa Morgan today:
(512) 610-0315 or e-mail lisa@eddocs.com for more details and mention job #1028-11.

---

The Emergency Group, Inc.
Honolulu, Hawaii

The Emergency Group, Inc. (TEG) is a growing, independent, democratic group that has been providing emergency services at The Queen’s Medical Center (QMC) since 1973. QMC is the largest and only trauma hospital in the state and cares for more than 60,000 ED patients per year.

QMC’s newest medical center opened in west Oahu in May and is expected to see an additional 40,000 ED patients annually.

TEG is actively recruiting for EM Residency Trained, Board Certified or Eligible Physicians. Physicians will be credentialed at both facilities and will work the majority of shifts at the west Oahu facility in Ewa Beach, HI.

We offer competitive compensation, benefits and partnership track.

Our physicians enjoy working in QMC’s excellent facilities and enjoy the wonderful surroundings of living in Hawaii.

For more information, please visit our web site at www.teghi.com or email your CV to teghawaii@gmail.com.

---

UNIVERSITY OF FLORIDA
College of Medicine – JACKSONVILLE

The University of Florida Department of Emergency Medicine is recruiting motivated & energetic emergency physicians to join our community affiliate in Winter Haven, Florida.

Winter Haven is located in central Florida with easy access to both the Orlando and Tampa areas. It is home to beautiful lakes, a majestic tower, a world-class collection of vintage aircrafts and the largest LEGOLAND in the world. There are plenty of places to play, explore and reflect both on land and on the water.

Winter Haven Hospital has 527 beds and is a nationally recognized Magnet hospital. The 33-bed ED provides services to 60,000 patients each year in a physician friendly environment with full nurse staffing, radiology services located in the ED and dedicated support staff including:

• Full subspecialty backup available 24 hours a day
• Twenty four hour CT, US, and MRI with stat dictation reports
• Nationally accredited stroke and interventional ACS programs
• Integrated EMR systems and ITS team

Join the University of Florida team and earn an extremely competitive community-based salary as a UF assistant or associate professor in a private practice setting. Enjoy the full range of University of Florida State benefits including sovereign immunity occurrence-type medical malpractice, health, life and disability insurance, sick leave, and a generous retirement package.

All physicians are ABEM / ABOEM Board Certified / Board Eligible.

E-mail your letter of interest and CV to Dr. Kelly Gray-Eurom
Kelly.gray-eurom@jax.ufl.edu

EOE/AA Employer
Sick of student loan debt?

Up to $250,000 in student loan debt gone in 24 hours!*

*For Physicians who meet the criteria.

WILL YOUR SALARY COVER YOUR STUDENT LOANS?
To find out scan this QR code or go to erdocsalary.com/ACEPNowClassAug2014

I'm looking for a way to reduce my student loan debt. Can you help?

More fulfilling careers in EM.
As one of the largest and fastest-growing Emergency Medicine groups in the nation, Schumacher Group is physician-owned and physician-led, providing great opportunities and benefits. We’re seeking qualified physicians to join us in these states:

**Alabama**
Explore lakefront living in the Appalachian foothills of Alabama. 14-bed ED with approximate annual volume of 18,815.

**Georgia**
Situate yourself on the beautiful riverfront of Georgia. 50-bed ED with approximate annual volume of 67,000.

**Louisiana**
Southern charm beckons you in Louisiana. Pick your pace with annual ED volumes ranging from 10,600 - 60,000.

**Missouri**
Don’t just heal - lead as a Medical Director in Missouri. End of the year bonuses and very competitive stipend options available.

**Pennsylvania**
Discover history and culture in the center of scenic Pennsylvania. 14-bed ED with approximate annual volume of 11,631.

**Texas**
From the Texas Panhandle to the Gulf of Mexico, we have just what you are looking for. Select your size with annual ED volumes ranging from 9,200 - 48,000.

---

Schumacher Group
Emergency Medicine

schumachergroup.com/heal
800-893-9698

---

IT’S ABOUT WHAT MOVES YOU.

As a Questcare emergency physician, you will have the freedom to jump towards what moves you both professionally and personally.

**PHYSICIAN-OWNED AND OPERATED**

**EMERGENCY MEDICINE GROUP**

**JOIN US AS WE GROW!**

EXCITING EMERGENCY MEDICINE OPPORTUNITIES AVAILABLE IN

**TEXAS AND OKLAHOMA**

**AS A QUESTCARE PARTNER:**

• You become an owner of your EM group
• Group decisions are made by you and doctors like you
• You will have scheduling flexibility to enjoy what moves YOU

---

Caren Reaves, MD
Questcare Physician / Horse Enthusiast

What moves you? Is it the opportunity to grow with a group of medical professionals who are serious about their work AND play? As an integral part of Questcare, you will find a platform and philosophy that are conducive to creating the work/life balance that you have the power to choose.

Let’s talk about what moves YOU.

jobs@questcare.com or (972) 763-5293

www.questcarecareers.com / facebook.com/questcare / twitter: @questcare

---

**Sick of student loan debt?**

You live to heal others.
We live to help you.

---

Kazimierz Ognowski, MD
Emergency Physician
Resident TP, Physician Trainees

www.premierdocs.com
EMERGENCY PHYSICIANS
Tysons Corner, VA and Largo, MD (Metropolitan Washington, D.C.)

When you join the Mid-Atlantic Permanente Medical Group (MAPMG), you’ll be able to get more out of your life and your career. As a physician-owned and managed multi-specialty group with over 1,000 physicians serving 500,000 patients at 30 medical centers, we know firsthand what it takes to advance professionally and thrive personally. That’s why we provide a comprehensive network of support services and a work and call schedule that’s designed to help you make the most of your time…both at work and at home.

Seeking BC Emergency Physicians:
- Integrated medical information system
- Excellent team approach to providing care
- Reasonable, predictable schedules
- Clinical autonomy with excellent subspecialist support
- Energetic focus on excellence and patient centered service, quality, safety and patient flow
- Comprehensive benefits
- 100% paid occurrence based malpractice
- Pension Plan
- Shareholder track and hourty opportunities are available

To apply, please contact Cooper Drangmeister at: (301) 816-6532 or apply online at: http://physiciancareers.kp.org/midatl/

KAISER PERMANENTE.
Mid-Atlantic Permanente Medical Group, P.C.

Chief of Emergency Medicine

Cambridge Health Alliance (CHA), an award winning public health system, is currently recruiting for a BC, FT Chief of Emergency Medicine to oversee a well established and talented emergency medicine department consisting of a faculty of 32 physicians and 16 physician assistants. CHA is a teaching affiliate of Harvard Medical School and the Tufts University School of Medicine.

Under the direction of CHA’s Chief Medical Officer, the Chief of Emergency Medicine will provide clinical, administrative and academic leadership and have oversight of the staff delivering high quality emergency department services. Our health system is comprised of two hospital campuses, an integrated network of both primary and specialty care practices in Cambridge, Somerville and Boston’s Metro North Region and three emergency department sites with approximately 97,000 annual patient visits. CHA is committed to be accountable for the quality, cost and experience of care that we provide. The Chief also oversees the educational programs for Harvard medical students and rotating Emergency Medicine, Pediatric, Medicine and Family Medicine residents.

The Chief of Emergency Medicine has both clinical and administrative responsibilities. The ideal candidate will have at least 10 years of post residency experience and 5 years of progressive leadership experience as well as successful track record of professional development and mentoring of junior staff. We seek a candidate with demonstrated ability to implement department wide protocols, identify and support clinical process improvement and quality initiatives in a multi site system. Candidates must have an understanding of the principles and requirements of Accountable Care Organizations, population health management and team based care models such as the Patient Centered Medical Home model of care. Successful experience in interdisciplinary collaboration is necessary and candidates must have excellent clinical and communication skills. Candidates must also possess a strong commitment to our underserved, multi-cultural patient population. Experience with developing and overseeing graduate and undergraduate medical education programs is strongly preferred. Previous employment in an academic, multi site, safety net system is a plus.

At CHA we offer a supportive and collegial environment with a strong infrastructure – including an Electronic Medical Record system (Emr), as well as the opportunity to work with dedicated colleagues committed to providing high quality health care to a diverse patient population. Excellent opportunities exist for teaching medical students/residents, and we strongly encourage both women and minorities to apply. Academic appointment will be at the rank of instructor, assistant or associate professor of Medicine at Harvard Medical School, commensurate with experience.

Please forward CV’s to Laura Schofield, Senior Director of Physician Recruitment, CHA, 1493 Cambridge Street, Cambridge, MA, 02139. Email: Lschofield@challiance.org
Phone: (617)365-3553, Fax: (617)365-3553. EO: www.challiance.org.

Who says you can’t have it all?

When Dr. Randy Katz joined TeamHealth, he wanted to be part of a group with national resources, physician-focused management, a network of respected peers, long-term stability and a leadership training program. He also wanted to protect cherished time for his family and hobbies. With TeamHealth, he got it all.

Text CAREERS to 411247 for latest news and info on our job opportunities! Visit myEMcareer.com to find the job that’s right for you.

Featured Opportunities:
KershawHealth Medical Center
Camden, SC

Grand Stand Regional Medical Center
Myrtle Beach, SC

Memorial Regional Hospital
Hollywood, FL
Phases I and II
November 17-22, 2014

As ED director, you play the role of both physician and business administrator, dealing with budgets, difficult staffing issues, and patient satisfaction. It can all seem overwhelming, and you may wonder how others in your position handle day-to-day life in the ED.

At ACEP’s ED Directors Academy, you can hear from veteran practitioners and management experts who have experienced the issues and lived through it, offering you tried-and-true solutions to your questions.

Learn why so many see this as the must-attend conference for ED directors and those aspiring to become director.

Register today online at www.acep.org/edda

American College of Emergency Physicians*
ApolloMD invites you to join our team of physician partners at CaroMont Regional Medical Center located just 20 minutes outside of Charlotte, NC.

CaroMont is a Level III Trauma Center annually serving over 95,000 patients. With a wide range of specialty support, CaroMont is a 435 bed not-for-profit facility with a 25% admission rate. Our highly-trained Emergency Physicians are all Board Certified/Board Eligible and practice in an advanced trauma center with FAST Ultrasound and Glidescope availability.

We are currently looking for motivated full time clinical partners and also interviewing candidates for leadership roles in the areas of EMS, Ultrasound, and Trauma.

As an ApolloMD physician partner, we will provide you with a competitive clinical compensation that includes performance, malpractice and tail availability.

Partnership opportunities are available.

Contact Heather Chappell
919-461-7130 or hchappell@apolomd.com

Ohio – Northeastern Ohio
Physicians Emergency Services, Inc. is a progressive, single hospital, independent democratic group seeking another BC/BE physician to join its team.

The hospital is located in Ravenna and has a 22 Bed ED with electronic medical record system. Annual census is 37,000. Competitive salary. Excellent benefit package. Equal opportunity at 2 years. Eight-hour shifts rotate amongst all physicians except two existing physicians work exclusively nights. ED Physician coverage is 40 hours per day and PA/NP coverage 20 hours per day.

A description of some our practice advantages along with a more detailed summary of our salary and benefit package is available.

For more information please contact
Bhan Adams, MD, FACEP 440-864-4242 or by email at phys_app@pesmed.com.

To place an ad in ACEP Now’s Classified Advertising section please contact:
Kevin Dunn: kdunn@cunnasso.com
or
Cynthia Kucera: ckucera@cunnasso.com
Phone: 201-767-4170
Why Take the National Emergency Medicine Board Review Course?

The fact is that taking certifying or recertifying board examinations is a stressful and time-consuming experience. The sheer mass of information that needs to be reviewed, combined with the press of occupational and personal responsibilities makes finding the time to study very difficult. Even with adequate time to study, the volume of material to be studied is staggering: Rosen’s 2006 edition is 3179 pages long and the latest edition of Tintinalli has 1917 pages. Bottom line - preparation for these exams can be a daunting process. The National Emergency Medicine Board Review was created 18 years ago to specifically address the needs of busy emergency physicians required to take their certification or recertification examinations and who wanted a highly focused, no-fluff course that delivers the information they need in a concentrated, high-yield manner.

If you Don’t Pass, You Don’t Pay! Period!* Plus Over $1000 in Free CME!

That’s right – 100% of your tuition refunded, plus the opportunity to attend selected future CME programs at no charge. There is no fine print and no administrative fees are withheld.

“Excellent – best I’ve attended in 30+ years”

“Learning should always be this easy and so much fun.”

“Excellent educational opportunity. I highly recommend this course.”

“Some of the best lecturers out there. It’s hard to keep everyone’s interest while reviewing the entire EM core curriculum, but you all pulled it off!”

“This course was a focused educational experience, and I could not think of a better way to prepare for the exam.”

“Great News! I got a 93% on my ConCert Exam. The NEMBR course was instrumental. Ten years ago, after I took the course, I got a 94%.”

If you Don’t Pass, You Don’t Pay! Period!*

*That’s right – 100% of your tuition refunded, plus the opportunity to attend selected future CME programs at no charge. There is no fine print and no administrative fees are withheld.

If you can’t get away to one of our live courses, we have fantastic emergency medicine board review study tools available. Our on-the-go options are available in several convenient formats to fit your lifestyle and preferred method of studying. We have the study tools to help you gain AMA PRA Category 1 Credits™.

Streaming Video
Audio CD
DVD
MP3

Center for Emergency Medical Education

For more information on all CEME Courses, call toll-free: (800) 651-CEME (2363)
To register online, visit our website at: www.ceme.org

To learn more, visit: CEME.org/board