Medical Technology Expert
DR. ERIC TOPOL
Discusses CBS Interview
SEE PAGE 4

6
APOLOGY RELASED BY ABIM
ABEM Weighs in on EM MOC

16
Myths in Emergency Medicine

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The Official Voice of Emergency Medicine

MARCH 2015 Volume 34 Number 3 FACEBOOK/ACEPFAN TWITTER/ACEPNOW **ACEPNOW.COM**

PLUS

TRICKS OF THE TRADE

MACGYVERING INCREASED INTRAOCULAR PRESSURE

SEE PAGE 18

WELLNESS

THE NIGHT SHIFT: IS SLEEP OVERRATED?

SEE PAGE 20

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STATE OF THE EM UNION

ACEP's President weighs in on challenges, opportunities for emergency physicians

Each year brings new challenges for our specialty to face and a new President to the lead the charge. Michael J. Gerardi, MD, FAAP, FACEP, who took over as ACEP President in October, shares his views on a few of those challenges with *ACEP Now* Medical Editor-in-Chief Kevin Klauer, DO, EJD, FACEP.

CONTINUED ON PAGE 10

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A TASTE OF RAT-BITE FEVER

A thorough history can shed light on nonspecific symptoms

by NICOLE VETTER, MD

The Case

Chief complaint: fever and rash. I stare at the triage notes of the eight-year-old female I had just picked up. Overwhelmed by the vast differential that comes to mind, I decide to approach the case by first ruling out the most life-threatening diagnoses, such as meningococcemia and Stevens-Johnson syndrome, even though they are highly unlikely in my patient.

As an EM intern, I'm still developing a sense for distinguishing "sick" versus "not sick," but upon entering my patient's room, I know immediately this girl is "sick." A thin, pale child lies before me, splayed out on the stretcher and holding her right arm across her chest. She doesn't even look up when I introduce myself. A morbilliform rash peeks through her gown, and I notice the rash on her face, extremities, palms, and soles (see Figure 1). "Palms and soles..." I recall the more-focused differential for a palms/soles rash: meningococcemia; Rocky Mountain spotted fever; hand, foot, and mouth disease; secondary syphilis...

CONTINUED *on page 8*

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PEARLS FROM THE MEDICAL LITERATURE

The ACEP tPA Clinical Policy Saga Continues

SEE PAGE 21

THE BREAK ROOM

[Regarding "Minnesota Becomes 19th State to Allow Nurse Practitioners Full Scope of Authority to Prescribe," published online Dec. 17, 2014,] physicians need to wake up and begin to lobby against the repeated intrusions into our scope of practice. There is a reason nurse practitioners (NPs) and physician assistants (PAs) are mid-level providers—they lack the education and training of physicians! Does it make sense to anyone that clinicians with less education and training should have the same prescribing authority as physicians?

I started my health care career as a paramedic, then went on to nursing, and now it seems as an emergency physician I could have just bided my time, and eventually at this pace NPs will have the same authority I do. I've already seen them introduce themselves as doctors now that many NP programs have gone to doctorate-level degrees.

Many states, including Alabama where I practice, have allowed NPs to place CVLs [central venous lines] and art-lines. I'm very opposed to this and have written to the medical board speaking out against it. Physician leaders are asleep at the wheel on this topic.

It reminds me of how physicians allowed themselves to become just another "cog" in the health care wheel in the early '80s. Physicians were at the top of the health care corporate structure, often then president or chairman of the hospital, then one day we decided that management should be turned over to HCAs. Now look where we are, hoping our reimbursements aren't reduced or tied to performance, accepting policies governing our practice instead of dictating them.

This is another issue where mid-levels will continue to take more and more rope. Wake up!

—Michael Menowsky, MD, RN, BSN
Birmingham, Alabama

SEND YOUR THOUGHTS AND COMMENTS TO ACEPNOW@ACEP.ORG

[In response to the marijuana pro-con, October 2014,] again, we need to look at risk/harm ratios. Yes, legalization will result in more visits—more access does. Should people use? I don't think so, especially kids and teens (just like alcohol). But should those who do be put in jail, stigmatized, and forever labeled? I think not, especially when it targets racial groups disproportionally. Most other civilized countries tend to approach this as a health problem, not a criminal problem. We have more people in jail than any other civilized (and many noncivilized) countries. In addition, the funding provided to gangs and cartels has distinct health harms. My vote is yes; on balance, the benefits (lower harms) outweigh the harms.

—Chuck Sheppard, MD, FACEP
Springfield, Missouri

The article by Dr. Waxman in the January *ACEP Now* ["What Is Really Driving Defensive Medicine?"] describes a study that found no real difference in clinical behavior after changing the malpractice threshold in three states. He suggests malpractice worries do not drive extra testing. I wonder if the time frame of the studies is sufficient. We are all aware of the concern that changes in clinical guidelines take several years to permeate the profession. I suspect the physicians in these states are just as slow to change longstanding behaviors, particularly when the legislature can always change the rules again.

—William E. Gotthold, MD
Wenatchee, Washington

Thank you, Dr. Rogers, for raising this important issue [in "Rural Hospitals Not Open for Business," January 2015].

1. Rural critical access hospitals *do* provide important local services for select patients. Not every elderly pneumonia patient should be transported two hours to a tertiary hospital. The scope of services needs to be clearly defined and funded.

2. Rural critical access hospitals need systems of training and quality monitoring so that standards of care are met.

3. A nod of appreciation to ACEP Rural Section for endorsing comprehensive advanced life support training, a team-based, evidence-based training for rural emergency departments.

4. Regionally directed, adequately funded paramedic-staffed EMS is critical in addressing needs of rural communities.

5. The role of PAs certified in emergency medicine coupled with telemedicine is an effective and cost-effective way to deliver emergency care in rural hospitals or freestanding EDs.

6. All rural hospitals should establish close collaborative linkages with tertiary facilities for referral, consultation, training, and outreach.

ACEP and the Society of Emergency Medicine PAs need to lead advocacy efforts for comprehensive reform of rural emergency health care based on the above points.

—John Graykoski, PA-C, MPAS
Colfax, Wisconsin

[Regarding "Rural Hospitals Not Open for Business,"] one of the easiest ways to help save our rural hospitals is to encourage states that have refused to expand Medicaid to accept the generous subsidy offered by the federal taxpayer (100 percent initially but never less than 90 percent) and expand the program so that all of the citizens of their state will be covered. The idea that Americans who earn less than $1,000 a month don't deserve health care is hard to understand in a country that pretends to admire the actions of the Good Samaritan.

—William Rogers, MD, FACEP
Alexandria, Virginia

WHAT ARE YOU THINKING?

SEND EMAIL TO ACEPNOW@ACEP.ORG; LETTERS TO *ACEP NOW*, P.O. BOX 619911, DALLAS, TX 75261-9911; AND FAXES TO 972-580-2816, ATTENTION *ACEP NOW*.

ACEP Now
The Official Voice of Emergency Medicine

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UPDATES AND ALERTS FROM ACEP

NEWS FROM THE COLLEGE

In Case You Missed It

In early January, the Cambridge Healthtech Institute announced that emergency physician and AMA President-Elect Steven Stack, MD, FACEP, will speak at the Medical Informatics World Conference, which is May 4–5 in Boston. Dr. Stack will provide an overview of the latest opportunities to improve patient care and safety in the midst of the industry's greatest changes, such as new electronic health record and telemedicine technologies and the implementation of the Affordable Care Act.


Dr. Stack

The session will explore how recent legislative and regulatory requirements are impacting physicians and how technology can be leveraged to overcome existing challenges, increase efficiencies, and ultimately improve patient care.

"I think some of the biggest innovations of the 21st century will be at the intersection of biology and technology," said Dr. Stack in the announcement. "The rapid pace of innovation in digital health is creating new opportunities for patients and physicians to be more actively engaged in their health and wellness but only if we can reasonably connect the flood of data to a patient's journey through the health care system."

Member Benefit of the Month: Portfolio Tracker

This online repository keeps your licenses, certificates, CVs, diplomas, and more all in a central location, all secure, and all available whenever you need them! The ACEP Portfolio Tracker keeps all your important career documents in one place, freeing you to spend less time searching and more time focusing on emergency care. We know the challenges you face. And your members-only access to the Portfolio Tracker is an ACEP benefit to help you with your individual practice needs and goals.

California Doctor Recognized for Contributions to Pediatric Care

At the 2015 Advanced Pediatric Emergency Medicine Assembly this month in New York City, Nathan Kuppermann, MD, MPH, was honored with the third annual ACEP and PEMSoft/EBSCO Achievement Award.

The award is annually conferred upon an emergency physician or pediatric emergency physician who has contributed significantly to evidence-based medicine in pediatric emergency care. Dr. Kuppermann holds the Bo Tomas Brofeldt Endowed Chair in the department of emergency medicine at the University of California Davis Medical Center

He has contributed to a wide range of practice-changing articles in the field of pediatric emergency medicine. He served as original chair of the Pediatric Emergency Care Applied Research Network (PECARN) and has published multiple scientific papers with PECARN. Recent publications have defined risk factors for cerebral edema in patients with diabetic ketoacidosis and derived a clinical decision instrument for imaging of pediatric patients with minor head injury.


Dr. Nathan Kuppermann was recognized in March for his contributions to the care of kids. Here's a picture of Dr. Kupperman at work. And here's one when he was a kid, with his mom, Roza.

"I am honored to be granted the ACEP PEMSoft/EBSCO award, as it recognizes advances in the care of acutely ill and injured children," Dr. Kuppermann said. "There are so many people who could be named for the contributions they have made in this regard; I am just one of many."

Nominations for the 2016 Achievement Award will be due in October. Look for more details in *ACEP Now* this fall.

TAKE ADVANTAGE OF THE SECTION GRANT PROGRAM

The ACEP section grant program was established to assist sections with meeting members' needs, educating the public, and advancing emergency medicine. Section members are invited to submit grant proposals that help meet their section's objectives. It is a great way to work together with support from the College. The Board of Directors awards up to $50,000 annually to section grant applicants. The following is a list of recently completed projects funded by the section grant program. ***To learn more, go to www.acep.org/sections.***

SECTION	GRANT	COMPLETED
Emergency Ultrasound Section	Ultrasound credentialing in North American emergency department systems with ultrasound fellowships: a cross-sectional survey white paper. Published in *Emergency Medicine Journal*.	JAN 2015
Emergency Ultrasound Section	www.globalsono.org is a collaborative website designed to serve as a resource hub for clinical sonographers, ultrasound educators, and researchers from around the world. The website focuses its efforts on resource-limited settings, which can range from the developing world to any location that does not have an established infrastructure for clinician-performed ultrasound.	DEC 2014
Quality Patient	Chief complaint–based performance measures: a new focus for acute care quality measurement white paper. Published in *Annals of Emergency Medicine*.	OCT 2014
Clinical Training	Interunit handoffs of patients and transfers of information: a survey of current practices white paper. Published in *Annals of Emergency Medicine*.	JUN 2014
ACEP Emergency Telemedicine Section	Telehealth in emergency medicine: a primer gives an overview of the definition of telehealth, its history, current technology, practical uses, cost and reimbursement, quality improvement measures integrated with telehealth, as well as potential risks and opportunities to its use. Available for download on the Emergency Telemedicine Section website.	JUN 2014
sportsmed	Virtual mentorship in sports medicine aims to facilitate the development of a mentoring relationship between experienced sports medicine/emergency medicine physicians and those individuals interested in pursuing further training or careers in primary care sports medicine.	MAR 2014
ACEP Young Physicians Section	*ACEP 101: a guide for young physicians, 2nd edition*. A resource for any physician or those new to the practice of emergency medicine or new to ACEP, with information on all aspects of ACEP and ACEP opportunities for members at both the state and national level. Available for download on the Young Physicians Section website.	FEB 2014
International Emergency Medicine	1st international ambassador program convention. Preconference event held at ACEP13 in Seattle.	OCT 2013
Forensic Medicine	*Evaluation and management of the sexually assaulted or sexually abused patient, 2nd edition*. Available for download on the Forensic Medicine Section website.	SEPT 2013
Informatics	Quality and safety implications of emergency department information systems white paper. Published in *Annals of Emergency Medicine*.	JUN 2013

ACEP Associate Executive Director Accepts PCMA Award

On the strength of a successful sophomore year for innovatED, ACEP Associate Executive Director Robert Heard, MBA, CAE, was recognized with an Achievement Award in Innovation by the Professional Convention Management Association (PCMA) at its Convening Leaders conference in Chicago. Mr. Heard and innovatED will also be featured in an issue of the PCMA monthly magazine.


Mr. Heard

NEWS CONTINUES *on page 5*

An Interview with **DR. ERIC TOPOL**

Is Technology Putting Health in the Hands of Patients or Taking It Out of the Hands of Physicians?

Fitbit, iHealth, MobiUS, HealthKit—the health care market is exploding with apps and gadgets that allow patients to track their health metrics on their phone or tablet. However, some physicians worry that these new technologies may overload patients with complex health data that they are not able to interpret—or may interpret incorrectly.

Dr. Klauer

ACEP Now's Medical Editor-in-Chief, Kevin Klauer, DO, EJD, FACEP, recently spoke with cardiologist and medical technology expert Eric Topol, MD, about the possibilities and dangers of consumer-focused medical technology.

This transcript of the conversation has been edited for length.

KK: I'm very excited and interested to talk to you because of your background in innovation with technology as well as your formal training in cardiology and your recent thoughts on combining those two disciplines to try to make care delivery more efficient.

ET: I think what's really exciting is that there is emerging technology that is truly transformative, that puts the consumer, the patient, in a very unique position of actually generating a lot of data and then having algorithms, cloud computing, even machine learning to help provide that data back to the individual. In many ways, it's the decompressed diagnostic monitoring aspect of doctoring.

KK: I saw a recent interview you did for CBS on January 6th, and it was great, as you were able to bring some gadgets with you. One I think I've seen before is AliveCor, with the two-finger rhythm strip. One of the devices looked like a Star Trek necklace, [the CoVa Monitoring System]. I. I felt really bad for you because it looked like it wasn't working right.

ET: The device was working really well, but the prop guy for CBS played with it when they took it from me, and by the time I got on live TV, it was all screwed up. I couldn't get it back quickly. That necklace is a really good example because you can get cardiac output stroke volume with every heartbeat and thoracic fluid, so for somebody with heart failure—or let's say if you're an emergency room physician—instead of having to put a Swan-Ganz in, which you're not likely to do in the emergency room, you could actually get these kind of hemodynamics quickly.

KK: This technology is fascinating, but have these devices stood up to scientific rigor and external validation?

ET: That testing is happening right now, but I'm familiar with data from hundreds of patients, many of them in intensive care units with heart failure, where they've had the data side by side with our conventional way of testing it. It looks promising, but we always need more validation before we go into wide scale use. The other [technology] that is exciting is a watch that reads your blood pressure with every heartbeat. With 70 million Americans who have hypertension, the ability to get vital signs like blood pressure in the real world for each individual contextualized with their life is really a phenomenal step forward, and that looks promising with respect to accuracy.

KK: What about that other technology that you were demonstrating that was almost like a temporal artery blood pressure monitor?

ET: We're testing that right now at Scripps. It's called Scanadu Scout, and it's about the size of a half dollar. You hold it up to your temple and you get blood pressure, heart rate, and oxygen concentration in the blood. You could carry it in your pocket or your purse, and if you need to get all of your vital signs intermittently, it takes about ten seconds. Who would've ever thought that that would be possible?

KK: Do you think this technology is better in the hands of a physician guiding care with their patient?

ET: At the end of the day, the consumers should be able to make that call. What I've learned is that with most patients who are worried about their heart rhythm, this electrocardiogram technology gives them a reading that is normal, and it's very reassuring. It saves a lot of emergency care visits and urgent care visits. It should be the choice of the patient, but obviously, they have the ability to consult with their doctor and ask them.

KK: Let's say someone has chest pain and they decide to use this device to decide whether they should go to the emergency depart-

ment. Let's make it even better—say they have palpitations or they feel a rapid heartbeat, but it's paroxysmal. They look at the rhythm strip, see nothing wrong, and think, "I don't have to go to the emergency department." Maybe they didn't define the abnormal rhythm they had. Or let's say it wasn't the rhythm that was the primary problem. They have a pulmonary embolism, which is why they feel that sense of tachycardia. The strip read as normal, but their resting heart rate is 60 and their current heart rate is 90. From a relative standpoint, they're tachycardic, but they just self-triaged themselves out of an emergency department. That worries me a little bit.

ET: Misdiagnosis is a big deal, but Kevin, I think you're well aware we've got a little problem with that right now anyway. Twelve million Americans or more each year are getting a serious misdiagnosis. We're working towards this ability to integrate multiscaled, multilayered information, so that it wouldn't just be one metric. You'd see the oxygen concentration, the SpO2 drop with the tachycardia, and you'd say, "I suspect a pulmonary embolism." The point is that things are getting datafied, more objective, and there are these machines that can actually do a good job of processing the data and learning. I'm predicting over time that this could work pretty well. It isn't the same as a doctor, but it's processing a lot of objective data in a meaningful way. Someday it could be a kind of medical Turing test [test of a machine's ability to exhibit intelligent behavior equivalent to, or indistinguishable from, that of a human] where you have a computer doing a pretty darn good job in terms of accuracy. Diagnosis is different from treatment; that's where the doctor has to come in, and the doctor would provide oversight that the diagnosis was correct.

KK: Back to that interview, it sounds like, in talking to you now, that your perspective is that as this evolves, there may be some more intricate ways to risk stratify and to help people make the decision as opposed to the example that was given, which was to use the rhythm strip, and you don't have to end up going to the emergency department—"go through all the rigmarole" you said in the CBS interview—if the rhythm strip is interpreted as normal. Is that what your perspective is, that would be enough, or do you think this just builds into a piece of a bigger puzzle that can help patients decide whether they have to go to the emergency department or not?

ET: Right, the piece of a bigger puzzle. We're still in the relatively early stages, but the ability to integrate big data per each individual is where we're headed. It's exciting but, obviously, it's a very big challenge for the medical community since it represents such a radical change.

> *"The emergency room is a really invaluable place because all of the technology we're talking about is not for serious matters. For anything that's significant, emergency rooms are here to stay, and they're going to be a center for acute illness forever as far as I can see."* **–ERIC TOPOL, MD**

KK: There's the pervasive thought in America that the emergency department is overutilized, but we find that we're the only type of facility that's open 24-7 for any type of acute or unscheduled care. If you're not sure what you have, we actually prefer that you would come to us.

ET: I agree with you about that, Kevin. The emergency room is not going away, unlike the hospital room, the actual room, which might not survive over the next decade. The emergency room is a really invaluable place because all of the technology we're talking about is not for serious matters. For anything that's significant, emergency rooms are here to stay, and they're going to be a center for acute illness forever as far as I can see.

KK: How involved are you in the development and ownership of these technologies?

ET: None of them are our devices. [Scripps] just happens to be a place that validates them if you're in clinical trials, so we get to see a lot of stuff and pick the ones that we want to do prospective rigorous studies on. It isn't our stuff; we just have the ability to take innovative ideas largely from engineers and get them into the medical testing mode so that some of them will make it to routine incorporation and practice.

KK: With your involvement with validation and studies and your profession as a cardiologist, are there any conflicts of interest that you feel are present? Do you find it difficult to avoid?

ET: I do think it's difficult to avoid. You have to separate out whether you're going to work with a company and financially benefit from it or going to do basically independent validation.

KK: Our whole specialty is thinking about ways we can really make acute care delivery more efficient, and certainly better, for our patients. This could be a way for us to assess our patients after they leave the emergency department if they don't have access to primary care. Maybe the emergency department can follow them for the next 72 hours if they have one of these devices (eg, congestive heart failure with the personal cardiac output monitoring device).

ET: I think that will bolster the confidence of emergency room doctors if people are getting really good monitoring when they leave the emergency department.

NEWS FROM THE COLLEGE

CONTINUED FROM PAGE 3

Leadership Conference Research Poster Abstracts Due March 29

The Young Physicians Section is accepting Research Poster Abstracts until March 29 for posters to be presented at ACEP's 2015 Legislative Advocacy Conference and Leadership Summit. The conference will be held May 3–6 in Washington, D.C. ***For more information about submission requirements and poster details, go to www.acep.org/youngphysicianssection.***

CAN'T-MISS EVENTS

Registration is now open for the Legislative Advocacy Conference and Leadership Summit. Join 500 of your closest friends as you work to improve health care policy and learn valuable tips on how to become a more effective leader.

DATE	EVENT	PLACE	WEB SITE
MARCH 24–26	Advanced Pediatric EM Assembly	New York City	acep.org/pem
APRIL 7–11	EM Academy–Phase 1	Las Vegas	acep.org/emacademy
APRIL 13–16	Council of Emergency Medicine Residency Directors Academic Assembly	Phoenix	cordem.org/academicassembly
APRIL 26–30	Emergency Department Directors Academy Phase II	Dallas	acep.org/edda
MAY 3–6	Legislative Advocacy Conference	Washington, D.C.	acep.org/lac
MAY 3–7	SEMPA 360	Lake Buena Vista, Florida	sempa.org/conference
MAY 18–20	ACEP Simulation-based Immersive Medical Training Course	Phoenix	acep.org/sim
OCT. 26–29	ACEP15	Boston	acep.org/acep15

American Board of Internal Medicine Suspends Portions of MOC Program

American Board of Emergency Medicine weighs in on the status of its own MOC program

The American Board of Internal Medicine (ABIM) issued an unprecedented apology letter to its diplomats, penned by Richard Baron, MD, President and CEO. "We got it wrong and sincerely apologize," the letter states. Dr. Baron further reported that ABIM launched its Maintenance of Certification (MOC) program before it was ready for prime time. Here is the complete letter:

Dear Internal Medicine Community:

ABIM clearly got it wrong. We launched programs that weren't ready and we didn't deliver an MOC program that physicians found meaningful. We want to change that.

Nearly 80 years ago, the American Medical Association and the American College of Physicians founded the American Board of Internal Medicine (ABIM). ABIM was charged with distinguishing the discipline of internal medicine from other forms of practice by creating uniform standards for internists. Those standards have evolved over the years, reflecting the dynamic nature of internal medicine and its more than 20 subspecialties.

A year ago, ABIM changed its once-every-10-years Maintenance of Certification (MOC) program to a more continuous one. This change generated legitimate criticism among internists and medical specialty societies. Some believe ABIM has turned a deaf ear to practicing physicians and has not adequately developed a relevant, meaningful program for them as they strive to keep up to date in their fields.

ABIM is listening and wants to be responsive to your concerns. While ABIM's Board believes that a more-continuous certification helps all of us keep up with the rapidly changing nature of modern medical practice, it is clear that parts of the new program are not meeting the needs of physicians like yourself.

We got it wrong and sincerely apologize. We are sorry.

As a result, ABIM is taking the following steps:

- Effective immediately, ABIM is suspending the Practice Assessment, Patient Voice and Patient Safety requirements for at least two years. This means that no internist will have his or her certification status changed for not having completed activities in these areas for at least the next two years. Diplomates who are currently not certified but who have satisfied all requirements for Maintenance of Certification except for the Practice Assessment requirement will be issued a new certificate this year.
- Within the next six months, ABIM will change the language used to publicly report a diplomate's MOC status on its website from "meeting MOC requirements" to "participating in MOC."
- ABIM is updating the Internal Medicine MOC exam. The update will focus on making the exam more reflective of what physicians in practice are doing, with any changes to be incorporated beginning fall 2015, with more subspecialties to follow.
- MOC enrollment fees will remain at or below the 2014 levels through at least 2017.
- By the end of 2015, ABIM will assure new and more flexible ways for internists to demonstrate self-assessment of medical knowledge by recognizing most forms of ACCME-approved Continuing Medical Education.

Please visit our FAQ page for more information about these changes. I do want you to know that, since the changes being made are significant, it will take time until your individual status page is updated on the ABIM website.

ABIM is changing the way it does its work so that it is guided by, and integrated fully with, the medical community that created it. However, I know that actions will speak louder than words. Therefore, ABIM will work with medical societies and directly with diplomates to seek input regarding the MOC program through meetings, webinars, forums, online communications channels, surveys and more. The goal is to co-create an MOC program that reflects the medical community's shared values about the practice of medicine today and provides a professionally created and publicly recognizable framework for keeping up in our discipline.

As the first non-academic physician to lead ABIM, I am particularly proud of my 30 years in private, community practice, and I see this letter to you as a start—a new beginning. The ABIM Board of Directors, staff and I are fully committed to doing a better job—to ensure that ABIM and MOC evolve to better reflect the changing nature of medical practice.

It remains important for physicians to have publicly recognizable ways—designed by internists—to demonstrate their knowledge of medicine and its practice. Internists are justifiably proud of their knowledge and skills. However, the current MOC program can and should be improved.

Over the next few months, you'll see communication from me and ABIM leadership, asking about your vision for internal medicine, the MOC program and your opinions about what it means to be a doctor today. We have also created "Transforming ABIM", a Google+ Community that you can join, to ask questions and share ideas, and a blog.

I have heard you—and ABIM's Board has heard you. We will continue to listen to your concerns and evolve our program to ensure it embodies our shared values as internists.

Thank you for your input and feedback—and for the important clinical work you do each and every day.

Sincerely,

Richard J. Baron, MD, MACP
President and Chief Executive Officer
American Board of Internal Medicine

Printed with permission from ABIM.

This release from ABIM has likely sensitized critics of MOC to the possibility that, perhaps, other member specialty boards—such as the American Board of Emergency Medicine (ABEM)—have also "gotten it wrong."

Will ABEM be releasing an apology? That's unlikely as it seems the similarities between ABIM and ABEM's MOC programs stop with the use of the term MOC.

In order to clarify ABEM's position on MOC and to address the potential concerns of ABEM diplomates, *ACEP Now*'s Medical Editor-in-Chief, Kevin Klauer, DO, EJD, FACEP, posed these questions to the ABEM leadership. Below, Francis L. Counselman, MD, President of ABEM, responds.

> "In order for a specialty to have legitimacy in the house of medicine, it must be recognized by the ABMS. This is why emergency medicine fought so hard decades ago to be recognized by the ABMS as the 23rd medical specialty."

KK: What do you (or ABEM) think about ABIM's letter of apology?

FC: ABEM supports ABIM's need to create a MOC program that is meaningful to its certified physicians (diplomates), and it appears to be seeking a process by which an effective program of continuous professional development can be offered. It is imperative that we keep in mind that ABIM is not eliminating its MOC program or discontinuing its key elements, but rather, it is temporarily suspending parts of the ABIM MOC program to make adjustments that will be in better service to its diplomates and the public.

KK: How is ABEM's MOC program different than ABIM's?

FC: The ABEM MOC program is distinctly different largely because emergency physicians are engaged daily in adherence to quality measures. We enjoy a specialty that, in its 35 years of recognition by the American Board of Medical Specialties (ABMS), has constantly been transforming itself by improving the manner in which emergency physicians deliver compassionate, quality care to every patient, in every circumstance, and at every moment.

Two specific differences between the ABEM and ABIM programs are the Part II Lifelong Learning and Self-Assessment (LLSA) and the Part IV Assessment of Practice Performance Practice Improvement (APP PI) components. The ABEM LLSA has been shown to be highly relevant and improve patient care.[1] This is, in part, because the selected articles come largely from recommendations submitted by major emergency medicine organizations and individual emergency physicians. Having representatives from EM organizations provide CME for the activity is a further indicator of the relevance of the articles. Because emergency physicians are universally involved in department-based quality improvement activities, meeting APP PI requirements tends to be straightforward.

Another distinguishing feature of the ABEM MOC program is the extremely high rates of participation by ABEM diplomates. In 2013, there were about 6,000 physicians with APP PI (Part IV) requirements, and more than 9,000 physicians attested to participating in these activities. In 2014, more than 10,000 diplomates attested to completing APP PI activities. Of the more than 2,000 diplomates who successfully passed the ConCert examination in 2013, only eight physicians lost certification solely due to not meeting MOC LLSA or APP PI requirements. Since then, five have completed the requirements and regained certification.

Finally, another indicator of the program's relevance is that clinically active emergency physicians, including members of the ABEM Board of Directors and the EM community at large, have been involved in the development of the ABEM MOC program. Since its beginning in 2004, the ABEM MOC program has undergone multiple refinements, including reducing the number of readings and questions on LLSA tests, delinking the topics on the LLSA tests and the ConCert examination, and allowing practice performance to include more low-frequency, high-acuity conditions. Changes such as these were largely based on feedback from diplomates.

KK: Why does ABEM require MOC?

FC: The ABMS is an organization involving 24 medical specialty member boards, of which ABEM is one. Every ABMS member board is required to have a defined MOC program. That program should be relevant to its diplomates. ABEM further feels that MOC should provide value to diplomates, which it currently does in the form of cost and compensation. The annualized cost of ABEM's MOC program is $265 per year, or about $5 per week, which is about the median cost of ABMS member boards and is less than 0.1 percent of the average emergency physician's total annual compensation. The 2013 ACEP–Daniel Stern study showed that board-certified emergency physicians received $35,000 more in total annual compensation than noncertified physicians.[2] ABEM also participated in the Physician Quality Reporting System MOC bonus program, which was not the case with the majority of ABMS member boards. Participating in the program will have resulted in emergency physicians receiving more than $3 million in additional Medicare reimbursement.

KK: Can you define ABEM's relationship with ABMS?

FC: In order for a specialty to have legitimacy in the house of medicine, it must be recognized by the ABMS. This is why emergency medicine fought so hard decades ago to be recognized by the ABMS as the 23rd medical specialty. That is also why, this past fall, ABEM proudly celebrated its 35th anniversary as an ABMS member board. As an ABMS member board, ABEM can also offer subspecialty certification. ABEM has worked hard to gain certification eligibility for emergency physicians in 12 different subspecialties, including critical care medicine, EMS, hospice and palliative medicine, medical toxicology, pediatric emergency medicine, sports medicine, and undersea and hyperbaric medicine.

ABEM has a representative, Michael L. Carius, MD, on the ABMS Board of Directors, and the Chair Elect of the ABMS, John C. Moorhead, MD, is an emergency physician. ABEM has sought broad representation on several ABMS committees so that the views of the emergency medicine community can contribute to ABMS policy decisions.

KK: What would happen if ABEM elected not to comply with ABMS requirements?

FC: Noncompliance with ABMS requirements would put ABEM's standing as an ABMS member board at risk. At the very least, ABEM's credibility within the ABMS certification community would be damaged. It is important to recall that ABMS recently adopted a new set of MOC requirements, the ABMS 2015 MOC standards. Prior to their approval, ABEM purposefully sent the 2015 MOC standards to every key membership organization in emergency medicine for comment and input. ABEM and the ABMS received no recommendations for revisions, and there were no concerns about the requirements expressed to ABEM or the ABMS from any emergency medicine organization.

KK: What would happen if ABEM were not an ABMS medical specialty board?

FC: The standing of emergency medicine in the house of medicine would plummet. If ABEM withdrew from the ABMS, decades of progress would be lost. It would be a devastating blow to thousands of physicians who have contributed to our specialty. Moreover, the ability to have accredited residency programs would be in jeopardy.

KK: Has ABEM supported the ABMS MOC initiatives (specifically at the board level)?

FC: As a member board, ABEM must comply with the 2015 MOC standards, and the ABEM Board of Directors supports these standards. As mentioned earlier, every emergency medicine organization had the opportunity to comment on the ABMS 2015 MOC standards.

In order for the ABEM Board of Directors to optimally meet the ABMS MOC standards in a way that best serves the specialty, ABEM continually surveys diplomates at nearly every step of the MOC process. In 2014, ABEM convened a national MOC summit that included representatives from every major EM organization (including resident organizations) to find ways to further enhance the ABEM MOC program. And, in 2015, ABEM will add even more opportunities for diplomate feedback.

In summary, the ABEM MOC program ensures the public that emergency physicians are actively engaged in a standardized, nationally recognized program of continuous professional development. High participation rates in the ABEM MOC program are largely due to the commitment that emergency physicians have to improving their care for the ill and injured. This is why ABEM has started to acknowledge ABEM diplomates who have been certified for 30 years or more though a special recognition program. These women and men have, throughout at least three decades of their medical careers, been involved in recertification activities and MOC activities without resting on the laurels of one-time initial certification. ABEM is proud to be in partnership with emergency physicians who demonstrate the absolute best in medical care by their unwavering service to the public and by embracing the highest standards in the specialty of emergency medicine.

> "In order for the ABEM Board of Directors to optimally meet the ABMS MOC standards in a way that best serves the specialty, ABEM continually surveys diplomates at nearly every step of the MOC process."

ABEM wishes to thank the ACEP Now *editorial staff for reaching out to ABEM at this important time about this important issue.*

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The parents describe their child as becoming progressively more "lethargic" and febrile over the past week (Tmax 104° F). They had already visited the pediatrician three times but decided it was time to come to the ED when the patient woke up refusing to walk due to pain in her knees and ankles. Delving into my bank of fever questions, I ask about headache, neck stiffness, skipped vaccinations, sick contacts, recent travel, or any new medications. However, all of these questions return negative. Fever, rash, joint pain—what else could I ask? At a loss, I decide to ask about any known tick bites, though this is unlikely because we are at the peak of winter in New England. Still negative. Any new pets? Well, now that I mention it, they admit to buying a new pet rat a few weeks ago.

On exam, the patient appears very fatigued. Her vital signs are significant for a fever of 38° C and heart rate of 126 bpm. Her respiratory rate, blood pressure, and SpO2 are within normal limits. The most striking exam findings are the patient's pallor contrasted against a blanching morbilliform rash over her face, extremities, palms, and soles but sparing her torso. I also notice a petechial rash developing on the patient's legs that I hadn't seen previously. Despite mild postauricular lymphadenopathy, the rest of her head, eyes, ears, nose, and throat exam is normal. Her heart, lung, and abdomen exams are also normal. However, when I attempt to move the patient's right shoulder and ankles, she moans in pain.

Rat-Bite Fever

As I return to my desk, the history of a new pet rat continues to resonate in my mind. I search the Internet for rat-borne diseases, and a recent news article appears as one of the top search results.[1] The article describes the case of a young boy misdiagnosed with a viral illness, but worsening of his symptoms resulted in his death a few days later. On autopsy, the boy was found to be infected with the bacterium causing rat-bite fever (RBF), *Streptobacillus moniliformis*.

The article further discusses the symptoms of RBF, which include fever (check), rash (check), and arthralgias (check) in a patient with exposure to rats (check). My attending and I are amazed how closely this diagnosis fits our patient. Upon further questioning, the patient denies any rat bites. However, she does admit to allowing the rat to lick her mouth and lips, much to my dismay. With guidance from a pediatric infectious disease specialist, we draw blood cultures and start empiric antibiotic therapy for RBF. The patient's basic lab work returns at this point and is remarkable for a platelet count of 178K and C-reactive protein of 4.9 mg/L. The rest of her complete blood count, basic metabolic panel, liver function test, and erythrocyte sedimentation rate are within normal limits.

The patient is admitted to the hospital on IV doxycycline (2 mg/kg BID), and her symptoms begin to improve the following day. She is discharged within 48 hours, with increased energy, a fading rash, and no joint pain. She is instructed to continue PO doxycycline for two weeks. At follow-up one month later, the parents state their daughter is "perfect" and back to her normal self.

RBF is a rare but fatal bacterial illness in the United States caused predominantly by *S. moniliformis*, a gram-negative rod that is part of the normal respiratory flora of rodents.[2] It is spread to humans via a rat bite, scratch, or, in my patient's case, a "kiss," but it is susceptible to antibiotics such as penicillin or doxycycline (see sidebar for dosing). If misdiagnosed or left untreated, however, the disease carries a 13 percent mortality rate.[3] Symptoms present anywhere from three to 21 days after rat exposure and include nonspecific symptoms such as fever, fatigue, headache, pharyngitis, and vomiting. These initial symptoms are followed by a rash, which is usually maculopapular, though it can be petechial or purpuric, and is most prominent on the extremities, palms, and soles. Polyarticular and asymmetric arthralgias develop in up to 50 percent of patients. When RBF is suspected, blood cultures should be drawn with specific instructions (see sidebar), as *S. moniliformis* is a fastidious organism.

Although RBF is a rare diagnosis, this case highlights the importance of taking a thorough history. Having a standard list of questions at your disposal to help sort out nonspecific symptoms, such as fever and rash, is crucial to avoid missing a fatal illness. Although it is unlikely I will encounter another case of RBF, this case serves as a reminder to maintain an open differential and to be less inclined to diagnose a viral illness without first considering other life-threatening diagnoses.

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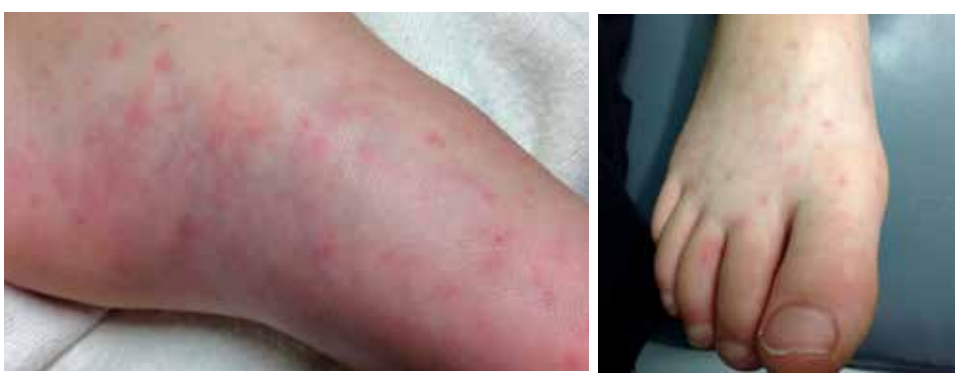
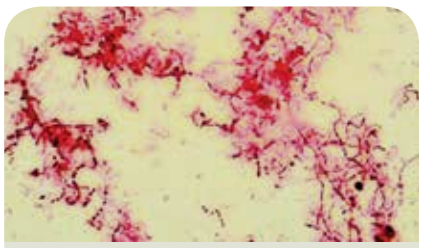
DR. VETTER is a resident in emergency medicine at the University of Connecticut in Hartford.

Figure 1. Morbilliform rash





DIAGNOSIS AND TREATMENT

S. moniliformis is an extremely fastidious organism that requires special conditions and culture media to grow. When drawing blood cultures, collect aerobic cultures in a purple-top tube, as the anticoagulant, sodium polyanethol sulfonate, in most aerobic culture bottles inhibits the growth of *S. moniliformis*. Alert the lab that you suspect the organism, which requires enriched trypticase soy agar or broth, and request that the cultures be held for up to two weeks, as the bacteria grow very slowly.[4] However, because of the difficulty in confirming diagnosis by culture, the diagnosis is often made by history, and empiric antibiotic treatment should be started immediately due to the high complication and fatality rate. Penicillin is the treatment of choice or doxycycline (as used in my patient) for penicillin-allergic patients.

- **DOSING (ADULTS)**
  - IV penicillin G: 200,000 units every 4 hours for 5–7 days (can be switched to PO once patient shows clinical improvement)
  - PO penicillin V: 500 mg QID, to complete a 14-day treatment course
  - Doxycycline (for PCN-allergic patients): IV or PO 100 mg BID for 14 days
- **DOSING (CHILDREN)**
  - IV penicillin G: 100,000–150,000 units/kg/day, divided in 4 doses, up to maximum 8 million units/day, for 5–7 days (can be switched to PO once patient shows clinical improvement)
  - PO penicillin V: 25–50 mg/kg/day, divided in 4 doses, up to maximum 2g/day, to complete a 14-day treatment course
  - Doxycycline (for PCN-allergic patients): 2–4 mg/kg/day IV or PO, divided in 2 doses, for 14 days

- to inform their healthcare providers and dentists if they plan to take, or are taking any prescription medications, over-the-counter drugs or herbal products
- to inform their healthcare provider immediately if they become pregnant or intend to become pregnant or are breastfeeding or intend to breastfeed during treatment with SAVAYSA
- that if a dose is missed, take SAVAYSA as soon as possible the same day, and resume the normal dosing schedule the following day. The dose should not be doubled to make up for a missing dose
- that if they are having neuraxial anesthesia or spinal puncture, advise patients to watch for signs and symptoms of spinal or epidural hematoma, such as back pain, tingling, numbness (especially in the lower limbs), muscle weakness, and stool or urine incontinence. If any of these symptoms occur, advise the patient to contact his or her physician immediately *[see Boxed Warning in the full prescribing information]*.

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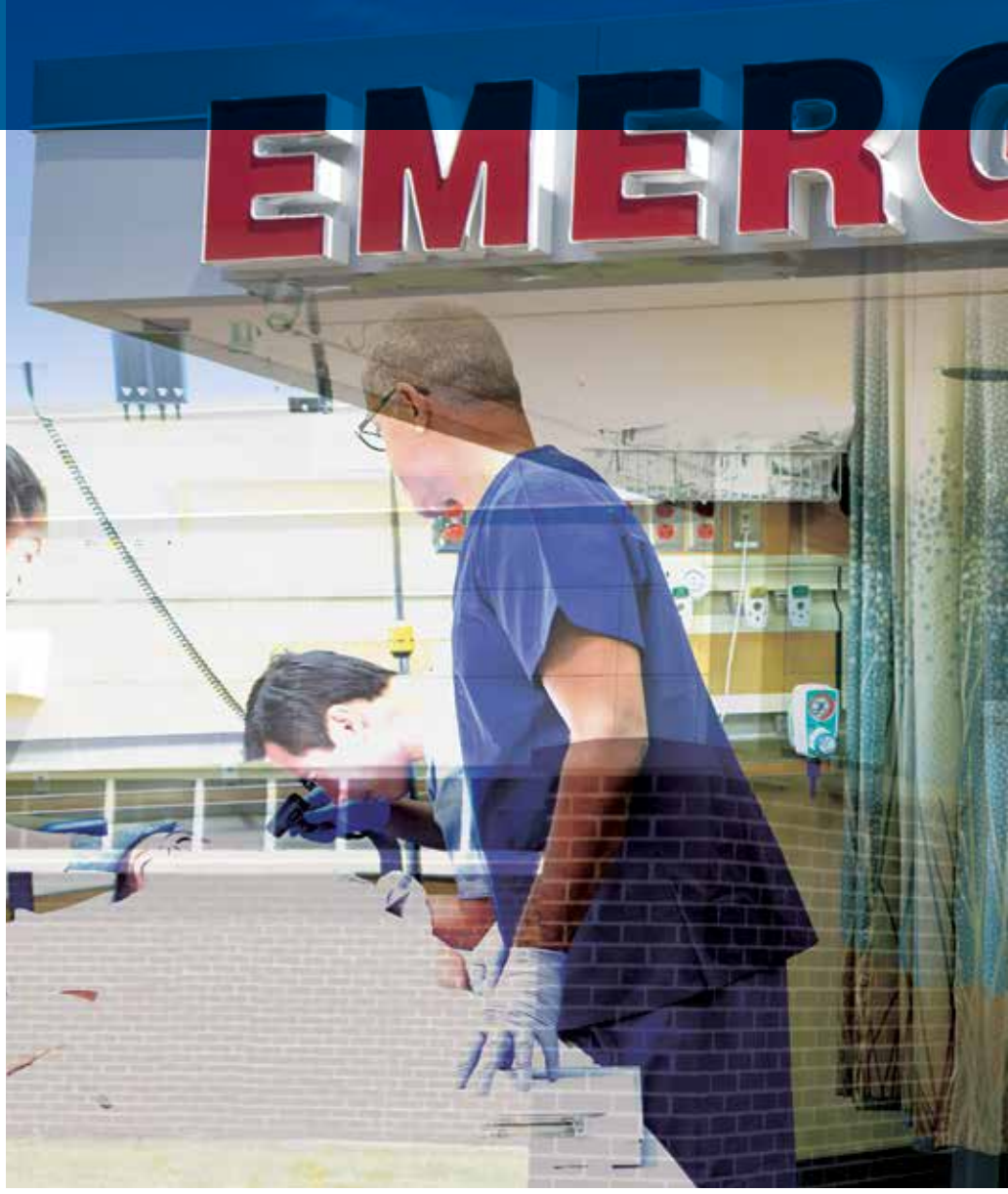
STATE OF THE EM UNION

CONTINUED FROM PAGE 1

"Just go to the chapter meeting and step up to say this situation is intolerable or headed to an intolerable level. ACEP is there to listen and ready to solve problems. An organization can't be successful or have the resources to put forth to solve a problem unless it has members. Members are our lifeblood."

–Michael J. Gerardi, MD, FAAP, FACEP



Kevin Klauer: What are the greatest challenges for emergency physicians today?

Michael Gerardi: Overcoming myths that have been promulgated over the last five to six years in the health care reform debate, such as EM is expensive and doesn't provide great value and that patients should avoid emergency departments at all costs. Hearing such ludicrous stuff drives me crazy, and we have to stop this nonsense. I think our patients already know that when they are sick or acutely injured or unsure of what ails them, they're going to get the right answer in the ED. You have heard me say publicly that, in America, we are the greatest diagnosticians in the world, and it starts in the emergency department. We are the prime comforters in times of crisis, we are great diagnosticians, we are the MacGyvers of medicine, and we know how to innovate from the perspective of access to care and putting together care plans.

The more we get involved and lead, as we are developing a qualified clinical data registry (QCDR), establishing relationships with other societies, getting involved with the big house of medicine, etc., the more people are going to look to us and say, "There is something about those emergency physicians; they just seem to be out there in front and to see things before they happen." I want people to view us as visionaries about where medicine needs to go and what it should be. Our challenges come from being misunderstood and not being valued.

KK: What do you think ACEP members get for their dues dollars?

MG: I think the value they are getting is fantastic. First of all, they're getting *Annals of Emergency Medicine*, one of the most impactful EM journals by the ratings of medical journals. Second, they get current information through the daily briefings from ACEP and *ACEP eNow*. But perhaps the greatest value of membership is this: if anyone who practices emergency medicine has an issue, frustration, or problem, I would be surprised if ACEP does not know about it and is not fighting to fix that problem already. ACEP is doing it's best with more than 110 staff members, hundreds and hundreds of volunteer committee members, and thousands of section members, to improve our practice. I think one of the most gratifying things to do is to join a section or dive into a cause and realize, "Look at how many people think the way I do." It's really galvanizing, and it supports the case that you want to be a part of something bigger. It helps you enjoy your practice more to know that someone is working on your behalf to solve a problem that is frustrating you.

If I'm missing some of the frustrations, by the way, they are what our board members and chapter leaders are finding out when we go to these meetings and get involved locally. We go to chapter meetings and members step up to say some situation is headed to an intolerable level. ACEP is there to listen and ready to solve problems. An organization can't be successful or have the resources to put forth to solve a problem unless it has content and dedicated members. Members are our lifeblood.

KK: What would you say to the emergency physician who says, "I get all the benefits even if I don't pay my dues because everyone else paid their dues"? Basically, herd advocacy.

MG: I'm not going to say that everyone should contribute to the overall welfare of our specialty. That's your own personal choice. I just think that if people were to investigate what the College is doing, they would find colleagues who are like-minded. Camaraderie and esprit de corps are invaluable to your own personal being. If you stand on the outside, you will feel isolated and lonely. You won't be part of the overall changes that impact you. Our members have the benefit of thought leaders constantly debating, having discussions, and writing about where things are heading. You are at a disadvantage if you don't see what is coming.

KK: What has ACEP been doing to support members in meeting Physician Quality Reporting System (PQRS) requirements?

MG: I feel like our specialty has been wrestling with a technical expert panel, trying to find quality measures that the Centers for Medicare & Medicaid Services (CMS) will accept for emergency medicine. It has been a very frustrating process because, even working through the National Quality Forum and others, our recommendations sometimes fall on deaf ears.

In 2014, CMS removed approximately 75 of 370 measures for all of medicine, many that impacted emergency medicine. Fortunately, we also learned that there was another option for PQRS reporting, called a QCDR.

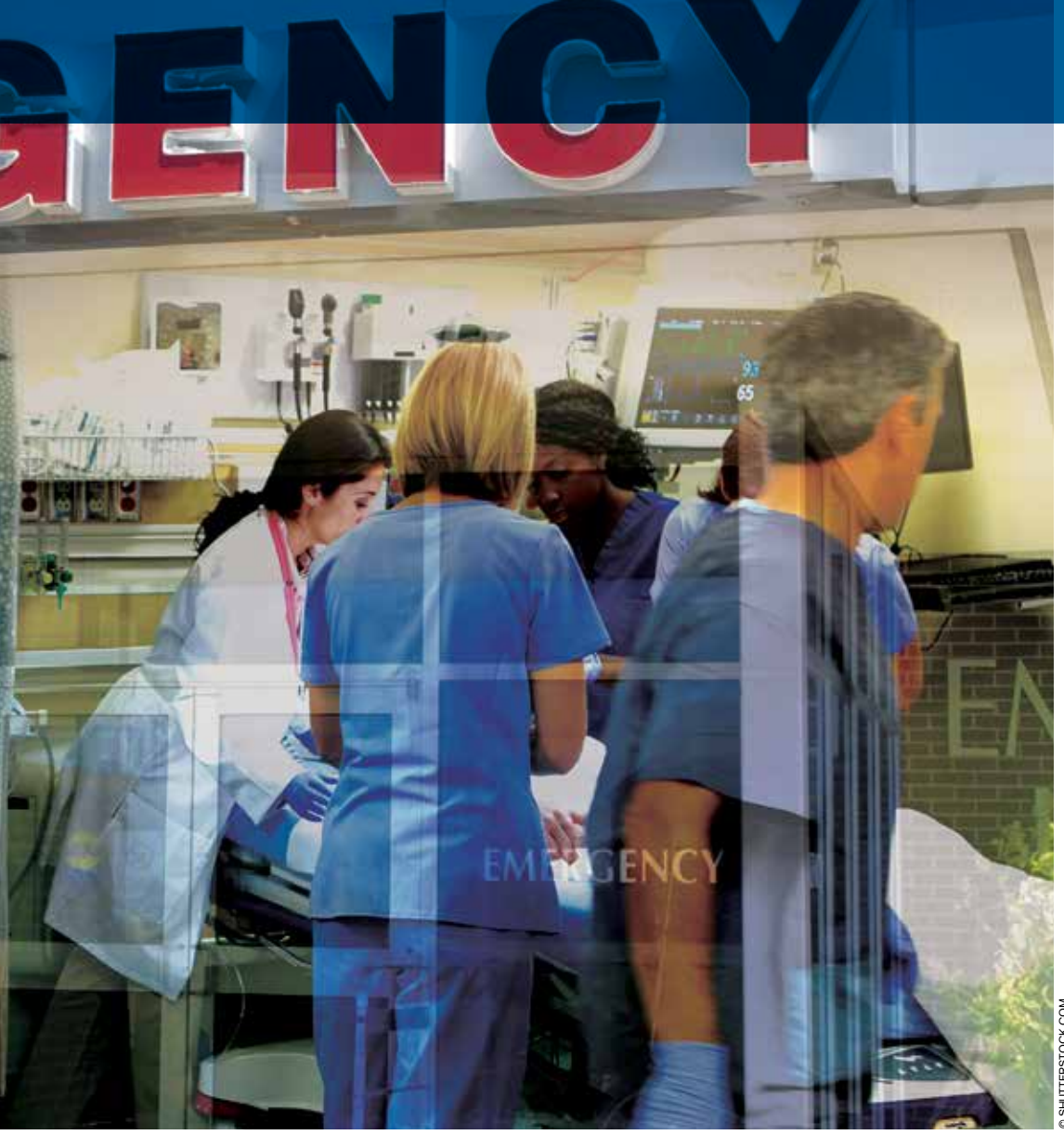
ACEP met with some experts in Washington, D.C., in August and found if we were to create our own QCDR, then we could create our own quality measures, get them approved by CMS through the QCDR methodology, disseminate them to our members, and be able report in 2015. Otherwise, we were looking at a potential 6–10 percent reimbursement cut in 2017 if reporting is not done in 2015. Obviously, this was a front-burner item—some things present themselves and we have no choice but to address them immediately.

ACEP Executive Director Dean Wilkerson, JD, MBA, CAE, the staff, and members of the board rapidly put out a request for proposals for development of a QCDR. I'm happy to say that we finalized a contract to have a software developer create an ACEP QCDR, the Clinical Emergency Data Registry or CEDR. We will immediately task the Quality and Performance Committee, QIPS (our quality improvement and patient safety section), our technical expert panel, and other committees to help us produce quality measures so that we can begin reporting by the third quarter of 2015. This will protect us from a draconian cut in 2017. I can't emphasize how important this initiative is.

With a QCDR, you can also develop your own patient-satisfaction tool. We may not necessarily be beholden to EDPEC, the Emergency Department Patient Experience of Care survey, which is going to be the ED version of the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey. We will also be able to use the QCDR for Maintenance of Certification with the American Board of Emergency Medicine and American Osteopathic Board of Emergency Medicine. This is a project that will have far-reaching effects on the function of the College. I think we can be leaders in the house of medicine in this process.

KK: What do you say to those who say ACEP is just another organization in bed with big pharma and practice management or contract management groups?

MG: If you look at the College from the outside



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and don't choose to be a member, I think that's the kind of rationalization rhetoric you hear. I see ACEP as the organization that truly represents me—as a practicing physician—and also my patients.

Let's talk about pharma. Pharma employees go to work every day trying to make or design more effective drugs at less cost; that's their fundamental mission. Are there examples where companies are profiteering and may be charging too much? Yes, but that's an economic discussion for a future article. If pharma is willing to help support research for a vexing problem, I don't call that being in bed with them. I call that having a partner who is willing to invest resources to help us do research.

Let's talk about the large contract management groups. When I put on my white coat to care for patients, I am just a physician (with a little gray hair), and I hope I can take care of their needs. But behind me is a billing company or somebody who helps me do my schedule, or helps me recruit for the shift that's open, or provides medical liability insurance, or helps me convene quality improvement committees, or runs interference with a hospital administration that doesn't see eye to eye with me about what our mission is. All those people working behind me are supporting my ability to practice and focus on the patient and their family, and I don't see why that is necessarily a bad thing.

There are certain benefits in larger numbers. Some of our smaller contract groups that have one, two, or three contracts sometimes need help. I think the College represents both the individual practitioner and members who work for a large management group that helps support their practice. Our members are free to choose their employment model, but I really hope they become ACEP members because of what the College represents: the physician at the bedside and the patient rather than these other entities.

KK: Consolidation is occurring, systems are growing, and the way we deliver care is changing. Some have asked whether free enterprise has extended into unfair business practices. Do you have any thoughts on that?

MG: I don't see that coming from the consolidation of hospitals, systems, contract management groups, or ED groups. I see unfair practices being implemented against emergency physicians by payers right now. In the negotiating process, we are at an extreme disadvantage. Unless you're in a rural market where they have very limited choices, where they can't play one group off of another, payers are using the excuse of the rising cost of health care as a justification to mistreat emergency physicians. The better ACEP is able to get us fair treatment and demonstrate our value, the more your practice is protected at the bedside. That's why out-of-network care, the greater-than-three rule, and being treated fairly are such big issues for the longevity and the viability of our specialty and the choice to practice in the environment that you want. For some, being an employee is a good thing. For some, it's anathema to their personal DNA. We have to let members have choices because when people have options, you find drivers to create efficiency and satisfaction with their practice.

One of our major initiatives last year was to look at the wellness and the longevity of our physicians. We have to find ways to make it so that every shift is like that occasional shift you have when everything clicks and goes just right. That's going to take a unified effort from different practice environments and people with different resources. I believe in accomplishing this through collaborative relationships with the Emergency Department Practice Management Association and other professional organizations like the American Academy of Emergency Medicine, American College of Osteopathic Emergency Physicians, Emergency Nurses Association, and American Medical Association.

KK: What are your thoughts on advanced practice providers and how they should be incorporated into the workflow and staffing models in emergency medicine?

MG: I think advanced practice providers—and I want to include scribes—are great career enhancers, people who can take some of the work that we are caught up with that distracts us from our highest abilities and practicing to our level of expertise. We need to be able to use our brains and experience to handle the more-complicated issues because our patients are getting more elderly and more complicated with comorbidities and very complex diseases.

Advanced practice providers can help us improve flow; they are a great friendly face to take care of that laceration or ankle sprain or more of the straightforward work-up. Advanced practice providers are definitely my colleagues, working shoulder to shoulder with me even with complex patients, but they expand my ability to touch more patients than I would be able to just working by myself. Advanced practice providers and career supporters like scribes not only make your shifts more enjoyable, but they make you feel like you're practicing to the top of your license. I think that's something that we all should strive to do, including advanced practice providers.

KK: Out-of-network payments have been a big issue with health care reform. Could you summarize the issue?

MG: A good element of the Affordable Care Act (ACA) is adoption of the prudent layperson definition of an emergency. In other words, people should have emergency care provided in their health plans. However, part of the payment structure in America is that a group or an emergency physician has a choice to participate with a particular plan and insurance company or not participate. If you don't participate, you're out of network. The hospital may be in network, but the emergency physician is out of network. If they are out of network, the physician has the right to provide a bill that's not covered by the insurance company's usual rate. Insurance may only pay 60 percent, so a physician will send a bill for the balance—that's called balance billing. Out-of-network bans say the doctors in emergency departments can't send that balance bill for out-of-network care.

With the ACA, banning balance billing is not allowed. For billing fee disputes, the ACA created a rule called "the greatest of three" to help determine a fair reimbursement schedule. A reasonable usual and customary rate is: [1) the average amount negotiated with in-network providers for the emergency service furnished; 2) the amount for the emergency service calculated using the same method the plan generally uses to determine payments for out-of-network services (such as the usual, customary, and reasonable charges); or 3) the amount that would be paid under Medicare for the emergency service]. The lack of this type of methodology created the Ingenix crisis in New York state, when Attorney General Cuomo sued Ingenix because they were taking away some of the higher reimbursements in their nontransparent database, causing a downward spiral in the usual and customary rates in their database and saying that was the usual and customary rate. We have to revise the out-of-network rules and the CMS final rule on this regulation such that there is transparency—like in the FAIR Health data repository—and not a black box so that we can have a fair discussion about what is the usual and customary rate for out-of-network care.

Emergency physicians are not the guilty party when it comes to exorbitant out-of-network rates. You're seeing them with some of the surgical specialties, surgical subspecialties, and hospitals, etc. We are fighting to have a fair database that compiles billions of charges to determine what is the 80th percentile for a usual and customary rate for an emergency physician for a level 3 or 5 code. We feel that would provide us some negotiating stance when we take on payers who are, almost by extortion contracting, forcing us to accept rates that are unacceptable for our practices.

KK: Final thoughts?

MG: Let's not forget about several other initiatives launched this year. We are tackling the disparity of care available for behavioral health and psychiatric emergencies and the psychiatric boarding problem.

Second, we have created a task force to promote a national discussion on end-of-life care and advance care planning. Emergency physicians are often stuck in the difficult situation of prolonging life because patients and families have not had an opportunity to discuss their wishes on how the patient wants to be treated when nearing death. These discussions should occur when patients are not in crisis, when they and their families are not under the duress of an ailment or terminal illness.

Third, emergency medicine needs to "own" sepsis care. We are the front line in recognizing sepsis and pre-sepsis syndromes and immediately initiating lifesaving therapies. We have convened an expert panel to review and summarize the science and develop educational materials for our members and the public.

Finally, please remember, in these times of change, our specialty will lead our country in creating an improved health care system and, at the same time, we will be recognized for the tremendous value we provide.

Why I Chose the VA

Emergency physicians find valuable opportunities for patient care and career advancement at VA hospitals

BY NICHOLAS LEZAMA, MD, MPH, FACEP

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After three deployments, 13 moves, and an incredible variety of jobs and experiences, I retired from the military. As I began my transition to civilian life, I discovered many great clinical and leadership opportunities for emergency physicians in the Department of Veterans Affairs (VA). I accepted a position as chief of emergency medicine at the Memphis VA Medical Center and began to reflect on my decision and the new team I had joined.

So, why did I choose the VA? My primary motivation was to continue serving my country and our veterans. Approximately 9 million veterans are enrolled in the VA health system, the largest health care organization in the nation. More than 70 percent of all US physicians have received training from the VA. Our veterans have sacrificed much for our country, and I wanted to be involved in their care.

I asked my VA emergency medicine colleagues why they work at the VA, and a number of common themes emerged: service, stability, professional satisfaction, career advancement opportunities, and financial benefits. The box below contains a sample of the responses I received.

Each specialty in the VA convenes a field advisory committee to advise VA leadership on current specialty practice standards. The Emergency Medicine Field Advisory Committee comprises seven emergency department directors from across the nation and is dedicated to improving emergency care across the nation's VA hospitals. This group of experienced VA physicians is working to create new emergency medicine policies, assist newer VA emergency medicine programs as they develop, and establish new affiliations with academic partners.

The VA is improving patient access. The new head of the VA, Secretary Robert A. McDonald, recently commented on patient access in an article published in the *Baltimore Sun*: "Fixing access to VA care is important; we have a plan to do that and are dedicated to implementing it. That process will take time—but it must be done, and we will be successful. Those who fully understand the value of the department in research, training, and clinical care understand that veterans and all Americans need and deserve their VA to continue providing exceptional care to those we serve."[1]

The VA is a dynamic organization with lots of opportunities for emergency physicians. VA emergency medicine is very professionally rewarding, and I would encourage emergency physicians to consider joining the VA team.

Thank you to Curt Dill, MD, chief of the emergency department at VA-New York Harbor Healthcare System Manhattan Campus, and Chad S. Kessler, MD, MHPE, deputy chief of staff at the Durham VA Medical Center in North Carolina, for their contributions to this article.

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DR. LEZAMA is chief of the emergency department at the Memphis VA Medical Center.

The views expressed in this article are those of the author and do not necessarily reflect the position or policy of the Department of Veterans Affairs or the United States government.

JOSEPH T. BURNS, MD
Fargo VA Health System, North Dakota

Generally, the patients here are more appreciative of what we do than those from civilian settings in which I have worked. The scope of what is seen is often more narrow, but is often deeper or more complex. We don't see pediatric patients or deliver babies, but patients here require "brain power" to work through their complaints. You will get a cerebral workout with each shift. Time spent with patients can be greater. On the whole, the opportunity to talk with patients is greater than in civilian settings. History is the most important component of making a diagnosis; it's easier to do that here. Many civilian nurses in our community have come to the VA because this represents "real" nursing practice as well, meaning they have time to spend with patients. The benefits are great, but the pay is less, and the total work intensity is generally less than civilian facilities.

THOMAS SCHNEIDER, DO
Muskogee VA Medical Center, Oklahoma

We get to work 24/7 for Veterans, who served our great nation. The better we serve these great people, the more people might step up and serve our nation in the future. I am a proud American physician, serving people willing to provide freedom and safety.

NEIL PATEL, MD
West Los Angeles VA Medical Center, California

"One of the chief reasons why I love working at the VA is that I can practice medicine without incorporating medico-legal concerns and patient financial circumstances into my medical decision-making. In other words, I can practice the art and science of medicine in its purest form, for the sole benefit of the patient, without worrying about my pocketbook, both in terms of reimbursement and medical malpractice. The fact that it's an integrated health care model, where I can see what other providers have done and can freely refer to specialists, isn't too shabby either!"

ANDREW AUERBACH, MD, FACEP
Dallas VA Medical Center, Texas

I think the best reason is the opportunity to improve the quality of emergency care in the VA system. A more material reason is paid time off; I never had that when I was in the private world.

HENRY PITZELE, MD
Jesse Brown VA Medical Center, Chicago, Illinois

Relative shielding from litigation restores the physician-patient relationship and allows us to actually care for our patient instead of concentrating on protecting ourselves. Longevity and predictability of career: In the current climate of change in insurance, payment, and oversight of medical decision-making, the VA offers a system that is unlikely to change in the near future. We will not see our department contract sold out from under us. We won't see our pay decreased, and we won't be downsized. Opportunities and funding for career development: the VA abounds with chances for professional development, both within emergency medicine (directorship, VA and national leadership, research, and teaching) and outside EM (local hospital leadership, non-EM development opportunities in integrative medicine, women's health, informatics, emergency medical services, policy, etc.) Hands-down, VA patients are the best patient population of any American medical system. I was thanked by patients and families more in my first week of work at the VA than in the preceding four years of urban, community EM.

PETER HASBY, MD
Ft. Meade VA Medical Center, South Dakota

Eligibility for VA services includes patient financial need. In other words, our patients are not only US military veterans, but most often low income. Many commonly use the VA not because they have no other option, but because they are proud of their veteran status and happy with our service to them. So, we see grateful patients, giving us the privilege to serve a low-income population without having to personally face the financial challenges that may impact a civilian hospital.

ALAN SORKEY, MS, MD, FACEP
Overton Brooks VA Medical Center, Shreveport, Louisiana

I have never been told thank you so often as by patients at the VA. Emergency medicine is relatively new at the VA, and it is very rewarding to makes changes that improve emergency services for the veterans and improve the care provided. The VA was the perfect transition from 20-plus years of full-bore private sector emergency medicine. The potential for career advancement is very good. As a former independent contractor, I wish I had known about the opportunity to work as little as one-fourth time at the VA and be eligible for full benefits—this is the ideal situation for many in emergency physicians. Anyone with prior military service can "purchase" that time towards Federal retirement.

CURT DILL, MD
VA NY Harbor Healthcare System, New York

We are modern trailblazers for emergency medicine. Veterans are entitled to the highest quality of care from an emergency department. Emergency medicine professional organizations now dominate the training of acute care physicians. As such, EM can meet its own standard by providing emergency care to all in need, including veterans who receive their care in VA hospitals. Students and EM residents rarely have an opportunity to see post-traumatic stress disorder, victims of military sexual trauma, and other conditions that disproportionately affect veterans. Understanding these entities is necessary and valuable for the sophisticated development of the modern emergency physician.

ACEP POLICY

The Doctor Will Video Chat You Now

ACEP is developing telemedicine policy for emergency medicine

BY BARBARA K. TOMAR

At ACEP's 2014 Council Meeting, Resolution 36(14), Development of Telemedicine Policy for Emergency Medicine, was adopted by the Council. This resolution calls for a group of members with expertise in telemedicine to create a telemedicine policy specific to emergency medical practice. "This is an exciting time for telemedicine," said Hartmut Gross, MD, section chair-elect. "The technology is evolving and poised for rapid growth, which in turn has attracted a lot of new investment in the marketplace. With it, we are solving progressively more common, as well as unique, problems with versatile and creative applications that will soon deliver big-city medicine to small-town America."

Currently, several academic EM programs and large groups have fully embraced the benefits of telemedicine and have developed innovative solutions for complex emergent clinical problems. The George Washington University Medical Faculty Associates department of emergency medicine, based in Washington, DC, contracts with clients in the maritime industry to provide telemedicine medical support to ships all over the world; The University of Mississippi in Jackson links board-certified emergency physicians with nurses staffing many of the state's critical access hospitals; the University at Buffalo's program provides telemedicine services to 51 correctional facilities across New York state; and Avera eEmergency in Sioux Falls, South Dakota, links board-certified emergency physicians and experienced critical care nurses with critical access hospitals, community hospitals, tertiary care centers, and correctional facilities across an eight-state region in the upper Midwest.

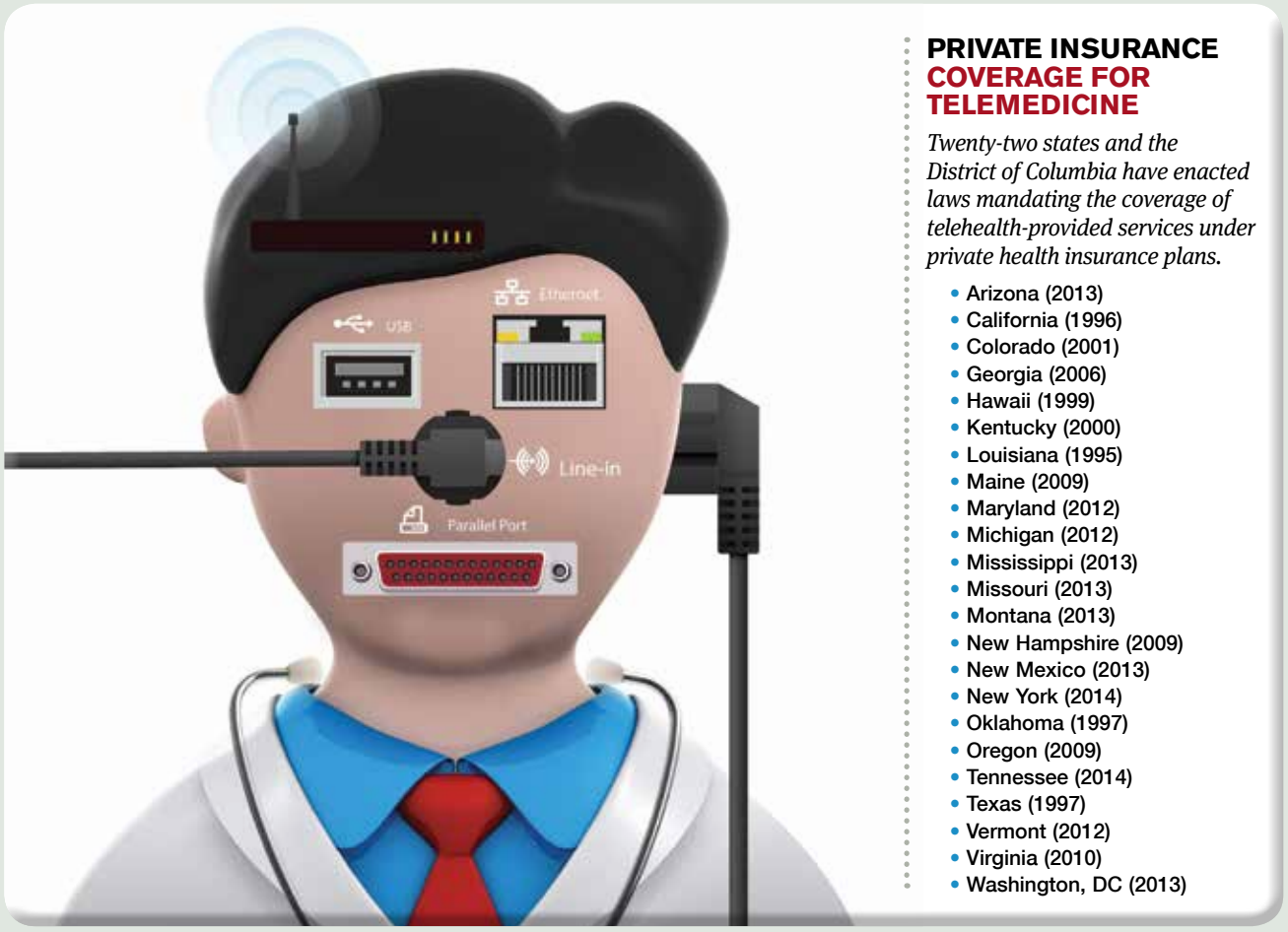
In contrast, regulation, coverage, and payment of telemedicine are lagging behind the practice. Issues of liability and other risks, privacy, and medical licensure requirements have not kept pace with technological innovations and applications. The unique challenges and practice environment of emergency medicine make the timely development of a telemedicine policy a top priority for ACEP.

Coverage for telemedicine is provided by some commercial health insurance companies, but only 21 states require that private payers cover telemedicine services, and the definitions also vary by state. Medicare coverage is limited to a small list of Part B (physician) services that are rendered in rural health professional shortage areas or areas approved by the government for telemedicine demonstrations. Any new Medicare coverage requests must be submitted by sponsoring physicians or organizations to the Centers for Medicare & Medicaid Services by Dec. 31 each year. No emergency physician services are covered to date. Medicaid pays for telemedicine services in 46 states and the District of Columbia, but scope of practice, coverage, and payment vary by state.

Recent policy statements from the Federation of State Medical Boards (FSMB) and the American Medical Association (AMA) highlight the urgent need for ACEP to develop its own policy for the use of telemedicine in emergency medicine. The FSMB's model guideline for appropriate use of telemedicine includes a statement that physicians using telemedicine technology must first establish a physician-patient relationship and be licensed in the state where the patient is located. The AMA also supports policy that requires a face-to-face telehealth consult and also requires the practitioner to be licensed in the state where the patient is located. The nature of emergency medicine's focus on unscheduled acute care makes it difficult for physicians to first establish a physician-patient relationship. Policies requiring physicians to be individually licensed in the state where the patient is located may also present significant roadblocks and hamper innovation.

An ACEP policy now may avert unintended adverse consequences of other organizations' future policies. It will hopefully help steer local and national stakeholders with rules and guidelines development, as well as eliminating or modifying restrictive covenants, in this rapidly evolving subspecialty. Creating our own telemedicine policy will additionally broaden awareness of telemedicine among the membership and establish principles for use of technology to create new practice opportunities and provide timely services to patients in more locations.

MS. TOMAR is federal affairs director for ACEP.



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PRIVATE INSURANCE COVERAGE FOR TELEMEDICINE

Twenty-two states and the District of Columbia have enacted laws mandating the coverage of telehealth-provided services under private health insurance plans.

- Arizona (2013)
- California (1996)
- Colorado (2001)
- Georgia (2006)
- Hawaii (1999)
- Kentucky (2000)
- Louisiana (1995)
- Maine (2009)
- Maryland (2012)
- Michigan (2012)
- Mississippi (2013)
- Missouri (2013)
- Montana (2013)
- New Hampshire (2009)
- New Mexico (2013)
- New York (2014)
- Oklahoma (1997)
- Oregon (2009)
- Tennessee (2014)
- Texas (1997)
- Vermont (2012)
- Virginia (2010)
- Washington, DC (2013)

WHO IS DEFINING EMERGENCY MEDICINE'S VALUE?

We need to drive the measures of value in the ED—or be left behind

BY JOHN G. HOLSTEIN AND ANDREW SAMA, MD, FACEP

The health care industry is changing daily and at a very rapid pace. Some of the changes surrounding and impacting emergency medicine are:

1. Patients self-directing their care.
2. The explosion of the urgent care industry.
3. Hospitals moving into the insurance business.
4. Telemedine and its potential applications for EM.
5. Increasing demand for quality and value metrics.
6. Retail competition in the delivery of health care and the issue of cost.
7. Dramatic increase in high-deductible insurance plans.
8. Medicaid expansion and the changing uninsured population.
9. Out-of-network care and the associated patient balance billing issue.
10. Increasing shift of patient care from inpatient to outpatient settings.

Where does emergency medicine fit into this emerging framework? Does it fit at all—does it even have to fit, or can it remain effectively outside and immune from this new world order of health care? How do we add value as the transformation occurs? To some degree, in the early days of managed care, the specialty did remain somewhat outside of the industry changes, although the specialty certainly took its hits, especially in the reimbursement arena via inappropriate and erroneous claims denials. Virtually all major insurers saw class action lawsuits filed against them and emergency medicine did recoup a substantial amount of previously lost revenue, but the recoupment came years after the original services were provided.

Today there are certain emerging trends that the specialty will be forced to address and it would be prudent to prepare sooner rather than later. This article is focused on the emerging trends requiring the establishment of metrics for quality and value and, very importantly, who will define these metrics as they apply to EM.

Defining Value

Rappleye includes "persist in driving change" as one of her seven steps to leading health care transformation.[1] If EM is, in fact, to emerge as a leader in effecting change and transformation, this may very well include partnering with other specialties, particularly to address the care continuum and continuity of care issues. We in emergency medicine will need to expand our role, especially as it relates to transitions of care. One way or another, it is imperative that EM define and stake out its ground by defining the performance metrics under which it will be measured and judged. The specialty should drive the process of developing and implementing these metrics, especially in the context of how others presently define quality and value. Let us review in terms of financial value.

Three of the most severely ill or injured emergency medicine patients, as described by the American Medical Association in the 2014 CPT manual, are (inclusive of their level of service designation):[2]

99284: Emergency department visit for a patient with flank pain and hematuria.

99285: Emergency department visit for a patient exhibiting active, upper gastrointestinal bleeding.

99291: First hour of critical care of a 45-year-old who sustained a liver laceration, cerebral hematoma, flailed chest, and pulmonary contusion after being struck by an automobile.

In today's evolving and very dynamic health care environment there are several determiners of value as it applies to emergency medicine. The industry's three major sources of financial value metrics are the Centers for Medicare & Medicaid Services (CMS), insurers, and the hospital c-suite. Regarding CMS and insurers, we'll focus on value as measured in payment rates. Regarding the c-suite, we will present a different set of metrics for review.

The current Medicare 2014 national reimbursement rates for the three levels of care noted above are:

Medicare 2014 Rates
99284: $118
99285: $174
99291: $225

Medicaid Traditional
99284: $96
99285: $148
99291: $207

Stark reality hits home here regarding the financial "value" placed on some of the most severely ill or injured patients seen every day in our emergency departments, starting with the Medicare program. In today's commercial world, people are paying, on average, $200–300 for their new mobile phones; $300 for a 30–39" television, and anywhere from $150–260 for a dinner outside the home for a family of four. The average daily corporate travel per diem rate is currently $293.[3] As the retailization of health care continues to evolve, it would seem payers have a way to go to more equitably reimburse emergency physicians, particularly for treatment of our most severely ill and injured patients. More specifically, Medicare reimburses $75 less for a critical care patient than the current price paid by thousands of people every day for their latest phone and $68 less than the current average corporate per diem rate. It gets far worse when scrutinizing our other governmental program, traditional Medicaid. By way of comparison and inclusion, Walmart is diving into the primary care arena at $4/patient visit, driving the economic value of care even lower.[4]

Medicare reimburses $75 less for a critical care patient than the current price paid by thousands of people every day for their latest phone.

What are the value metrics used by the hospital c-suite today? These also likely play a role in payer determinations of value in establishing their proffered reimbursement rates. As itemized by Ellison, these metrics are:[5]

1. Average time spent in the ED before patients were admitted to the hospital as an inpatient: 274 minutes.
2. Average time spent in the ED after the physician decided to admit them as an inpatient but before leaving the ED for their inpatient room: 98 minutes.
3. Average time patients spent in the ED before being sent home: 134 minutes.
4. Average time patients spent in the ED before being by a health care professional: 26 minutes.
5. Average time patients who came to the ED with broken bones had to wait before receiving pain medication: 57 minutes.
6. Percentage of patients who came to the ED with stroke symptoms who received brain scan results within 45 minutes of arrival: 57 percent.

Why are these particular metrics isolated, and what is behind monitoring these types of metrics? Eggbeer and Bowers make two very relevant and cogent points regarding two of the major determiners of value in today's health care marketplace, namely the hospitals and insurers.[6] First, "an estimated 20 percent of health system networks offer either their own insurance product or a co-branded product. An American Hospital Association survey of 100 hospitals last year found that 38 of the hospitals already owned health plans, while an additional 21 were planning to offer a health product in the next three to five years." In this marketplace hospitals are beginning to forge relationships with payers, and therefore blurring traditional provider/insurer lines of demarcation.

The second major point made by these same authors is, "a health plan is fundamentally a risk-selection business, wherein cost control and financial stability are core values. In the emerging consumer market of public and private exchanges, quality, cost, service, and convenience are the major value drivers." Emergency medicine practices, save for independent, freestanding EDs and their practices, all are housed within hospitals and these hospitals are increasingly viewing every aspect of care and the providers associated with that care from a commercialized and retail-oriented lens. Mellin and Funk go so far as to include physician profiling as one of their six key metrics in population health management.[7] Measures of clinical efficiency are coming more frequently to the forefront as the health care landscape continues to take

shape. There is a clear message for emergency medicine in Musssallem's words, "we need to show up with evidence."[8]

Regardless of where we look, it is also important to recognize that many of the programs and associated metrics being measured are focused on reducing emergency department visits. We are, therefore, looking at a potential revenue hit for emergency medicine practices, especially in hospitals developing these programs that are many times formed from partnerships of hospitals and insurance plans.

When evaluating an ED practice, Alan Channing, one of our nation's most respected c-suite executives, uses a very straightforward methodology with the following benchmarks for "keeping the hospital happy":[9]

- Build business
- Have rapid throughput
- Achieve high Hospital Consumer Assessment of Healthcare Providers and Systems (HCAPS) scores
- Have good communications
- Keep referral sources happy
- Simplify management issues
- Earn consistent and high quality scores
- Minimize hospital's financial participation
- Support mission, vision, and values (specific to the Sinai Health System)

What does all this mean for EM? Where is the specialty going and in what direction? Will it emerge as a leader in effecting change? What are the metrics the specialty believes are critical to its success and legitimate for others to measure us by in this emerging new landscape? What new challenges should we be embracing? How can we help our hospital partners master transitions of care? The opportunities and timing are peaking for emergency medicine.

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MYTHS in Emergency Medicine

ROOTED IN CULTURE, BASED ON TRADITION

BY KEVIN M. KLAUER, DO, EJD, FACEP

TAKE-HOME POINTS

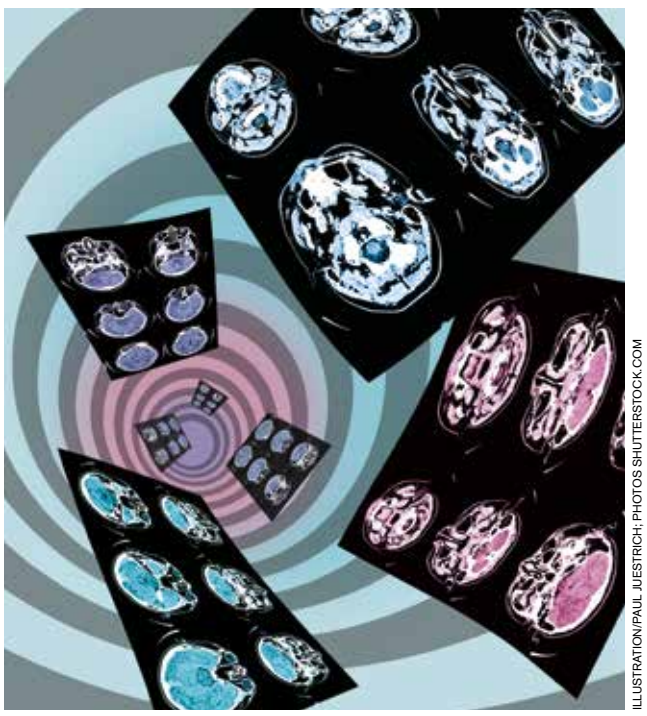
1. Diagnostic evaluations are wildly inconsistent and should be based on justified clinical suspicion for the abnormalities being tested for.
2. Neuroimaging is performed in less than half of all cases (based on the above studies).
3. CT is worthless and expensive in the evaluation of dizziness.
4. MRI has much better utility but is often unnecessary for the complaint of dizziness.
5. Nystagmus is an unreliable sign and does not differentiate serious neurological disease from other causes of dizziness.
6. Gait instability or imbalance, other subtle neurological findings, and age >60 years are predictors of stroke or other serious neurological diseases causing dizziness.
7. Isolated dizziness is very unlikely to be serious or to require an extensive diagnostic evaluation.

Does Dizziness Cause You Diagnostic Disequilibrium?

Although most providers have developed a standardized approach for the evaluation of dizziness, the variation from one provider to the next is likely as vast as the difference in the ways patients report their symptoms.

For several reasons, including improved outcomes, utilization control, operational efficiency, and patient safety, it's time to narrow the gap in practice variation.

Most cases of vertigo are benign and are not associated with serious pathology or likely to result in bad outcomes no matter what we do. However, the real key is to trim the diagnostic fat without becoming so diagnostically lean that you miss something important. One way, and perhaps the most common, is the shotgun approach (check all the boxes and let the tests guide you), and another is the dartboard approach (random selection of testing combinations based on gestalt). However, a rational approach to dizziness is available with a review of the evidence.



ILLUSTRATION/PAUL JUESTRICH; PHOTOS SHUTTERSTOCK.COM

Nine months ago, I started down my evidence-based pathway, evaluating a 67-year-old female patient with new-onset dizziness. I was working at a facility that had easy access to MRI. Despite the fact that brain CT lacks sensitivity for posterior fossa pathology, it is often ordered in the evaluation of dizziness. We do so because MRI frequently isn't available emergently for this complaint and brain imaging of some kind just seems to make sense. Well, with MRI readily available, I elected not to order the standard CT, which rarely if ever yielded any positive findings, and ordered an MRI, which ultimately was normal as well. This patient led me to challenge whether imaging is necessary at all in patients with dizziness, whether CT has any utility, and in which patients imaging should be obtained. Three studies answered these questions for me, taking care of my diagnostic disequilibrium.

In 2012, Chase et al from Beth Israel Deaconess Medical Center in Boston published a study to determine what clinical factors were associated with stroke in vertiginous patients.[1] MRIs of the brain were obtained during the ED visit or within two weeks. Of the 131 patients, 12 (9.2 percent) experienced a cerebellar or brainstem stroke (posterior fossa). CTs were negative in all five stroke cases in which one was performed. The complaint of gait instability and subtle neurological findings were associated with stroke, with odds ratios (ORs) of 9.3 and 8.7, respectively. Of particular note was that nystagmus was only present in a third of those with stroke and in a fifth of those without stroke.

Also in 2012, Navi et al published a paper reviewing the records of 907 patients presenting to the University of California, San Francisco emergency department between 2007 and 2009. The patients presented with the complaint of dizziness, vertigo, or imbalance for a mean duration of one day.

There was substantial variation in the diagnostic evaluations performed. Laboratory diagnostics were ordered in 72 percent, ECGs were performed on 68 percent, neuroimaging in 35 percent, and neurology consultation in 20 percent of the patients. Serious neurological disease was identified in 5 percent, with stroke being the most common (diagnosed in 3 percent). The independent predictors for serious neurological disease were:

- Focal neurological abnormalities: OR 5.9
- 60 years of age or older: OR 5.7
- Imbalance: OR 5.9
- Isolated dizziness: OR 0.20

Patients older than 60 experiencing imbalance with an identifiable focal neurological abnormality were the most likely to experience serious neurological disease. However, even more helpful is the OR of 0.20 when the patient experienced isolated dizziness. Patients experiencing isolated dizziness and no other symptoms or neurological abnormalities were 80 percent less likely to be experiencing a serious neurological cause.

Finally, in September 2013, Ahsan et al evaluated the costs and utility of neuroimaging of ED patients complaining of dizziness. A total of 1,681 patients seen at Henry Ford Hospital's ED in Detroit from 2008 to 2011 were included. CTs were performed 48 percent of the time; MRIs, only 5 percent of the time. Overall, 0.74 percent of the CTs were abnormal (6/810), as were 12 percent of the MRIs (11/90). The cost associated with identifying one abnormal CT was $164,700 and $22,058 for a positive MRI. In addition, all patients with a positive CT or MRI had a headache, neurological findings on examination, or ophthalmological complaints along with their dizziness.

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PROTECT YOUR POT OF GOLD FROM BAD ADVICE

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 adviser, accountant, or attorney and recommends you consult with your own advisers prior to acting on any information you read here.

Roth Versus Traditional 401(k) Contributions

If you are a great saver who wishes for more tax-protected retirement account space, Roth may be for you even during peak earnings years.

by JAMES M. DAHLE, MD, FACEP

Question. ***My 401(k) now allows me to make Roth contributions. Should I do that or continue making the tax-deferred contributions I have been making for years?***

A. It turns out that this is a very complex question, and anyone who pretends the answer is simple doesn't really understand all the factors involved. There is no universally correct answer, only a right answer for you. However, rather than spending a lot of time worrying about how best to manage this decision, realize that both tax-deferred and Roth 401(k) contributions are very good things and both have great advantages. Also, when in doubt, it never hurts to just split the difference, minimizing regret either way.

Roth contributions are made with money that has already been taxed. When the money is finally withdrawn from the account in retirement, both the original principal and the earnings come out completely tax-free. Tax-deferred, or traditional, 401(k) contributions provide you a tax break in the year you make your contribution. They also grow in a tax-protected manner, but upon withdrawal, the entire principal and earnings are taxed at your full marginal tax rate. So the first factor to consider when deciding between Roth and traditional 401(k) contributions is the difference between the tax rate at which you would contribute the money and the tax rate at which you would withdraw it.

For a resident, who is most likely in a very low tax bracket, making Roth contributions is usually the right move. However, it can increase student loan payments due under the Income-Based Repayment and Pay As You Earn programs, as well as decrease any forgiveness received under these programs or the Public Service Loan Forgiveness program. For an attending in peak earnings years, the right move is usually to make tax-deferred contributions and then use that money to "fill up" the 0 percent, 10 percent, 15 percent, and 25 percent brackets in retirement. Putting money away at a 33 percent marginal tax rate and then withdrawing it at an effective tax rate under 25 percent is a winning formula.

Unfortunately, there are numerous other factors involved that complicate the decision for many people. First, it is nice to have both tax-free (Roth) and tax-deferred accounts available to you in retirement to provide tax diversification. This puts you in control of your retirement tax rate. You can withdraw from tax-deferred accounts up until you hit the higher tax brackets, then use your tax-free money if you need additional income. If your ratio of tax-free to tax-deferred accounts is very low, it may be more worthwhile for you to make Roth 401(k) contributions even in your peak earnings years. However, if you have a significantly sized Roth IRA from your resident years and you make annual backdoor Roth IRA contributions for you and your spouse, you may have a decent ratio already and would be better off maximizing your tax-deferred contributions.

Making Roth contributions also allows you to put more money into retirement accounts, which have many tax, estate-planning, and asset-protection benefits. Because the limit is the same ($18,000 in 2015 for those under 50) for both a Roth and a traditional 401(k) employee contribution (employer match and profit-sharing contributions are always tax-deferred), if you choose Roth, you will have more after-tax money in your account. Think of it this way: you only own some of the money in a tax-deferred account. Uncle Sam owns a certain percentage, and you are just investing it for him until withdrawal, at which time you get your share and he gets his. However, with a Roth account, you own the whole thing. If you are a great saver who wishes for more tax-protected retirement account space, Roth may be for you even during peak earnings years. Great savers also run into the issue of having a very large tax-deferred account. Once your tax-deferred accounts are more than $2–$3 million in today's dollars, the required minimum distributions alone will get you into a high tax bracket, so there won't be much of an arbitrage between today's tax rates and tomorrow's. It turns out that the more you save for retirement, the less benefit you will see from using tax-deferred accounts. The same is true if you have a lot of taxable income from Social Security, a pension, or real estate investments.

Your personal economic and political views may also impact your decision. Some people are very concerned that the tax brackets themselves will be much higher in retirement, so they prefer to pay taxes now and use Roth accounts. Others are worried the government will change the law in order to tax money contributed to Roth accounts twice. These folks take the "bird in the hand" approach by using a tax-deferred account. Frankly, I think planning is done best using current law as your guide since predicting future Congressional acts seems to require a crystal ball.

There are also other, more minor, considerations. For example, if you plan to move from a state with a state income tax to a tax-free state in retirement, you should favor tax deferment. Although most physician families won't qualify for much significant college financial aid (aside from loans), using Roth accounts can lower the expected family contribution on the Free Application for Federal Student Aid. There are also estate-planning considerations. Estate tax is levied against the total amount of the account. Therefore, if you expect to have an estate tax problem, it might be best to favor Roth accounts since you have more after-tax money available for the same-size account. Heirs also prefer to inherit a tax-free Roth IRA over a traditional IRA. It is also possible that the total tax due could be reduced by leaving the traditional IRA to an heir in a lower tax bracket.

Confused yet? With good reason, you might be—it's a complex decision. Roth 401(k) contributions are a great option to have, but the decision about whether to make Roth or traditional contributions is a complex one that depends on many personal and nonpersonal factors that may change in the future. Following these guidelines can help you optimize your retirement savings and tax situation.

GENERAL GUIDELINES
THAT SHOULD HELP WHEN EVALUATING THIS DECISION:

1. If you're a resident or military member, maximize Roth contributions.
2. If you're in a low-income year for any reason, such as a sabbatical, use Roth contributions.
3. Use a personal and spousal backdoor Roth IRA each year. That way, even if you choose to make all tax-deferred 401(k) contributions, you're still getting some money into Roth accounts.
4. If you can pay the tax with money in a taxable account and expect to work part time or retire in your 50s, then consider making Roth conversions during those years before receiving Social Security or a pension to "fill up the lower brackets."
5. If you save and invest more than 20 percent of your gross income, lean a little more toward Roth investments. If you save and invest less, use tax-deferred accounts preferentially.

PRACTICAL TIPS FOR THE PRACTICAL DOC

TRICKS OF THE TRADE

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MacGyvering Increased Intraocular Pressure

A novel approach to improve lateral canthotomy and cantholysis

by TERRANCE MCGOVERN, DO, MPH, JUSTIN MCNAMEE, DO, AND NILESH PATEL, DO, FACOEP, FAAEM

The Case

A 24-year-old male presents to the ED late Saturday night after leaving the local watering hole. One may say he had a few too many, but according to the patient, he was just "minding his own business" when he was "sucker punched" in the right eye. The patient now is unable to see out of his right eye. On exam, you find severe periorbital edema, decreased visual acuity, and an afferent pupillary defect (Marcus-Gunn) in the right eye. A CT of the head and maxillofacial bones is performed, which is negative for intracranial hemorrhage or retrobulbar hematoma. After fluorescein staining, you check the intraocular pressure only to find it to be 45 mm Hg. As an emergency physician, you begin to have flight of ideas: Is there any indication to perform a lateral canthotomy without a retrobulbar hematoma? Visualization to perform the procedure is a problem due to edema. Is there a trick to improve visualization and prevent iatrogenic globe rupture?

Indications for Lateral Canthotomy

Emergency physicians are commonly taught that the indication for lateral canthotomy and inferior cantholysis is acute trauma with a retrobulbar hematoma causing an increase in the intraocular pressure. While this is a classic example, and an appropriate indication to dust off the iris scissors, it is far from the only reason to perform this potentially vision-saving procedure.[1–5] Orbital compartment syndrome (OCS) is an ophthalmologic emergency that, unfortunately, is on the rise due to increasing use of antiplatelet and anticoagulant medications.[1] In turn, emergency physicians across the country are going to be called upon more frequently to perform a decompression of the orbit in a timely fashion. Studies suggest permanent vision loss can be seen in as little as 30 minutes once the intraocular pressure (IOP) threshold is met.[2] Prompt recognition and familiarity with the indications to perform a lateral canthotomy are crucial to improve the chances of preserving the patient's vision. This begets two questions: When do you perform a lateral canthotomy? And does releasing the inferior tendon from the bony orbit improve outcomes?

When discussing outcomes of a lateral canthotomy, most studies look at intraocular pressure as the primary outcome of the trial. With regard to IOP, a 2009 article by Lima et al showed a greater reduction in intraocular pressure was achieved by lateral canthotomy and cantholysis (30.4 mm Hg) compared with canthotomy (14.2 mm Hg) or cantholysis (19.2 mm Hg) alone, answering the age-old question of whether inferior cantholysis is helpful.[1]

The indication to perform a lateral canthotomy does not change regardless of the underlying cause. Astute emergency physicians will attempt to uncover the cause of OCS in the setting of multiple etiologies not commonly mentioned in texts or the literature. The commonly cited retrobulbar hematoma is only one of many underlying etiologies requiring emergent decompression. Others include orbital cellulitis; foreign material; orbital edema (trauma, massive fluid resuscitation, thermal injuries); orbital emphysema; intraocular injections; postoperative complications from periorbital surgery; caustic injuries; or retrobulbar hemorrhage from thrombolysis, sickle cell disease, or leukemia.[1] In the setting of any of the aforementioned injuries or disease processes, physicians should look for primary or secondary indications to perform a lateral canthotomy to preserve vision. Primary indications include proptosis and decreased visual acuity or IOP >40 mm Hg, while secondary indications are more subjective findings such as an afferent pupillary defect (APD), ophthalmoplegia, nerve head pallor, or a cherry red macula (see Table 1).[3] Physicians should look for any sign of orbital compartment syndrome and immediately move forward with a lateral canthotomy once the decision is made because "time is vision."

A Paper Clip and a Morgan Lens: Tricks for Lateral Canthotomy

Performing a lateral canthotomy is a heroic—yet stressful—potentially vision-sparing procedure all emergency physicians prepare for and yet rarely perform. When the time comes to perform a lateral canthotomy, emergency physicians may play back *Roberts & Hedges' Clinical Procedures in Emergency Medicine* in their mind to carry out each step. It seems so simple, almost mindless, to cut the lateral canthal tendon—that is, until you add in the periorbital edema and chemosis that impairs visualization for the procedure. While there are several strategies to help improve visualization, and therefore success rates, using a paper clip bent into a hook to displace the eyelid for the procedure is a safe adjunct and utilizes equipment easily found in any ED.

Any time emergency physicians perform a procedure such as a lateral canthotomy, providers experience a surge of endogenous catecholamines leading to tachycardia, perspiration, and even tremors. With one slip of the hand, the iris scissor point can accidentally penetrate the lateral aspect of the globe, leading to an iatrogenic globe rupture. What if this fear could simply be put to rest by a device readily found in all EDs? A Morgan lens can be placed on the cornea prior to the procedure to act as a shield to prevent iatrogenic globe rupture.

Equipment (see Figure 1)

1. One Morgan lens
2. Medium-sized paper clip
3. Topical anesthetic ophthalmic drops (eg, tetracaine)
4. Standard equipment for lateral canthotomy and cantholysis

Technique

1. Place the patient in a comfortable supine position at a height suitable for you to perform the lateral canthotomy and cantholysis.
2. Bend the medium-sized paper clip into a hook with a handle (see Figure 2) that can be used to retract the eyelids for the procedure (see Figure 3). (Paper clips can be used for both upper and lower eyelids if deemed necessary for visualization.)
3. Place two drops of topical anesthetic ophthalmic drops into the eye in which you will be performing the lateral canthotomy. (**Caution:** Do not use the anesthetic drops prior to checking the pH if the underlying etiology is a caustic exposure.)
4. Place the Morgan lens into the affected eye prior to the start of the lateral canthotomy and cantholysis (see Figure 3). No irrigation fluid is necessary.
5. Have an assistant use the paper clip to hook the eyelid and retract it to improve exposure and visualization during the procedure (see Figure 4).
6. Perform the lateral canthotomy and cantholysis (see Table 2).

Table 1. Indications & Contraindications to Perform a Lateral Canthotomy

PRIMARY INDICATIONS	SECONDARY INDICATIONS	CONTRAINDICATIONS
Proptosis	Cherry red macula	Globe rupture
Decreased visual acuity	Afferent pupillary defect	
IOP >40 mm Hg	Nerve head pallor	
	Ophthalmoplegia	

Table 2. Lateral Canthotomy & Cantholysis Procedure Steps

STEP 1	Clean and prepare the skin overlying the lateral canthus of the affected eye.
STEP 2	Inject 1–2 cc of lidocaine with epinephrine into the lateral canthus.
STEP 3	Apply a hemostat from the lateral canthus to the bony orbit for 30–90 seconds.
STEP 4	Remove the hemostat and cut the demarcated area 1–2 cm laterally.
STEP 5	Using forceps and paper clips, pull down the lower eyelid to visualize the inferior lateral canthal tendon, then cut through the tendon.
STEP 6	After releasing the inferior canthal tendon, reassess the IOP. If IOP is still >40 mm Hg, elevate the upper eyelid to visualize the superior canthal tendon and cut through it.

Patient Selection

This technique is typically applicable to cooperative pediatric and adult patients who will allow the insertion of a Morgan lens onto their cornea. In the case of an uncooperative patient, procedural sedation may be used in order to successfully and safely perform the procedure. The use of a paper clip and Morgan lens remains very valuable after procedural sedation and prior to the onset of the lateral canthotomy.

Caution

A 2002 *Canadian Journal of Emergency Medicine* article by McInnes and Howe reports several complications of lateral canthotomy, ranging from minor postoperative bleeding and infection to the most-feared complication, iatrogenic globe rupture.[3] Our proposed technique for performing a lateral canthotomy and cantholysis protects against iatrogenic globe rupture. However, it potentially increases the risk of corneal abrasions due to placing the Morgan lens over the cornea. In a risk-benefit analysis, most providers would opt for a corneal abrasion as opposed to an iatrogenic globe rupture. The Morgan lens also provides a sense of comfort by having a physical barrier present during this critical procedure and period of high stress.

Caution should be exercised when placing topical anesthetic drops into the eyes of patients who have suffered a caustic injury. A litmus-paper test to determine the pH prior to placing the drops should be performed because topical anesthetic drops, in theory, could lower the pH, leading to worsening injury or permanent vision loss.[4]

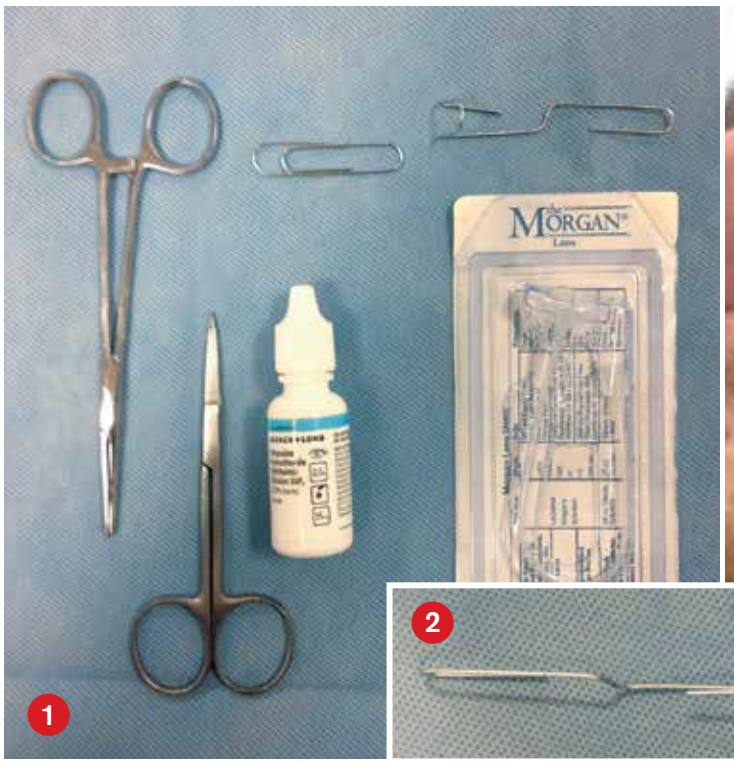

Figure 1. Equipment needed for the lateral canthotomy and cantholysis.

Figure 2. A medium-sized paper clip bent into a hook with a handle.

Figure 3. How to place the Morgan lens and use the paper clip for better visualization.

Figure 4. Have an assistant use the paper clip to hook the eyelid and retract it to improve exposure and visualization.

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The Night Shift: Is Sleep Overrated?

by PATTI VAN LEER, MD

You have just finished an overnight shift and are driving home after you stayed in the emergency department an extra hour to complete your charts. It was a difficult shift, with one STEMI, a bad child-abuse case, a trauma resuscitation that did not go well, and an overabundance of abdominal complaints necessitating multiple rectal exams—you are 100 percent exhausted. You came to a stop in a line of cars at the red light and must have drifted off to sleep for a few seconds because you now have an angry driver from the car ahead of you at your window screaming, "You hit my car! Have you been drinking?" Your overnight shift is turning into a morning-after nightmare!

As emergency physicians, we are shift workers and have to develop strategies to accommodate the disruptions that occur with shift work. How do we prevent such episodes as the one above from occurring?

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Assess Your Sleep Situation

To start, let's look at your current situation. Answer the following three questions by choosing the answer with which you identify most.

1. In anticipation of an overnight shift, my plan of attack for sleep is:

- **A.** What plan? I can sleep whenever and wherever. I can sleep until 6 pm if I want!
- **B.** I try to take a nap before the overnight shift, but it never works.
- **C.** I try to sleep until at least 3 pm the day after an overnight, but I find myself awake at noon and exhausted but unable to fall back asleep.
- **D.** What plan? I have two kids and administrative duties. An overnight is just a missed night of sleep.

2. On a typical overnight shift, I find myself:

- **A.** Ready for anything!
- **B.** Inserting a caffeine IV while taking shots of espresso.
- **C.** Fading around 4 am and desperately pacing to stay awake.
- **D.** Wondering how comfortable the stretchers are for napping.

3. Working overnight shifts is:

- **A.** The best thing about EM.
- **B.** A necessary evil.
- **C.** An impossible task.
- **D.** Easier when you are younger.

If most of your answers are A's, you are lucky and kind of a freak of nature. Are you interested in joining our practice? We always can use more "night people."

If you answered mostly B's, C's, and D's, read on for some strategies you can use.

Combating Sleep Disorder

Shift work sleep disorder (SWSD) is common in people who work nontraditional hours. It is defined as difficulty sleeping and excessive sleepiness due to a noncircadian-based schedule. Some people with the disorder have an increase in accidents or work-related errors and increased irritability. While most of us do not have true SWSD, we probably all can identify with some aspects of the disorder.

Multiple studies have shown that night shifts are hard on the body in many ways. Studies suggest that people who work nights are at an increased risk of developing breast cancer, metabolic syndrome, and type 2 diabetes.[1] One study has determined that short-term memory is most affected by both overnight and day shifts.[2] Anecdotally, a 32-year-old physician commented that her husband has diagnosed her with "decision fatigue" after she arrives home from a night shift, citing that she has difficulty making small decisions such as what to eat or drink.

The good news is there are ways to combat the evils of night shifts. I will make a few suggestions here, but I'd also like to hear from you about the strategies that you have found helpful. Send your tips to acepnow@acep.org.

1. SLEEP!

This one seems obvious, but sleep needs to be a priority. The day after an overnight is not the best time to have someone cleaning and running the vacuum in every room of your house. Don't schedule a meeting in the middle of your daytime sleep and assume you'll be OK. Be selfish with your sleep! Let family and friends know that you are out of commission until a certain time and request that they avoid texting or calling during your sleep times. Put a sign on the door that reads, "Day sleeper, do not disturb, and do not open the door."

Anecdotally, a 32-year-old physician commented that her husband has diagnosed her with "decision fatigue" after she arrives home from a night shift, citing that she has difficulty making small decisions such as what to eat or drink.

2. DARKNESS

Our bodies want to sleep when it is dark. Create a dark, quiet place for daytime sleeping. Think about installing blackout shades on your windows to create artificial nighttime. Unplug the phone and use earplugs. One overnight attending in the Bronx wears blackout goggles on his way home from work to avoid seeing the bright sun and throwing off his sleep cycle. (Just to paint a picture, this man is 6'5" and riding the subway home during morning rush hour in a hooded sweatshirt and black metal goggles.) You can wear sunglasses home instead of blackout goggles. Your fashion sense will guide your decision.

3. SCHEDULE

A schedule that bounces from day to night, then night to day without a second to breathe is going to be hard for anyone. Some emergency physicians bundle their night shifts together, while others find that night shifts randomly worked throughout the month is better. You should experiment with both strategies and find which best fits your biorhythm and lifestyle.

4. REWARD FOR WORKING NIGHT SHIFTS

It is possible that some people just can't do night shifts. One emergency medicine program just implemented a policy where employees do not have to do nights in the third trimester of their pregnancy. Many EDs do not require physicians over a certain age to do night shifts. One hospital in the Northeast has shortened the night shift from midnight to 6 am so that the overall impact on sleep is less.

Certain medical and psychiatric conditions, for example, seizure disorders, depression, and attention deficit hyperactivity disorder, are also affected by overnight shifts. Does your practice have specific guidelines for who is not required to work night shifts? This is a discussion that should take place. Many departments offer compensation for night shifts to ease the pain.

5. DRIVING

The solution to driving after a night shift was developed by a residency director in Washington, D.C. She recommends that if you come to a stoplight, put your car into park. If you then doze off, drivers behind you will beep their horns and alert you that it is time to move. You cannot inadvertently run into the car in front of you with this fail-safe strategy.

The reality of emergency medicine is that night shifts are not going to disappear. Further, most hospitals are trying stay fiscally sound 24-7. The general population is working a less-traditional 9 am to 5 pm business schedule, leading more and more people to work nontraditional hours in the future. We will need to know how to treat this disorder not just for ourselves but also for our patients.

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EM LITERATURE OF NOTE

PEARLS FROM THE MEDICAL LITERATURE

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The ACEP tPA Clinical Policy Saga Continues

The changes enshrined in this draft are substantial. The 2013 version made two recommendations regarding the use of IV tPA in the emergency department.

by RYAN PATRICK RADECKI, MD, MS

In 2013, ACEP updated its clinical policy for the use of intravenous tissue plasminogen activator (tPA) for the management of acute ischemic stroke in the emergency department.[1] This statement, eight years in the making, was published jointly by ACEP and the American Academy of Neurology (AAN) and endorsed by the Emergency Nurses Association and the Neurocritical Care Society.

Now it's toast.

The ensuing outcry following its publication, followed by an ACEP Council resolution to reconsider the content, has led to a wholesale revision. Most important, even more than the proposed changes to this policy, were the changes to the clinical policy process, with improved adherence to rating methodology, an open comment period to draft policies, and improved management of conflict-of-interest (COI) issues. The last issue, management of COI, was a substantial source of prior controversy, covered in part by an investigative piece about untrustworthy guidelines in *The BMJ*.[2] The authorship of this new version of the tPA policy has changed, and any association with the AAN is conspicuously absent.

The changes enshrined in this draft are substantial. The 2013 version made two recommendations regarding the use of IV tPA in the emergency department. The first, a Level A recommendation reflecting a high degree of clinical certainty, recommended tPA be offered to ischemic stroke patients meeting National Institute of Neurological Disorders and Stroke (NINDS) criteria who are treatable within 3 hours. The second, a Level B recommendation reflecting moderate clinical certainty, recommended tPA be offered to patients meeting European Cooperative Acute Stroke Study (ECASS) III criteria who are treatable between 3 and 4.5 hours. A caveat provided for this second recommendation noted the US Food and Drug Administration license for tPA is limited to 3 hours, with the subsequent application for extension having been rejected.

Many emergency physicians felt these recommendations placed them in a difficult position by endorsing a treatment with significant adverse effects. While stroke neurologists and the American Heart Association forged ahead, with substantial contributions from Genentech, a vocal cohort of emergency physicians continued to express reservations and call for more data. In March 2014, the Australasian College for Emergency Medicine outlined a position statement indicating tPA was a potentially beneficial treatment for stroke but such treatment could not be considered a standard of care in light of conflicting evidence.[3] Then, in September 2014, the UK Medicines and Healthcare Products Regulatory Agency reopened a review of the "balance of benefits and risks" of the use of tPA for stroke.[4] Now this new tPA policy draft shifts ACEP in the same direction.

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Rather than giving treatment with tPA the Level A recommendation in this go-around, there is a new Level A recommendation (requiring high clinical certainty). It concerns the greatest fears of treatment with tPA, the risk of intracerebral hemorrhage (ICH):

"The increased risk of symptomatic intracerebral hemorrhage (approximately 7 percent compared to a baseline of 1 percent) must be considered when deciding whether to administer IV tPA to acute ischemic stroke patients."

Essentially, based on a systematic review of randomized trials and observational registry data, the only consistent finding suitable for a Level A recommendation was a recognition of the serious adverse effects of systemic thrombolysis.

Treatment with tPA within 3 hours now becomes a Level B recommendation:

"With a goal to improve functional outcomes, IV tPA may be given to carefully selected acute ischemic stroke patients within 3 hours after symptom onset at institutions where systems are in place to safely administer the medication."

Along with the downgrade in strength of the recommendation, the language also addresses the systems necessary to administer tPA. One safety concern shared by many emergency physicians stems from the generalizability of trial and registry data collected at dedicated stroke centers staffed by stroke neurologists. Many practice settings do not have access to the same level of subspecialty, radiology, and nursing expertise as the centers conducting stroke trials, resulting in less-safe conditions for treatment.

Use of tPA in the 3–4.5-hour time frame remains a Level B recommendation:

"Despite the known risk of symptomatic intracerebral hemorrhage and the variability in the degree of benefit in functional outcomes, IV tPA may be given to carefully selected acute ischemic stroke patients within 3 to 4.5 hours after symptom onset at institutions where systems are in place to safely administer the medication."

Finally, the clinical policy authors added a new Level C recom-

CONTINUED *on page 22*

mendation, based on expert consensus, suggesting patients must be included in the decision-making process:

"Shared decision-making between the patient (and/or their surrogate) and a member of the health care team must include a discussion of potential benefits and harms prior to the decision whether to administer IV tPA for acute ischemic stroke."

While this ultimate recommendation seems simply like sound, ethical practice, there are several publications from the stroke neurology literature suggesting patients ought be given tPA under "implied consent" as the "standard of care." This recommendation reinforces the obvious necessity of a full patient and surrogate involvement when administering a medication with potentially devastating consequences. In other words, informed consent should be obtained for tPA administration.

Guidelines ought to accurately reflect the strength of the evidence, not the collective wishes and hopes of a small cohort of experts. Happily, this new version makes profound strides in sticking to appropriate grading of the evidence.

It should be noted, however, the clinical policy summarized here is only a draft, open for feedback to all concerned parties, as part of the new writing process. In general, it is a laudable effort regardless of one's personal stance regarding tPA in acute ischemic stroke. Guidelines ought to accurately reflect the strength of the evidence, not the collective wishes and hopes of a small cohort of experts. Happily, this new version makes profound strides in sticking to appropriate grading of the evidence. That said, there are a handful of aspects in which this policy could potentially be improved:

- The policy statement describes shared decision-making and cites two examples of information graphics potentially usable for illustration of the risks and benefits. However, it is very clear from stroke trials the risk-benefit ratio differs depending on many factors, including stroke severity, specific stroke syndromes, and individual patient substrate. Several models have attempted to individualize the risk of symptomatic ICH compared to baseline with uncontrolled diabetes, uncontrolled hypertension, and age the most important predictors. The policy statement alludes to a need for further research necessary to tailor treatment to the individual patient but understates this critical need. Considering it has been 20 years since the original NINDS trial, still having inadequate evidence with which to guide decision-making is nonsensical. This document could be a powerful platform with which to state clinical equipoise and call for additional placebo-controlled trials.
- The Level B recommendation for the 3–4.5-hour time window is difficult to justify based on the stated recommendation criteria. The authors rate the one positive study, ECASS III, as Class II evidence based on potential for bias. Class III data from ATLANTIS and IST-3, however, provide negative data. ATLANTIS was modified several times (including due to safety monitoring) before ultimately settling on a 3–5-hour time window and was then stopped early for futility. IST-3 suffered from an open-label design but was particularly unfavorable within the 3–4.5-hour window, with 31.5 percent having good outcomes given tPA compared with 37.7 percent in the control group. The individual-patient meta-analysis further cited in support of the 3–4.5-hour window derives most of its patients from these three trials, providing limited additive information. This probably does not meet their stated criteria for a recommendation with "moderate clinical certainty."
- Several statements use vague terminology to describe the specifics of treatment. Each recommendation for tPA use mentions "carefully selected patients" and "systems in place to safely administer the medication." If the recommendations propose strict adherence to ECASS III or ECASS III enrollment criteria, this should be clearly stated. Likewise, if "systems in place" refers to a certification such as The Joint Commission Advanced Comprehensive Stroke Center, this should also be clarified.
- Ultimately, even though the document explicitly states it is not intended to represent a legal standard of care for emergency physicians, it will certainly be wielded as such to either protect or crucify. To that end, it could use language specifically protecting the clinician who chooses not to offer tPA, in recognition of the persistent uncertainty responsible for the downgrading of recommendations from Level A.

But these are only my initial reactions, subject to the limitations of my own knowledge base and biases. Luckily, this document was open to feedback from all emergency physicians. The comment period closed March 13, 2015. The final policy should be forthcoming.

I hope you made your opinions known!

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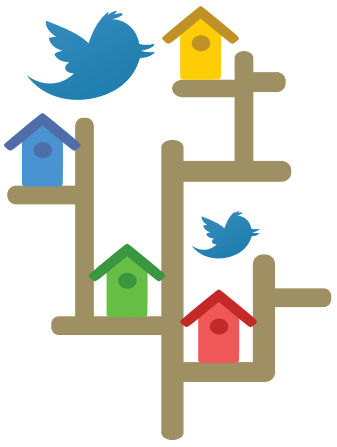
SERVING UP THE BEST EM TWEETS

THE FEED

DR. FAUST is an emergency-medicine resident at Mount Sinai Hospital in New York and Elmhurst Hospital Center in Queens. He tweets about #FOAMed and classical music @jeremyfaust.

Too Much Twitter? Try These Other FOAM Resources



by JEREMY SAMUEL FAUST, MD, MS, MA

The most common question I am asked about Free Open Access Medical Education (FOAM) is, "Do I have to be on Twitter?" The answer I give is, "No, but you should be." But for some, the format doesn't mesh for them. Some people just want links to high-quality FOAM content without having to sift through comments and opinions regardless of how expert they may be. Here are a few great ways to do this. For other suggestions, check out Thoma et al in the October 2014 *Annals of Emergency Medicine*.[1]

1 Search by topic using a FOAM-only search engine. Generally, Googling a topic itself is far too clumsy if you are looking for good resources on a particular topic. (Go ahead—I dare you to try a few topics; some work reasonably well, and some don't.) Try GoogleFOAM.com. This will bring up only FOAM resources on any topic.

2 Consume only the latest and greatest content curated by a trusted source. At the moment, the Life in the Fastlane Review (http://lifeinthefastlane.com/tag/litfl-rv/) is the most trusted and utilized. Their weekly reviews promise "the very best of global #FOAMed emergency medicine and critical care education." It sounds Paleolithic, but you can actually sign up for email notifications so that when the latest review comes out, you get a good, old-fashioned email, if email is your thing.

3 Instead of searching out individual FOAM websites, use Rich Site Summary (RSS) feed, which syndicates many different websites into one feed—the way a TV channel creates a lineup from various shows. Feedly, for example, is both an app and a website that brings you a feed of only the content you want. If you wanted nothing but FOAM, you could subscribe only to "FOAM EM," and you would always know what's going on. You can also subscribe to some peer-reviewed journals. One strength of Feedly is that you can tag any post as "save for later," and whenever you have time, you can check your saved file and find a slew of interesting content you'd been meaning to consume. It's a lot less clunky than emailing links or files to yourself or saving them on your computer, that is unless you have a pristinely organized system for that sort of thing. I do not.

4 Visit a FOAM database such as FOAMbase.org (which I have mentioned in "The Feed" previously). FOAMbase, created by my coresident Ben Azan, MD, has two especially useful features. The first is a table of contents of FOAM resources organized by category. Looking for FOAM on pediatrics or neurology or procedures? Those resources are all in one place. The other great feature of FOAMbase is that takes what Feedly does and adds a social dimension to it. Anyone can submit a new FOAM resource along with a brief description of the content, and others can comment and up or down vote on the quality of the content.

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5 inally, there's Reddit.com. I resisted checking out Reddit for the longest time, but I finally caved. Verdict: it's good once optimized for our purposes. Reddit is actually quite similar to FOAMbase once you've set it up. For better or worse, there is a ton of other content on Reddit, and unfortunately, by default that content is thrust upon you when you first join (and it is pretty terrible content at that). In fact, if you make a Reddit account, the first thing you will want to do is find the "edit" button, find "my subreddits," and unsubscribe from *everything* that you were automatically subscribed to. After that, you can search for FOAMed (www.reddit.com/r/foamed) and subscribe only to it. Once you've done that, you will have created a beautiful haven of FOAM-only links similar to Feedly and FOAMbase. The links in the FOAMed subreddit are only ones that other users have actively added to the feed. That's unlike Feedly, which incorporates new FOAMed posts automatically regardless of the quality. Like FOAMbase, you can easily add suggestions of your own, and you can easily promote your own FOAM if you are trying to get the word out on your new blog or podcast. Both FOAMbase and Reddit have comment sections, though these are currently fairly quiet.

So there you have it: five ways to find great FOAM content without—perish the thought—having to be on Twitter.

Reference

1. Thoma B, Joshi N, Trueger NS, et al. Five strategies to effectively use online resources in emergency medicine. *Ann Emerg Med.* 2014;64:392-395.

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

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Emergency Physician

Cambridge Health Alliance, Cambridge MA

Cambridge Health Alliance, a nationally recognized, award-winning health system is seeking a full-time board certified/board eligible Emergency Physician to join our exceptional team. The Cambridge Health Alliance Department of Emergency Medicine staffs three community Emergency Departments located in the Greater Boston offering varied practice environments. We provide outstanding and innovative care to a diverse patient population. Our team of almost thirty physicians and thirteen physician assistants serves approximately 100,000 patients annually across the three sites and has lead us to become a national model for patient flow.

We are looking for a dedicated physician who excels in a collegial environment, is willing to grow professionally and help shape future clinicians. As a Harvard Medical School teaching affiliate, we offer ample teaching opportunities with medical students and residents. We have an electronic medical record, and offer a competitive benefits and salary package.

Please send CV's to: **Benjamin Milligan, MD, FACEP, Chief, Department of Emergency Medicine**, Cambridge Health Alliance. 1493 Cambridge Street, Cambridge MA 02139. **Email:** bmilligan@cha.harvard.edu. EOE. www.challliance.org

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TEG The Emergency Group, Inc

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.

Southeast Alabama Medical Center

Excellent opportunity for full- or part-time ABEM/AOBEM BC/BP emergency medicine physician to join our well-established single hospital group.

Annual ED volume 60,000. Equitable scheduling with 7-day block off each month. 420-bed Level 2 trauma center serves 600,000+ as the area's regional referral center. Excellent subspecialty and hospitalist support.

Big city medicine in a congenial small-town community, low cost of living, excellent family-oriented quality of life. Active outdoor recreation area; beautiful Gulf beaches within 75 miles.

Current opportunities to teach medical students; be part of planning for future residency training.

Competitive hourly rate with productivity bonus and malpractice allowance. Educational loan repayment available.

Contact Sarah Purvis, SAMC Physician Recruiter sbpurvis@samc.org or 1-800-248-7047 ext. 8145

SEEKING A BE/BC EMERGENCY MEDICINE PHYSICIAN

to work full time in our new 16 bed state-of-the-art Emergency Department at Soldiers + Sailors Memorial Hospital with annual volumes estimating 18,000. Our group of physicians and allied health staff work in an environment highly motivated by a "team approach" with excellent rapport with Medical Staff. We offer 12-hour shifts in the ED and have very skilled support and nursing staff. Our system is dedicated to keeping up with technology, keeping our community healthy as well as an excellent work environment. If you are an outdoors person, our community offers some of the best recreational activities in the Northeast. Our community has a great variety of cultural activities, such as theater, music, dance and art, as well as excellent schools for our children.

- 146 shifts per year - 7A-7P or 7P-7A
- Salary competitive with the most recent MGMA salary guidelines
- 16 hour PA-C/CRNP coverage

For more information on this opportunity, contact:
Tracy Manning
570-723-0509
Fax: 570-724-2126
Email: tmanning@laurelhs.org

Susquehanna Health
Soldiers + Sailors Memorial Hospital

SusquehannaHealth.org

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HAWAII

EMERGENCY MEDICINE PHYSICIAN OPENING

Surf, Snorkel and Hike among the Hawaiian Islands

Hawaii Emergency Physicians Associated (HEPA) is looking for experienced Emergency Medicine physicians who desire more in their practice and are looking to experience the natural surroundings of living and working on the islands.

CREATE THE WORK/LIFE BALANCE THAT'S RIGHT FOR YOU!

You'll enjoy great benefits including fair and flexible scheduling; a true partnership opportunity that allows you to invest in your future and builds your nest egg.

- **Employed with Partnership Availability**
- 10.5 Month Work Schedule - 110-130 hours/month
- Generous Employer Retirement Contribution
- **$40,000 Sign-on Bonus Offered**
- Full Complement of Benefits - CME Allowance
- **14 Year Average Individual Tenure Within Group**
- Ask About Our "Island-Hopper" Opportunities!

HEPA
HAWAII EMERGENCY PHYSICIANS ASSOCIATED

Contact **JD Kerley** at **(877) 379-1088** or email your CV to **HEPA@EMrecruits.com**

Andrew Pacos, MD
Senior Vice President, Clinical Affairs

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Emergency Medicine Physicians

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Grand Strand Regional Medical Center
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Racine, WI
58,000 volume
Assistant Medical Director

Garden Park Medical Center
Gulfport, MS
38,000 volume

St. Vincent's Blount Medical Center
Oneonta, AL
13,000 volume

Christian Hospital Northeast-Northwest Healthcare
St. Louis, MO
55,000-58,000 volume

St. Joseph Hospital
Lexington, KY
45,000 volume

Providence Centralia Hospital
Centralia, WA
33,000 volume

El Centro Regional Medical Center
El Centro, CA
50,000 volume

Memorial Hermann The Woodlands Hospital
The Woodlands, TX
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Texas - Austin

Everyone's moving here for a reason!

Enjoy the live music, stunning lakes, and a laid-back culture while delivering concierge-style, patient-focused care in a stunning, brand new, facility.

Five Star ER is owned and operated by the physicians of Emergency Service Partners, L.P., an Austin-based physician partnership that has earned the respect of Texas hospitals since 1998.

Four locations opening this year, all designed for patient comfort and medical staff efficiency. Exceptional benefits.

You belong here!

Contact Lisa Morgan at lisa@eddocs.com and mention job #289744-11.

Texas - Seton Medical Center

Harker Heights opened in 2012 to serve a booming Central Texas area near Waco, Temple, Killeen, and Fort Hood.

Residents enjoy easy access to the sights and sounds of Austin.

Come join a great ED team with active, engaged leadership. The modern 17-bed ED sees 40,000 patients per year with mid-level support.

Emergency Service Partners, LP offers productivity-based compensation, full benefits including generous 401(k), and true partnership opportunity in as little as one year.

Contact Lisa Morgan at lisa@eddocs.com and mention job #285070-11.

Texas – Bryan-College Station Area

Work as few as 6 days a month and be a partner in your practice!

Openings for Family Medicine-boarded and EM-boarded emergency physicians. Convenient and easily accessible location midway between Dallas and Houston. Madisonville offers easy transfers to a nearby Level II trauma center.

$10,000 start-up incentive for full-time physicians!

Emergency Service Partners, L.P. is committed to both physician and patient satisfaction, with flexible scheduling plus paid malpractice and tail insurance.

Contact Renaldo Johnson at renaldo@eddocs.com and mention job #266647-11.

WASHINGTON, Olympia:

Full-time, partnership track opportunity for residency trained BC/BE emergency physician. Established, independent, fee-for-service democratic group. Annual volume 67,000+.

State-of-the-art deparment located on the scenic Puget Sound.

Send CV to Kathleen Martin, 413 Lilly Rd. NE., Olympia, WA 98506 or kathleen.martin@providence.org

University of Florida

College of Medicine – JACKSONVILLE

The University of Florida Department of Emergency Medicine is recruiting motivated & energetic emergency physicians to **join our new UF Health – Northside Emergency Department in Jacksonville.**

Live and play at the beach.

Work and learn with academic colleagues on the cutting edge of

- simulation
- ultrasound
- advanced airway management
- critical care and wellness.

Be part of a growing and supportive academic faculty that will work to help establish your professional goals.

UF Health – Northside will begin as a 28 bed full-service, free-standing emergency department with six observation beds. There will be comprehensive radiology and laboratory services, and consultation will be available from all UF Health specialty and sub-specialty services. Phase 2 of this project will include the addition of 99 inpatient beds to this facility. This is a rare opportunity to get in on the ground floor of an exciting project, and take care of patients in a beautiful, state-of-the-art emergency department.

Join the University of Florida Faculty 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.grayeurom@jax.ufl.edu

EOE/AA Employer

4MEMERGENCY

OHIO - Parma

EM Physician - Full and part time positions available at UH Parma Medical Center. This 39 bed ED has an annual volume of 41k, with 36 hours of physician coverage and 36 hours of independent midlevel coverage. UH Parma is a Stroke & Chest Pain Center and is pursuing Level III Trauma Center status. Located 11 miles from downtown Cleveland, Parma was recently recognized by Businessweek Magazine as one of the best places in Ohio to raise a family! 4M Emergency offers an extremely competitive compensation and benefits package including: signing bonus; incentive plan; family health, dental, and vision plan; 401k with 100% match up to 6% of earnings; malpractice with tail; paid life & long/short term disability; HSA contribution.

To learn more about our practice, please contact Erin Waggoner at (888) 758-3999 or ewaggoner@4Mdocs.com.

EmCare is seeking a Medical Director at Christus Hospital St. Elizabeth in Beaumont, TX.

We are also seeking ED physicians and mid-levels with EM experience to join our team there as well as Christus St Mary in Port Arthur and Christus Jasper Memorial Hospital in Jasper.

Contact Craig McGovern at (727) 437-0846 or Craig.Mcgovern@emcare.com.

For more info visit www.emcare.com

Corpus Christi Texas

EmCare has a new Site Medical Director opportunity located on the crystal clear oceanfront of Corpus Christi Texas, within the Christus Spohn Health System. We seek those candidates with proven and innovative leadership skills.

Christus Spohn Health System is the largest hospital system in South Texas with 3 metro and 3 rural locations in/near Corpus Christi. Currently, we are seeking F/T ED physicians and mid-levels with EM experience to join our team at these Christus Spohn locations.

For more details, please contact: David Guffey at (423) 322-9574 or david.guffey@emcare.com.

For a complete list of openings, visit www.emcare.com

March madness.

Huge signing bonuses come with strings attached. Sure, you might not see them right away, but after a few months of taking marching orders from suits who have never cared for EM patients, you'll feel the maddening pull. EMP is 100% owned and managed by EMP physicians. We have more than an excellent benefits package. We have a voice: equal vote day one and equal partner opportunity, no buy-in. Join EMP and you'll be marching to the beat of EM physicians who are passionate about caring for patients– and each other.

EMP
Emergency Medicine Physicians

March to your own beat. Visit emp.com/jobs
or call Ann Benson at 800-828-0898. abenson@emp.com

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