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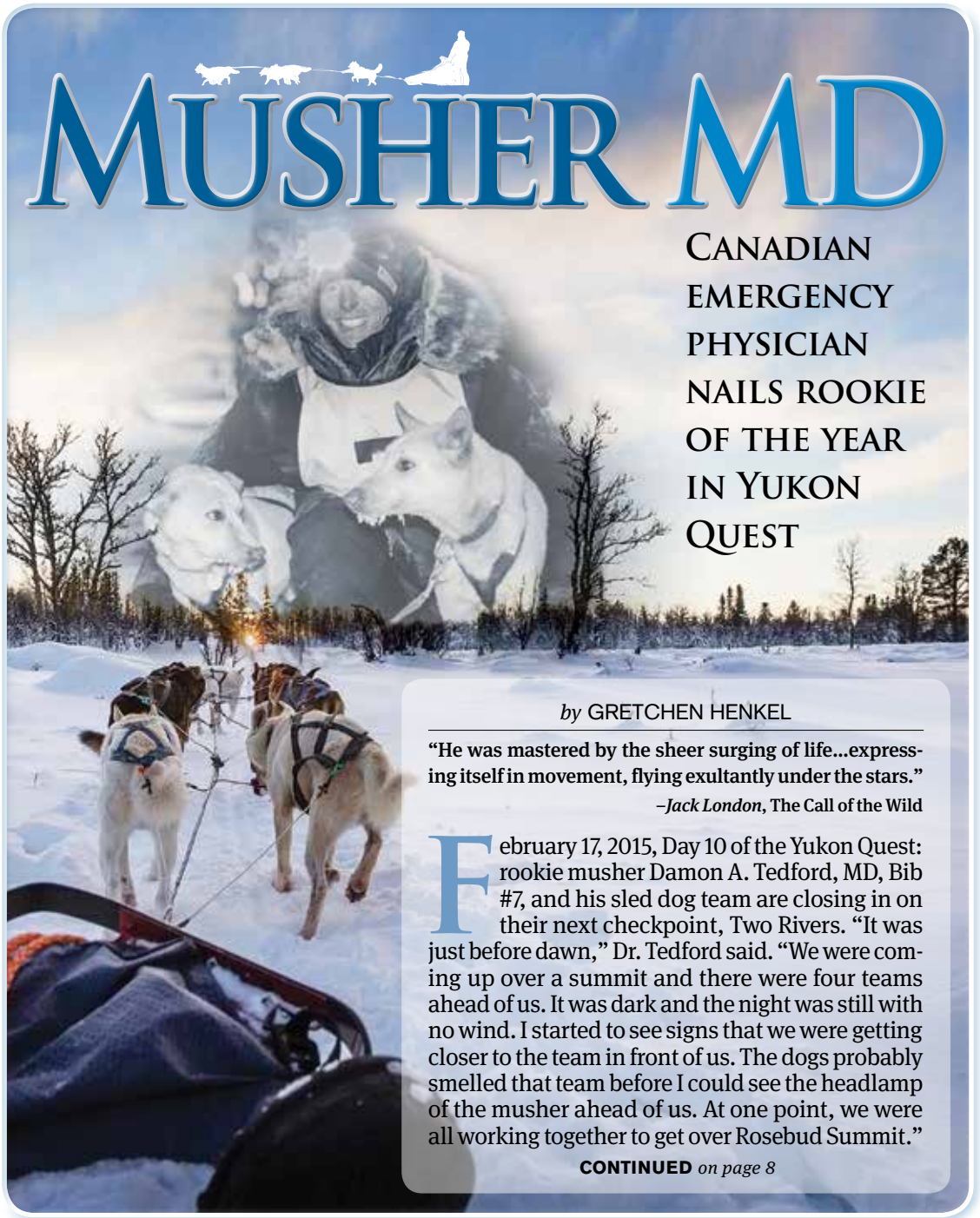

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MUSHER MD

Canadian emergency physician nails rookie of the year in Yukon Quest

by GRETCHEN HENKEL

"He was mastered by the sheer surging of life...expressing itself in movement, flying exultantly under the stars."
–*Jack London*, The Call of the Wild

February 17, 2015, Day 10 of the Yukon Quest: rookie musher Damon A. Tedford, MD, Bib #7, and his sled dog team are closing in on their next checkpoint, Two Rivers. "It was just before dawn," Dr. Tedford said. "We were coming up over a summit and there were four teams ahead of us. It was dark and the night was still with no wind. I started to see signs that we were getting closer to the team in front of us. The dogs probably smelled that team before I could see the headlamp of the musher ahead of us. At one point, we were all working together to get over Rosebud Summit."

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A Vision for the Future: Presidential Priorities

AMA President Dr. Steven Stack keeping it real on MOL and MOC

On June 9, 2015, Steven J. Stack, MD, FACEP, was sworn in as President of the American Medical Association (AMA). Dr. Stack recently spoke with ACEP Now *Medical Editor-in-Chief Kevin Klauer, DO, EJD, FACEP, about the licensing and certification challenges facing emergency physicians.*

Check out the May issue of ACEP Now *or visit **ACEPNow.com** to read the first part of this conversation.*

DR. KEVIN KLAUER: I'm hearing a lot of discontent from physicians regarding licensure and being able to get licensed from one state to another. The Federation of State Medical Boards (FSMB) is looking at this, and its interstate licensure compact makes a lot of sense. How does the AMA feel? Should this be a national process or state-by-state determination of participation?

DR. STEVEN STACK: This is one of the joys of our federal system of government, right? It's a state's rights kind of issue, and at the highest level, the AMA has policy that opposes national licensure and that supports state-based licensure. Part of the premise is that this is one of the ways where the states are accountable for the safety and well-being of their citizens. State-based licensure is the

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THE PARAMEDICINE DEBATE

PRO **FILLING THE GAPS IN OUR SYSTEM**

CON **911 ALTERNATIVE DESTINATIONS**

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THE BREAK ROOM

Klauer Dizzy After Taking a Neurological Spanking

Comment

Good to know that computed tomography (CT) scans are worthless in these cases. I will be sure to send a copy of this article to the patient I recently saw with dizziness and an acute brainstem infarct on CT scan. He had just been sent home from a stroke center with no CT scan.

How does this balance with the malpractice payout for missed stroke diagnosis? How about factoring in the time spent responding to patient complaints and to peer review?

Take-home point: CT is not worthless in the evaluation of dizziness. It is what the patient expects; it is what the peer-review panel (in retrospect) will expect. A normal CT makes for a happy patient and protects the doctor, very worthwhile in my opinion.

—Alan J. Sorkey, MD
Shreveport, Louisiana

Response

Alan, I sense some tension in your voice. You are wise to recognize that many patients do not fit our anticipated paradigm(s) for stroke presentation and do not have to conform to our diagnostic expectations either. Having said that, I think the question at hand is whether to image or not as opposed to the use of CT or magnetic resonance imaging (MRI). The data are clear. Compared to CT, diffusion-weighted MRI is better suited for the evaluation of acute cerebral ischemic events in general and, in particular, posterior fossa ischemia. I would speculate that this patient presented with enough clinical findings (ie, not isolated dizziness) that appropriately prompted the need for imaging, and if MRI were selected, the referenced patient's brainstem infarct would have been identified. Thus, the identification of the infarct on CT, to me, speaks more to the severity of the infarct than it does to the superiority of CT to diffusion-weighted MRI.

I couldn't agree with you more that if MRI is not available, CT may be the only alternative. However, providers should be well aware of its limitations and consider informing patients of the same. I would also suggest that whenever possible, we begin to change our ordering patterns to move from CT to MRI for evaluation of posterior fossa ischemia, which may eventually improve availability of this important diagnostic modality.

As risk managers, we have to part ways in our thinking. First, as outlined in my original

CONTINUED *on page 4*

article, appropriate patient selection is key. If the patient is very low risk for posterior fossa ischemia, imaging *may* not be indicated (ie, isolated dizziness odds ratio 0.20 for serious neurological cause). Although reducing utilization, meeting patient expectations, and reducing one's professional liability risk is a challenging and fine balance, I would suggest that overutilization of CT, which is known to be inferior for the disease being looked for, shouldn't be the answer. I do agree that patients have expectations. However, until we ask each individual patient, we cannot presume to know what those expectations are; communication is key. I do agree that many may expect imaging. However, most patients will not possess the sophistication to fully understand if imaging is indicated or not and which imaging modality is best for their presentation. It is our job to shape expectations, educate our patients, and employ shared decision making to meet the patient's needs. I believe that this approach substantially reduces risk to the patient and the providers. Again, if CT is utilized, the provider should include an explanation of its limitations. Otherwise, patients may be left with the impression that normal CT means no stroke or serious neurological disease, and that is a path toward medical-legal disaster.

Thank you, Alan, for submitting this very important perspective.

—Kevin M. Klauer, DO, EJD, FACEP
Medical Editor-in-Chief, ACEP Now

Comment

Since a large percentage of posterior fossa strokes are from vertebral artery dissections, what is the value of CT angiograms?

—Chuck Pilcher, MD, FACEP
Kirkland, Washington

Response

Thank you for your question. To provide some additional background for the readership, in general, dissections are responsible for 2 percent of all ischemic strokes but are more of a concern in those under 45 years, representing 20 percent of ischemic strokes in this age group. The annual incidence of spontaneous carotid dissection has been estimated to be 2.5 to 3 per 100,000 while that of vertebral arteries is 1 to 1.5 per 100,000.[1,2] The most common symptoms associated with vertebral artery dissection are vertigo (58 percent), headache (51 percent), and neck pain (46 percent).[2] Although CT angiography may demonstrate a vertebral artery dissection, MRI/MRA is the preferred diagnostic modality for vertebral artery dissection.[2]

—Kevin M. Klauer, DO, EJD, FACEP
Medical Editor-in-Chief, ACEP Now

SEND YOUR THOUGHTS AND COMMENTS TO ACEPNOW@ACEP.ORG

Comment

Although it is good to see an emphasis on the diagnosis of the dizzy patient, Dr. Klauer is perpetuating another myth—that "nystagmus is unreliable." He is right that the mere presence of any kind of nystagmus does not help to differentiate peripheral from central causes of the acute vestibular syndrome. However, that is akin to saying that "the presence of ECG changes is unreliable" for diagnosing an acute coronary syndrome (ACS). All abnormalities are not created equal; a flat T wave does not have the same significance as ST segment elevation.

It's the same with nystagmus. Its mere presence does not always help—but the *kind* of nystagmus is *very* helpful to the diagnostician in sorting out the cause of dizziness. Some of the source for this comes from the Chase article, but this article (I was an author) only described presence or absence of nystagmus (unfortunately, this is the way more emergency physicians chart it), but it's not meaningful.[3]

In a patient with ongoing dizziness, one should be hesitant to diagnose vestibular neuritis or labyrinthitis if there is *no* nystagmus. The nystagmus is "direction-fixed"—ie, the fast component always beats to the same side no matter what direction the patient is looking in.

On the other hand, direction-changing nystagmus in this setting means that there is a central process (probably stroke). So does torsional or vertical nystagmus. Patients with peripheral causes will have direction-fixed horizontal nystagmus.

In positional (episodic) dizziness, these rules shift. Emergency physicians must learn some of the details about nystagmus as it can really help us to make a confident diagnosis. The presence/absence of nystagmus, but more important, its quality, is very helpful in making a specific diagnosis in dizzy patients.

—Jonathan Edlow, MD
Boston

Response

Jonathan, thank you for submitting your thoughts. I will certainly defer to your expertise on this topic and appreciate the work you have done to improve our understanding of headache and other serious neurological diseases.

Honestly, I don't think, fortunately for me, we are that far apart on our thinking.

My statement, "Nystagmus is an unreliable sign and does not differentiate serious neurological disease from other causes of dizziness," was made in reference to the article by Chase et al, which stated, "Nystagmus was only present in one-third of those with stroke and in one-fifth without stroke."[3] Thus, nystagmus is an unreliable sign with respect to ruling in or ruling out stroke, particularly when, as you noted, many emergency physicians only document its presence or absence.

This is much akin to the ECG analogy you provided: "'the presence of ECG changes is unreliable' for diagnosing an acute coronary syndrome." Although I agree completely that all ECG changes are not created equal, I do think

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UPDATES AND ALERTS FROM ACEP

NEWS FROM THE COLLEGE

Want to Make Things Better? Submit a Council Resolution

The deadline to submit a resolution to the Council is July 27, 2015. Over the course of two days, the Council will consider dozens of resolutions that will shape the direction of ACEP for the coming year and beyond. Get your idea or policy considered at the Council meeting Oct. 26–29, 2015, in Boston by following these guidelines:

- Resolutions must be submitted by at least two ACEP Councillors or by any component body represented in the Council.
- Resolutions may be submitted by mail, fax, or email (preferred). Resolutions are due at least 90 days before the Council meeting. Submit resolutions to:

  Sonja Montgomery
  Governance Operations Director
  American College of Emergency Physicians
  PO Box 619911
  Dallas, TX 75261-9911
  email: smontgomery@acep.org
  fax: 972-580-2816

- Resolutions consist of a descriptive Title, a Whereas section, and a Resolved section. The Council only considers the Resolved section when it votes, and the Resolved section is what the Board of Directors reviews to direct College resources.
- There are two types of resolutions: general resolutions and bylaws resolutions. General resolutions require a majority vote for adoption, and bylaws resolutions require a two-thirds vote.
- Councillors receive the resolutions prior to the annual meeting along with background information and cost information developed by ACEP staff. Resolutions are assigned to reference committees for discussion at the Council meeting on day one. You, as the author of your resolution, should attend the reference committee that discusses your resolution.
- The Council considers the recommendations from the reference committees on the second day of the Council meeting. The reference committees present each resolution, providing a recommendation and summary of the debate to the Council. The Council debates each resolution and offers amendments as appropriate.
- Any ACEP member may attend the Council meeting, but only credentialed Councillors are allowed to participate in the floor debate and vote. Past Speakers and Presidents may participate in floor debate and address the Council with ordinary recognition by the Speaker. Other members may address the Council at the discretion of the Speaker, and such requests must be submitted in writing to the Speaker before the debate.
- When considering a resolution, the Council's options are to adopt the resolution as written; adopt as amended by the Council; refer to the Board, the Council Steering Committee, or the Bylaws Interpretation Committee; or not adopt (defeat or reject) the resolution.
- ACEP has more resources on the resolution process at www.acep.org/council. Review the "Guidelines for Writing Resolutions" for tips.
- Writing and submitting Council resolutions keeps our College healthy and vital. A Council resolution is a great way for members to provide information to their colleagues and ACEP leadership. Please take advantage of this opportunity and exercise your rights as part of our emergency medicine community.

ACEP Councillors vote on resolutions at the 2014 meeting.

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THE PARAMEDICINE DEBATE

FILLING THE GAPS IN OUR SYSTEM

There's a role for mobile integrated health care practice

by MELISSA W. COSTELLO, MD, FACEP

- *"Mrs. A is back with her CHF. She was discharged yesterday, but she didn't have a ride to go get her prescriptions filled."*
- *"Mr. B is hearing voices again. They say it is cold outside, and he is hungry."*
- *"Mrs. C is dying and with hospice. The family called her doctor when she started having trouble breathing, and the recording told them to call 911 if it was an emergency."*
- *"Miss D is here because she wants to get off of drugs."*
- *"Mr. E could go home, but he lives alone. I guess we will have to admit him."*

Every one of the hypotheticals above represents a case in which someone has fallen through a gap in our health care system. Successful 21st-century health care systems must provide continuous care across all aspects of inpatient and outpatient care from cradle to grave. Mobile Integrated Healthcare Practice (MIHP) is a growing and evolving practice of medicine that incorporates new and existing resources in the out-of-hospital environment in an effort to remedy the multitude of discontinuities that exist in our health care system. Some call this "community paramedicine." While accurate to describe some systems, this discounts the enormous variety and potential of MIHP around the country and across the whole spectrum of providers and patients.

Powerful motivation exists for hospitals to develop care networks and teams of providers working collaboratively in the prehospital, in-hospital, posthospital, and clinic environments to help patients better participate in their care, smoothly navigate the system, and enjoy healthier and longer lives. We are seeing rapid consolidation of practices into bigger systems, but we have not effectively identified a way to handle the transition between different settings. There are gaps created by timing of discharges, availability of follow-up, communication failures between in-hospital and out-of-hospital physicians, legal barricades, high demands on outpatient practices, geographic distances, provider shortages, access to care, and, more generally, 24-7 needs in a nine-to-five world. Failure to address these gaps breeds increased length of stay, increased 30-day readmits, decreased patient experience of care, and, at worst, progression of disease or death.

MIHP is collaboratively designed through careful analysis to fill in the unmet needs of a community. Those who argue that MIHP is unnecessary, duplicative of existing services, or infringes on their scope of practice have not taken a careful look at the benefits of MIHP as they can be tailored to each community. A well-designed MIHP creates no redundancy, collaborates seamlessly, and →

911 ALTERNATIVE DESTINATIONS

Unproven assumptions and patient-safety risks underlie paramedicine diversion programs

by THOMAS J. SUGARMAN, MD, FACEP

Community paramedicine (CP) supporters argue that diverting 911 patients from the emergency department decreases costs, ambulance wall time (the inability to offload patients in the ED), and ED crowding while providing more appropriate care. Unfortunately, data do not support these assertions. Prehospital diversion of 911 callers threatens patient safety, undermines the prudent layperson definition of an emergency, and erodes Emergency Medical Treatment & Active Labor Act (EMTALA) protections.

CP Diversion Poses Danger to Patients

Over the past 40 to 50 years, the United States has trained people to call 911 for perceived medical emergencies, EMTALA was enacted, and ACEP fought to establish the prudent layperson definition. Once requested via 911, an ambulance is dispatched to provide needed prehospital stabilization and transport the patient to an ED. The ED identifies emergency medical conditions and provides stabilizing care without regard for ability to pay. CP programs risk changing that paradigm. If the paramedic determines the patient to be nonurgent, then the paramedic decides, perhaps partially based on payer class, where to transport the patient or perhaps even refuses to transport. We will switch from a prudent layperson to a prudent paramedic definition of an emergency.

There are no validated protocols demonstrating that paramedics have the training, experience, and ability to determine which conditions are nonurgent and, of those nonurgent conditions, which can be safely and efficiently cared for in alternative settings. A 2014 review found that "nearly all of the studies published to date have found significant rates of under-triage by EMS personnel, ranging from a low of 3 percent to a high of 32 percent."[1] The authors opine, "If it is difficult for experienced emergency nurses to accurately identify nonurgent patients, is it reasonable to ask whether paramedics working in the field can do better?"

As part of the paramedic assessment done in an austere, prehospital environment, some CP programs require a wallet biopsy to determine if the patient has the correct health coverage. The paramedics then decide if the proposed destination has the capability and willingness to care for the patient's presumed condition. If the patient has the wrong funding or the destination cannot provide the needed care, what will happen? Will 911 be accessed again? Will the →

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offers several benefits when added to existing services, including:

- **24-7-365 availability:** MIHP is designed as an around-the-clock system. Many communities choose to build MIHPs upon the existing emergency medical service and public service systems. The equipment and personnel to provide dispatch and basic medical assessment and the ability to bring provider to patient already exist within the infrastructure and in a 24-7 model.
- **Scope of practice:** MIHP models include a variety of independent or paramedical practitioners (physician assistants, nurse practitioners, paramedics, basic emergency medical technicians [EMTs], social workers, psychologists, nurses, etc.) who work in collaboration with online and offline physician medical direction. Incorporation of EMTs and paramedics is common because the MIHP scope of practice is distinct from that permitted by most state boards of nursing, particularly as it pertains to unscheduled visits. Recent objections to the development of MIHP have come from the home health industry, which is puzzling. MIHP can do so much to augment the ability of a talented home health nurse to keep patients in their homes and can provide additional resources to both home health and hospice nurses in cases where the nursing scope of practice is restrictive. MIHP is not home health, and it is not meant to replace this valuable and unique work. MIHP provides an important partner for home health, hospice, and primary care practices to help patients remain in their homes safely around the clock.
- **Matches needs to resources:** MIHP has the ability to provide or arrange transportation to many potential destinations suited to the patient's and family's needs, including psychiatric facilities, primary care offices, urgent care clinics, drug treatment, congestive heart failure clinics, hospice intake, respite care centers, homeless shelters, and the ED when indicated. It also allows the collaborative establishment of a care plan that may evolve over several hours to days and include multiple visits by the MIHP provider in a 24- to 48-hour period. It is designed to get the right patient to the right resource in the right way at the right time.
- **Virtual house calls:** Technology is making the gap between the hands and eyes in the field and the education and experience of the physician smaller and smaller. Secure, portable, streaming video platforms; robust wireless networks; and the growing acceptance of telemedicine are allowing the virtual house call to be a reality. Getting that technology into the patient's home for simple follow-up becomes an important part of the role of MIHP without the cost of a physician or nurse visiting the home or the patient requiring ambulance transport to a clinic.
- **Responsiveness to monitoring:** Our ability to monitor patients from home is growing, but what can we do with the data? MIHP adds the ability to respond to abnormalities or changes in the patient quickly (within minutes to hours) rather than the next day. All physicians want to make sure their discharged patients are safe at home. MIHP provides a skilled partner who is available to check on the patient at any hour of the day or night.
- **Patient advocacy:** MIHP providers are highly attuned to the multiple barriers to care in their own community and have the time and training to help patients get the resources they need in the most cost- and time-efficient ways. MIHP provides the "knowledgeable friend" who is crucial to getting patients what they need to be successful postdischarge.
- **Community support:** MIHP can help supplement the income of small, rural services by completion of many patient care visits between emergency calls using providers who are already in the community every day. Low-volume systems are able to maintain critical 911 coverage while helping fellow community members avert readmits, medical catastrophes, or long trips for simple follow-up visits.
- **Decreased length of stay and readmits:** How many inpatients could go home sooner if the physician had a reliable MIHP partner to see patients in 12 to 24 hours, review their medications and instructions, check their vital signs, or just make sure they have eaten or know how to use their new glucometer? Could we avoid an admission if the congestive heart failure clinic nurse could send the MIHP service to the house with a dose of IV furosemide and a plan to reassess in six hours? Home health fills some of these roles in some communities but not all of them, not 24-7-365, and not unscheduled. The competing goals of shorter length of stay and fewer readmits require new resources to keep patients safe.

Could we avoid an admission if the congestive heart failure clinic nurse could send the MIHP service to the house with a dose of IV furosemide and a plan to reassess in six hours?

The next time you stand in your ED, slap your forehead, and say, "Why is this here in the ED?" or "Why didn't we prevent this?" or "Where did the system fail?", you have identified the foundation for your MIHP program. With complex systems, payment incentives, looming penalties, an aging population, and a flood of newly insured patients, failure is not an option. Preservation of sacred cows, at the expense of patients, is not an option. MIHP is not a magic bullet, but it is another important and infinitely customizable tool in the building of the brave new world of health care delivery.

DR. COSTELLO is director of emergency medicine at Mobile Infirmary Medical Center in Mobile, Alabama, medical director, air methods for Baptist LifeFlight and Mississippi MedFlight, and President of Alabama ACEP.

CON CONTINUED

patient receive a bill for the clinic visit and the subsequent ED visit? Or because EMTALA only applies in hospital settings, will the patient not receive needed care?

The premise that paramedics can safely and quickly determine who has an urgent medical problem discounts emergency physician expertise. Perhaps the most important service emergency physicians provide is the diagnostic acumen to rapidly determine which patient has an emergency. Do we really think that a paramedic with 10.5 additional hours of training (as under the Orange County, California, plan) can safely ascertain if an emergency exists, even for specified complaints?[2] What about identifying significant hemarthrosis in a patient with seemingly minor extremity trauma who happens to have a coagulopathy? What about an apparent viral illness in an immunocompromised patient? The toothache that is a myocardial infarction? Emergency physicians complete medical school and a three- to four-year residency to master the crucial skill of considering and ruling out the worst case. If paramedics can safely identify these unusual but not infrequent problems in the field, then what is the value of an emergency medicine residency?

Paramedicine Won't Solve ED Crowding or Cost Problems

The purported benefits of CP diversion programs are highly questionable. Although ambulance wall time is a worsening problem, it is unlikely that low-acuity patients contribute to this. Most EDs care for less-urgent patients in an efficient fast track. During busy times, ambulatory patients are triaged and moved to a waiting area, freeing the ambulance to return to service. Typically, only patients unable to ambulate or sit remain on a gurney. It is doubtful that many of these sicker patients can be safely diverted to alternative destinations.

Diverting 911 patients will not mitigate ED crowding; ED crowding is due to boarding. As emergency physicians know, the major contribution to ED boarding is the inability to disposition patients after the ED evaluation is complete. For admitted patients, it is because of bed availability. For discharged patients, delays in disposition are often due to insufficient follow-up resources. For these patients, CP programs will not improve the system; patients cannot be transported to other locations if an alternative destination does not exist or does not have the capability and willingness to evaluate and treat them. Simply changing the destination does not improve access to care; rather, it limits timely access to needed emergency care.

Lastly, when comparing the cost of care between EDs and clinics, the comparison must be apples to apples. ED costs generally are bundled per visit (facility, doctor, lab, radiology), but clinic costs usually do not include ancillary testing or consultations, nor do cost-saving estimates include the cost of the CP service or the second visit for those patients referred from alternative destinations to the ED.

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What about identifying significant hemarthrosis in a patient with seemingly minor extremity trauma who happens to have a coagulopathy? What about an apparent viral illness in an immunocompromised patient? The toothache that is a myocardial infarction? Emergency physicians complete medical school and a three- to four-year residency to master the crucial skill of considering and ruling out the worst case.

Recognizing the patient risks of CP programs, the ACEP Board of Directors wisely included this final bullet in the October 2014 ACEP CP policy:

> *"Assurances that if a person calls 911 (or similar emergency number) for a patient's apparent emergency medical condition or medical emergency and requests an ambulance, the patient has a right to a medical screening examination and stabilizing treatment by a qualified medical person in accordance with EMTALA. For the purposes of an EMTALA-mandated medical screening exam, paramedics and community paramedics are not believed to be qualified medical persons."*[3]

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DR. SUGARMAN is chairman of emergency services at Sutter Delta Medical Center in Antioch, California.

MUSHER MD

CONTINUED FROM PAGE 1

To help the dogs maintain their speed, he ran and pushed the sled rather than standing on the runners. "We were all sweating together, and you could only hear our breaths as we worked to close the distance with the musher ahead of us. It was almost as if we were hunting as a pack," he said. "It was incredible, a magical experience."

It's a thousand miles from Whitehorse to Fairbanks, and during the 10-day Yukon Quest, mushers experience numbing cold, sleep deprivation, and hunger. These are the conditions which Dr. Tedford, an emergency physician at Surrey Memorial Hospital in Vancouver, BC, had been training for since last October. Running the sled dog race in February delivered exactly what Dr. Tedford had hoped it would: the opportunity to challenge himself. From his experiences in the military and as an ultra-marathon runner, he understood that physical challenge leads to a satisfying sense of accomplishment. "When you push yourself to your limit and get to the point where you don't think you can go any further, you just feel energized by it," he said.

His training and determination paid off. At the end of that early morning, six-hour run to Two Rivers, his team overtook the other team. He was on track to secure fourth place and won Rookie of the Year honors.

Attraction to Medicine

Seeking challenge appears to have been a guiding principle in the 37-year-old Dr. Tedford's career choices as well. He joined the military after high school, graduated from the Royal Military College in Kingston, Ontario, and served five years with the First Battalion of the Princess Patricia's Canadian Light Infantry. His last deployment, as a light armored vehicle captain, was in 2006 to Kandahar, Afghanistan. "I got into the army because I wanted to help people and I wanted to be challenged," he said. During his tours in Afghanistan, part of the mission was to form liaisons with local police officers, heads of families, and community power brokers. Where he and other soldiers had difficulty trying to make connections with local populations and authorities, Dr. Tedford observed that medics and physicians were able, "in the blink of an eye," to establish trust as they came to the aid of locals in need of medical attention. That ability to quickly foster trust was a quality that led him to consider a career in medicine when he finished his military service.

ABOVE: Dr. Tedford in Dawson. PHOTO/PAT KANE

LEFT: Dr. Tedford in Braeburn. PHOTO/PAT KANE

BELOW: Dr. Tedford at the finish line with his lead dogs Chile (left) and Woody (right). PHOTO/JULIEN SCHRODER

Training for the Race

Dr. Tedford's initial exposure to dog sledding was a one-hour introductory trip run by an adventure company in Algonquin Park, Ontario. The trip was a Christmas present from his partner Lauren Kimball, MD. He was immediately captivated by mushing and resolved to explore the possibility of participating in a full-on endurance run, such as the Iditarod.

Last summer, Dr. Tedford became interested in doing a 1,000 mile endurance sled dog run and contacted Mitch Seavey, a two-time Iditarod champion (who just finished second behind his son Dallas Seavey in the Iditarod on March 18). The three-generation Iditarod family also breeds and trains sled dog teams and leases teams to qualifying mushers. Mitch's father, Dan Seavey, was the oldest musher, at 74, to run the race on the 40th anniversary in 2012.

Seavey explained that in order to run the Iditarod, Dr. Tedford would have to run several qualifying races and for the 2015 season, there wouldn't be time. However, entry into the Yukon Quest, he noted, was possible, if Dr. Tedford were willing to run shorter qualifying races. The Yukon Quest began in 1984 (the Iditarod, its renowned counterpart, was first run in 1973). After relocating to Seavey's kennel in Sterling, Alaska, Dr. Tedford ran in the Gin Gin 200, the Copper Basin 300, and the Northern Lights 300, exceeding the Yukon Quest qualifying requirement to run at least one 200-mile and one 300-mile race. "The qualifying races helped with my confidence level," Dr. Tedford recalled. "I had no previous racing experience, so it was useful to get out and run the dogs during these qualifying races to see the effectiveness of our training and implement the tempo we planned to run during the Yukon Quest."

Working with his leased sled dog team comprised the major portion of Dr. Tedford's four-month training regimen. Learning to care for the dogs is both essential to bonding with them and a racing requirement—on the race trail, veterinarians examine every dog at the beginning of the race and at six checkpoints to

be sure that they are staying healthy.

Dr. Tedford cared for the dogs daily, tending to their feeding and cleaning up their kennel areas. Working with the dogs every day, he said, allowed him to learn more about their individual temperaments. He learned it was necessary to put extra effort into making a connection with the dogs and to "make sure they felt comfortable around me." While one of the dogs, Bumper, was friendly and extroverted, other shyer dogs needed a bit more attention. Dr. Tedford socialized with these dogs more, bringing them along on errands in the car, or letting them sleep in the cabin with him at night.

Dr. Tedford praised Seavey's guidance and savvy knowledge about dealing with adult learners. The veteran musher emphasized that Dr. Tedford needed to create a secure environment for the dogs. "That's essentially what everybody wants, isn't it? If you can create an environment that's secure, the dogs will know what's going on and what's expected of them," said Dr. Tedford. "They're more relaxed. They're just happier animals, and you sort of fall into that pack structure with them." Leaving the dogs after the 10-day race, he said, was hard.

Now back at work in Vancouver, Dr. Tedford said it may be a while before he attempts another long distance run, but he is determined to help promote the sport. He reflected that running the race was a peak experience: "At those limits of fatigue, hunger, and even cold, you really just feel charged by it. It's remarkable to be out there, to see the northern lights and to be with the dog team in areas where no one else is."

Regimen on the Trail

DR. TEDFORD'S USUAL RACE ROUTINE was to run for five to six hours and then rest for five hours. During that rest period, he fed his dogs, bedded them down for their rest, and treated any injuries with massage or compression wraps. After those tasks, he usually got only two hours of rest per stop.

Homemade soups and stews, frozen flat in one-gallon-Ziploc bags, comprised his most common meal items. He ate two times a day, once during each stop, after reheating the meal in the water he boiled for the dogs' meals. He also carried a large tube of peanut butter in his jacket, along with lots of chocolate and trail mix for snacking on the move.

Still, he lost about 15 pounds during the race. "With the cold temperatures this year, it was hard to keep weight on," he said. The temperature often dropped to -40 degrees Celsius, said Dr. Tedford. He wore multiple layers and a good-quality down parka and overalls, kept his hands warm with a high loft mitten, and also used hand warmers. However, when the temperatures are low and the snow is coarse, the musher has to put protective booties, thick canvas sacks with an elastic-Velcro strap that tightens just above the wrist, on each dog to protect their feet. Putting these booties on requires dexterity requiring no gloves or a pair that will not stick to Velcro. "In any case, you are wearing no gloves or thin ones, so putting 56 booties on was a slow process in -40 degree Celsius temperatures," Dr. Tedford said. "I often needed to reheat my hands in my armpits to prevent frostbite. When you are tired, cold, and hungry, the little things can wear you down mentally. If you let them, they'll sit on your shoulder and nag you until a small problem seems like a catastrophe. Learning to shake off that feeling is a skill. Mitch had a way of reminding us to stay focused that I really appreciated. 'Just mush,' he would say. It was like a reset button; a way of returning to the things that really mattered: how the dogs were running and their health. As the training progressed and during the race, it turned into a positive self-talk mantra for me."

Dr. Tedford applies ointment to a wrist before wrapping it during a rest stop in Pelly Crossing.
PHOTO/JULIEN SCHRODER

All in all, the greatest challenge for Dr. Tedford was leaving the dogs at the end of the season. "You really form an incredible bond with these animals. They just work so incredibly hard for you. It was hard to say goodbye and return to Vancouver."

GRETCHEN HENKEL is a medical journalist based in California.

Why Palliative Care? Why Now?

The Choosing Wisely *campaign and ACEP efforts are encouraging emergency physicians to address palliative care options in the ED*

BY REBECCA GOETT, MD, MARNY FETZER, MD, KATE ABERGER, MD, FACEP, AND MARK ROSENBERG, DO, MBA, FACEP

The *Choosing Wisely* campaign is making a big push to involve palliative care in the emergency department. Also, Michael J. Gerardi, MD, FAAP, FACEP, President of ACEP, has put palliative care in his strategic plan for this year, but why the ED?

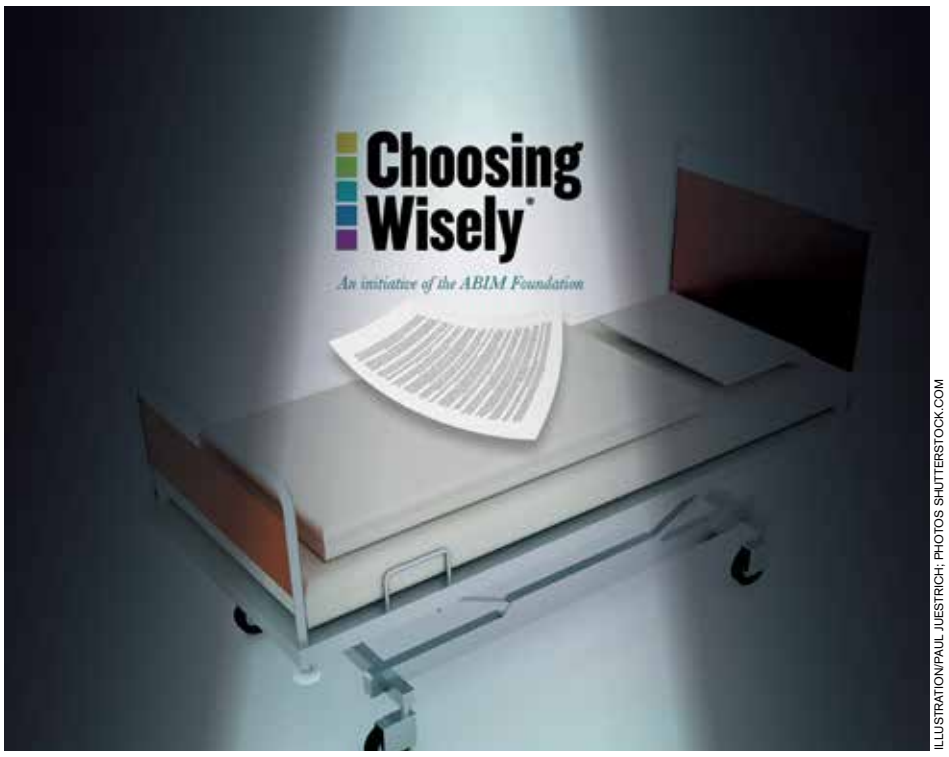
We are caring for many patients with advanced chronic obstructive pulmonary disease, congestive heart failure, dementia, and other chronic conditions. More than 133 million Americans, or approximately 45 percent of the U.S. population, have at least one chronic disease.[1,2] These chronic diseases are responsible for more than 1.7 million, or seven out of every 10, deaths in the United States.[1–3] For the seriously ill, the ED is a staging area, which makes ED providers positioned to "screen and intervene."[4]

Ideally, most conversations about a patient's goals or prognosis wouldn't happen in the ED, but they do. Often, the ED sees chronically ill patients declining without them understanding their waning medical situation or "having the talk" with their provider.[5] This is likely due to a combination of factors: shrinking availability of primary care, lack of education and training by providers to discuss prognosis, and our silo system of medical subspecialties.[5–10] In 2013, the US Department of Health and Human Services predicted the need to increase the number of primary care providers (PCPs) by 14 percent. However, the expected number of PCPs will only increase by 8 percent.[11]

The average Medicare patient has seven different doctors, with the more chronically ill patients visiting approximately 11 doctors in seven different practices within the same time frame.[11] Patients still aren't getting the opportunity to talk about the "big picture" (their goals) or their health's decline.[10]

Often, these patients enter a cycle of nursing home to hospital to subacute rehab and back again, where they eventually spend more time in the hospital and less time at home without a clear benefit from each recurrent hospitalization.[8]

Over the past five years, emergency medicine has increasingly become an important place to implement palliative care. Often, emergency providers are reluctant to take on this responsibility because we are not the patient's regular doctor, don't have time, or don't have the rapport to discuss goals of care or prognosis with a patient.[12,13] Therefore, we defer "the talk" or do not make palliative or hospice care referrals. We must remember that the ED remains a safety net for patients underserved or overlooked by our medical system.[7,14,15] This includes patients who are being underserved by their own physicians who are not informing them of their prognosis and helping plan for their medical future.[8,16] If not us, then who?



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DEFINITIONS

PALLIATIVE CARE: Patient-centered care for any patient with a serious or chronic life-limiting illness, which can ideally be implemented for years. Palliative care aims to improve patients' quality of life by providing pain and symptom relief and spiritual and psychosocial support. Integration of palliative care should be by patients' regular providers or by dedicated palliative care providers who work alongside patients' regular providers.[17,18] Palliative care has been proved to improve quality of life, reduce hospital length of stay and number of repeat ED visits, improve patient and family satisfaction, lessen utilization of intensive care units, and provide overall cost savings to hospitals.[6,18–20]

HOSPICE: A type of health care for patients in the last months of their life when curative treatments are either not available or no longer wanted by patients. Hospice enrollment enables patients with a terminal diagnosis to receive comprehensive medical care outside the hospital, including nursing visits, medications, equipment, social work, and spiritual support.[17,18] Although palliative care can overlap with hospice and the two are often lumped together, palliative care and hospice are not the same.

GO ONLINE

For helpful palliative care links, visit the ACEP Palliative Section website at www.acep.org/palliativesection. Learn more about Choosing Wisely at www.acep.org/choosingwisely.

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Are You Ready for ICD-10?

Tips to prepare for big changes in documentation

Soon, your hospital or group will be expecting you to document your emergency visits in an ICD-10-CM–friendly manner. To paraphrase a famous Vice President, "ICD-10-CM is a big %%^& deal." All emergency physicians will need to have a basic understanding of ICD-10-CM key concepts.

ICD-10 will be impossible to ignore since it is tied to physician and hospital reimbursement as well as value-based and quality-of-care metrics. The reality of working in a busy emergency department within an electronic medical record means that ICD-10 will likely present unique challenges.

ACEP has a number of ICD-10 resources designed for the busy emergency physician that can be found at www.acep.org/content.aspx?id=28754.

This article presents two experts' guidance on ICD-10.

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Vice President Reimbursement
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1. How will this impact how I document?

Dr. Jeffrey Linzer: In reality, there isn't much more required than would currently be expected for good medical documentation with the current system. The emergency physician is choosing the right term that will demonstrate why the patient was being seen and explain resource utilization. This will also help support quality metrics.

The emergency physician should consider performing a descriptive history of the present illness (HPI) instead of using checkboxes. While some electronic health records try to put this information into a "readable" format, actually dictating or free texting the HPI will provide for better details for the coder to be able to extract information. In documenting the physical exam, the emergency physician should also be clear as to the location of the problem, including laterality (left, right) and in some cases anatomic site (eg, proximal, distal, forearm, upper leg).

Dr. Pamela Bensen: The diagnosis is like a user ID, and ICD-10-CM codes are like the password—they must match to open the payment stream. ICD-10-CM will contain more than 140,000 diagnosis codes that must be selected based on the documented diagnosis. About 4,200 of the ICD-9-CM diagnosis-code pairs have a 1:1 match in ICD-10-CM (only the code numbers change, while the descriptors remain the same). However, these diagnoses match to ICD-10-CM codes that are unspecified—unspecified as to right-left, acute-chronic, type of condition, and links to etiology or manifestations. Since these codes are unspecified and represent a low severity of illness (SOI) that may not warrant medical care, many payers have decided not to pay for care related to unspecified codes. In order to get paid, emergency physicians will have to document to avoid unspecified codes by using specific words to more accurately represent the patient's SOI.

2. Why is SOI important, and how and why should I document it?

JL: Clearly documenting SOI is important regardless of which diagnosis coding system is being used. ICD-10 will allow for better clarity in identifying the severity of the problem. For example, there are codes to identify if acute respiratory failure is associated with hypoxia or hypercapnia or if a sickle cell crisis is associated with acute chest or splenic sequestration.

For patients with pregnancy-related conditions, the emergency physician will need to document the specific trimester as this will help identify risks associated with the presenting problem. In patients with severe sepsis, documentation should reflect the presence or absence of shock.

PB: Each diagnostic code has a SOI level assigned to it. The SOI is designed to represent how sick the patient really is. By adding together the SOI for each diagnosis, you can determine how sick the patient is. The higher the SOI of each diagnosis and the more diagnoses present, the sicker the patient. It is simple arithmetic. The sicker the patient, the more we can get paid.

Payers have determined exactly what resources, including physician pay, are appropriate for each diagnosis, as adjusted for concomitant comorbid conditions that contribute to the patient's SOI. The higher the total SOI, the more resources allocated to caring for the patient.

How to document for ICD-10-CM is only slightly more complicated. First, it is logical to include, in the assessment/diagnosis part of the record, every single diagnosis the patient has, which impacts the evaluation, treatment, or medical decision making of the current medical complaint.

Second, it is necessary to capture an accurate SOI for each of the diagnoses documented. Heart failure has 15 ICD-9-CM codes, each with its own SOI. ICD-10-CM has 23. Selection of the code depends on the words used in the documented diagnosis.

Finally, emergency physicians must include certain mandatory accessory information that the ICD-10-CM coding guidelines require for individual diagnoses (codes).

3. How do I document in ICD-10-CM for a patient with trauma and injuries?

JL: The majority of the new trauma and fracture codes are orthopedic related and should not directly affect the emergency physician. Many of these new codes are related to the healing phase of a fracture, something the emergency physician will not usually have to deal with directly. As in ICD-9, the emergency physician should identify the anatomic location of the fracture (eg, proximal, shaft, distal). ICD-10 does add greater specificity as to the type of fracture (eg, displaced, nondisplaced, greenstick). Much of this detail can be incorporated into the emergency physician's documentation by acknowledging the radiologist's reading of the X-ray. For those times when the emergency physician is making an independent interpretation, the documentation should include as much detail as possible. This will allow the coder to determine the correct diagnostic code.

Open wounds can now be clarified as a laceration or puncture wound. The term "complicated" open wound has been omitted; the emergency physician should document, however, if the wound is infected or has a foreign body present. Lacerations involving blood vessels and muscle bundles should be identified by anatomical location (eg, popliteal artery, posterior muscle group of lower leg).

Emergency physicians have expressed concern about when to use the term "initial" or "subsequent" encounter. These terms only apply to injuries, fractures, and related external causes. The term "initial encounter" is used whenever active treatment is being provided. This includes evaluation and continuing treatment by the same or different physicians. For example, if a patient had a laceration repaired by emergency physician #1 and was seen by emergency physician #2 three days later because of concern of infection, both encounters would be considered initial for the laceration. A "subsequent encounter" occurs during the healing or recovery phase of care. If emergency physician #3 saw the same patient for suture removal, that would be considered a subsequent encounter.

Open wounds can now be clarified as a laceration or puncture wound. The term "complicated" open wound has been omitted; the emergency physician should document, however, if the wound is infected or has a foreign body present.

PB: It is true that a majority of the new codes are for "injury, poisoning, and certain other consequences of external causes"—bread and butter for most EDs. However, only 2.5 percent of the new codes are unaffected by the need for specific documentation.

Please note that I did not refer to this as *new* documentation. Fifty percent of the documentation required by ICD-10-CM is currently required by ICD-9-CM for the codes that are both specific and represent higher severity of illness; 40 percent of the documentation for ICD-10-CM specificity is laterality, right or left. Only 10 percent is really new.

If 50 percent of the documentation is the same as ICD-9-CM, then what's the problem? The problem is that physicians are *not* taught the rules of diagnostic code selection. Each code must exactly match the terminology used in the physician diagnosis documentation. Unspecified codes are for use when information is missing from those stated diagnoses.

Most physicians do not document adequately for the higher SOI ICD-9-CM codes. So, today, many bills are submitted with unspecified codes.

Should Families Watch CPR?

Despite physician reservations, allowing families to be present during resuscitation is often the ethical choice

BY CATHERINE A. MARCO, MD, JOHN JESUS, MD, ELIZABETH PHILLIPS, MD, MA, AND GREGORY LUKE LARKIN, MD, MSPH

The Case

A 72-year-old man is brought in by emergency medical services in full cardiac arrest. He was found at home by his wife, with an unknown down time. Resuscitative efforts, including CPR, bag-valve-mask ventilation, defibrillation, and multiple rounds of advanced cardiovascular life support (ACLS) medications, by prehospital providers were unsuccessful. The nurse alerts you that the wife has arrived to the ED waiting room.

Should you invite her into the resuscitation room?

Background and Evidence

Family-witnessed resuscitation (FWR) has been controversial for many years. On the one hand, family members are at high risk for psychological trauma and may distract the providers, who may fear family response to termination of resuscitative efforts or subsequent litigation. On the other hand, FWR may give patients' family members one last moment to say good-bye and allow them to see the level of effort that went into the resuscitation.

The evidence behind the practice of FWR generally supports its use but within a specific set of circumstances. Clinical investigation started with small observational studies, which found that while health care providers' initial opinions about family member presence were mixed, most participating family members would choose to be present again and believed it aided their grieving and was beneficial to their dying family member.[1–3] Furthermore, when surviving patients were interviewed, most expressed a desire to have family members present.[4] Providing loved ones a last opportunity to say good-bye is a natural extension of the ACEP Code of Ethics Principle 7, which states, "emergency physicians shall work cooperatively with others who care for, and about, emergency patients."

These initial studies called for greater research to better elucidate what harms and benefits might exist. The first randomized, prospective trial of FWR was terminated early after just 25 enrolled subjects, without any reported psychological harms to family members, when investigators feared protocol violations by participating providers who became convinced of its benefits and resisted randomization to non-FWR.[5]

Those preliminary pilot studies were followed by the randomized, prospective trial of 570 patients conducted by Jabre et al, who found that FWR was associated with psychological benefits without any corresponding increase in provider stress or medical-legal conflict.[6] It is important to emphasize, however, that family members in the Jabre et al study were all offered a choice to participate and were always accompanied by a chaperone offering emotional support and informative explanation, and the trial involved trained personnel following a scripted protocol.[7] Underscoring the importance of provider training and guidelines is a study examining the impact of health care provider education about FWR combined with departmental guidelines, which resulted in more positive perception of family presence by health care providers and greater participation in its practice.[8]

Barriers and Pitfalls

While aforementioned concerns about FWR-induced traumatic memory and litigation are largely unfounded, other pitfalls may prevent a positive family experience during resuscitative efforts. First, it is important to set expectations for family members, whose expectations for resuscitation might come from television shows such as *ER* or *Grey's Anatomy*. Many people do not have an accurate perception of what occurs during resuscitative efforts, and some advocate that more education is needed to prepare families to attend resuscitative efforts. There is also concern that families will have a traumatic reaction or negative memories from witnessing a resuscitation. Opponents of family presence also have concerns with potential disruption of the resuscitative efforts, performance anxiety of the providers, more aggressive resuscitation efforts when family members are present, and the potential risk of litigation.[9]

ILLUSTRATION/PAUL JUESTRICH; PHOTOS SHUTTERSTOCK.COM

First, it is important to set expectations for family members, whose expectations for resuscitation might come from television shows such as *ER* or *Grey's Anatomy*. Many people do not have an accurate perception of what occurs during resuscitative efforts, and some advocate that more education is needed to prepare families to attend resuscitative efforts.

Despite these concerns, the evidence demonstrates that the overwhelming majority of family members who were present during resuscitative efforts confirm that they would repeat the experience given the choice. Resistance to family presence seems to come primarily from providers, physicians more than nurses. Overall, avoiding negative experiences can be easily achieved by increasing awareness of the benefits to both providers and families, creating a universal protocol that guides families through this experience, and allowing staff as well as family to reflect upon these difficult scenarios.[10]

Practical Guidelines

Staff education and preparation are critical to successful family presence during resuscitations. It is important to develop an institutional policy or structured guidelines that will formalize the process and optimize the experience.[11] Currently, few institutions have such specific policies or guidelines.[12] A protocol may include guidelines regarding family assessment, preparing the family, the facilitator's role, postevent family support, and postevent staff support. Development of institutional guidelines should include clinicians, advanced practice providers, nursing staff, pastoral care, social services, and patients.

CONTINUED *on page 14*

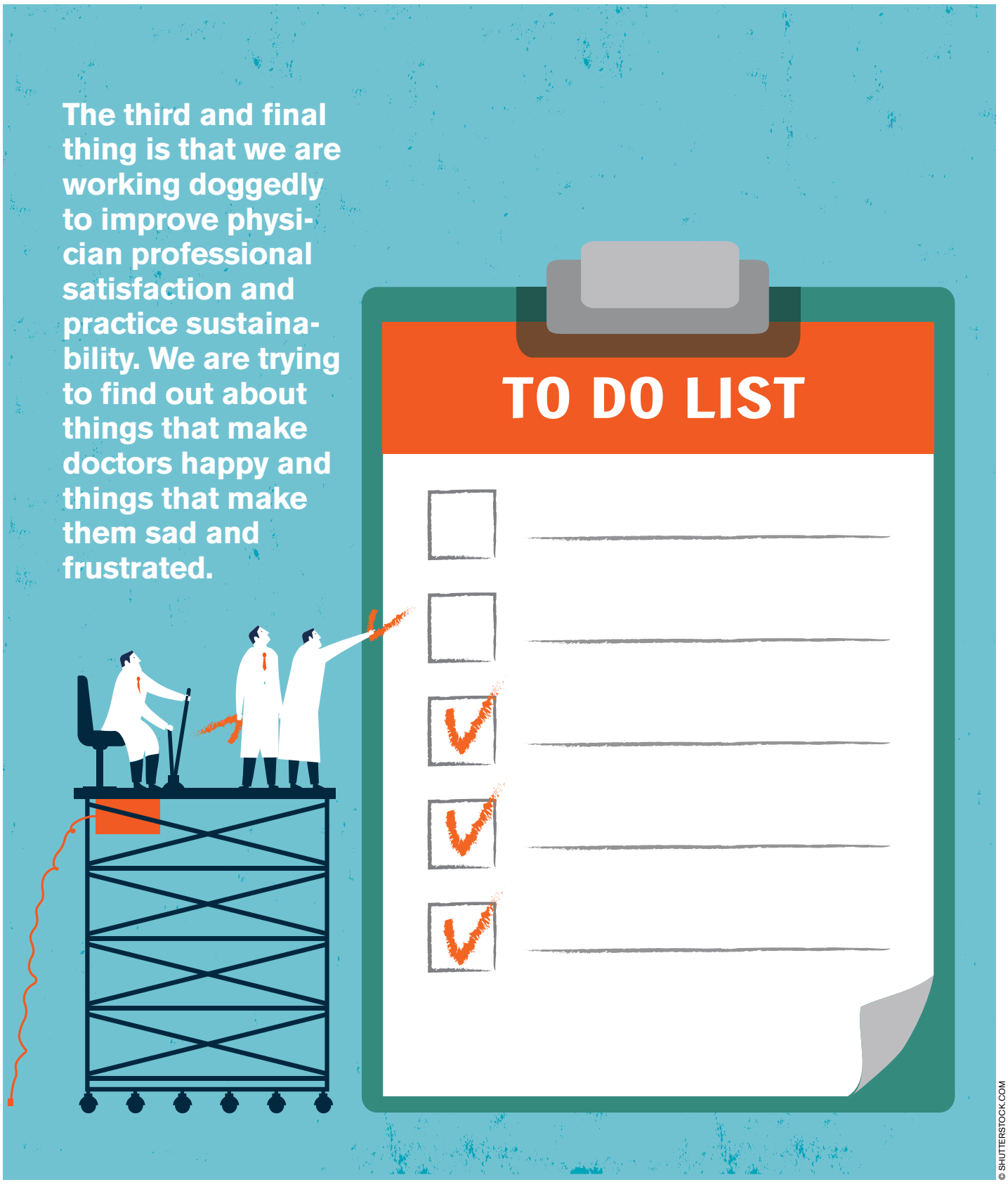
way we license all professions, and so that's not going away anytime soon.

As far as the complexity, burden, and lack of coordination across states, that has to be fixed, and there's no reason in the modern era with all the technology we have that it shouldn't be fixed. To that point, we support the FSMB's work on its compacting initiative, which would simplify and streamline being able to get additional licenses in other states. So if you have a primary license, which is your main or anchor license, there'd be an expedited process to apply for licenses in other states. You would still have to pay a fee, and you would still have to complete some paperwork, but through the compact, various agreed reciprocities between states that participate, and the use of the FSMB Federation Credentials Verification Service, a lot of that information can be prepopulated, streamlined, and simplified to lower the overall burden to physicians and the overall cost and still provide for state-based oversight for the practice of medicine. We're very supportive of the work that the FSMB is doing and have tried to partner with state medical societies to advance it so that state legislatures and state boards adopt this quickly to make it easier for physicians and so that patients have better access to docs. With the growth in telemedicine and telehealth, there is a real need to get access to scarce services to more people, and telemedicine is going to be one of the ways that probably happens.

KK: Let's discuss a related topic that is often a bit confusing for providers: Maintenance of Licensure (MOL). Some are wondering how it differs from Maintenance of Certification (MOC), but my specific question for you is regarding the frustration that docs have about MOC. Is this really a process that fosters quality of care, lifelong learning, and being a better, competent provider? Or is this just extra expense for providers and an intrusion into their practice?

SS: There's a perception among the licensure and certifying boards that there is a need for the public to know and be reassured that their physicians are engaged in lifelong learning and self-assessment throughout their careers and that they're achieving board certification. A license is not an anointment until death. It is one step in a journey that is your lifelong professional practice. Now, we can agree or disagree on whether that is the case, but it is their belief that the public is requiring this, and so they have moved forward with these different paradigms.

The board-certifying bodies are way out ahead, and the licensure boards are not, but the concern is that only 70 to 80 percent of physicians in the United States are board certified. This means that if you are licensed but not board certified, the assertion can be made that you have no expectation to demonstrate continuing competency because you're not subject to a specialty board and its requirements. Once you get your license, a lot of times, as long as you send in your check, you get to keep it unless you get into trouble with the board. Some in the licensure community have said, "We have to come up with some way to address that part of the population that is not board certified." So MOC does not equal MOL, nor does MOL equal MOC, but MOC, being a robust program to ensure the lifelong self-assessment and competency of physicians, certainly should stand in fulfillment of anything that would be required for MOL. They are very different programs, and MOL, I would say, is more intended to make sure there is some base floor of safety because licensure does not guarantee excellence, it only increases the likelihood of minimum competency. Board certification may directionally foster some aspect of excellence, but licensure is really about a minimum standard. It's not about aspiring to great things. There are more than 70 licensing boards in the United States because there are some states that have separate boards for DOs and MDs, each one of which would have to ratify, for its own internal rulemaking or state lawmaking, a process for MOL. That's going to take a long time. If some states are going to say, "Heck, we're not doing that at all," they may never do it. There are some states that are going to jump right in and want to do it. For MOC, that's a big discussion.



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The American Board of Medical Specialties (ABMS) created MOC, and they are physicians. This is not someone else—they are us. If people are upset, they need to communicate with them. The AMA has been engaged, and we have worked with the ABMS to say, "Look, these programs have to be responsive to the burden on physicians and the cost to physicians, they have to be based on evidence, and they have to be able to demonstrate they're actually improving quality and making physicians safer or better. They can't just be busy work without value." We have partnered with the ABMS to try to have its overarching structure be more flexible and more tailorable to these specific specialties so the tools that can be developed make sense because each specialty has different needs.

Here's an instance where I would say, "I'd love to think the AMA can solve everything for everybody," but it can't. This is fundamentally about specialty-certifying programs. This is a place where ACEP's role is arguably far more impactful than what the AMA's is. I just got back from California, where I spent the whole weekend with dermatologists, and they hate their board. Hate is not too strong. People were walking around with pins on, like little campaign buttons, made with the red circle and the slash that said, "No MOC." The comments people made conveyed visceral disdain, disgust, and outrage at their board. Now, if it's just one board, you can say it's just one board, but you're aware the American Board of Internal Medicine (ABIM) gave a mea culpa that was effusive. It was, "We're sorry, we were wrong" repeated over and over in their communication to their diplomats. There's a prominent group of internists, I'm not going to use names, many of whom are nationally known, who are creating their own board to directly compete with ABIM because they feel the ABIM's program is so out of touch with reasonableness or demonstrated value to their profession or patients that they are going to try to compete with ABIM and offer an alternative. It's a big deal; it's a really, really big deal.

CONTINUED *on page 14*

There were a couple of articles published in the JAMA journals with evidence that says, "Hey, it doesn't look like these programs actually improve quality or safety." The boards would likely say they have their own evidence. Maybe they were the only ones doing research in the last few years so they have evidence, but now people are energized, and there will be other doctors who demonstrate their own evidence that may tell another story. I would say that emergency docs need to speak up, and they need to speak up strongly and to the extent they feel that their board is either assessing them reasonably or that it is unfairly burdening them and giving them busy work. ACEP and the other specialty societies are on point for this because, fundamentally, this is a specialty board issue. We [AMA] will be around to be supportive and be helpful, but the individual docs in the specialties will have to push on this one.

KK: I completely agree. It's easy to look to the AMA for solutions and also to criticize the AMA when certain things don't change, but it's important to highlight the AMA can't be responsible for everything, and it doesn't have jurisdiction over all of these issues. Now a more broad-based question for you: on June 9 you were sworn in. What is the priority list for your year?

SS: The overarching response is that I will exist in service to the association. Steve Stack has no mission or agenda other than to ensure the success of the AMA, which is to help support our profession and the work we do for patients. That's not a platitude; it's real. I have no agenda. There is no Steve Stack theme. There is no, "I'm going to change the whole world to fit my image of it." I'm going to give my very best as a practicing physician who still works days, nights, holidays, and weekends, just like other emergency docs. I'm going to give the best I can and use whatever experience I have to try to shine light on physician concerns in a way that is impactful and constructively received by policy makers and other leaders in society in the hope that we can work together to make things better for physicians in our profession and for patients.

Now, the AMA has a three-part strategic plan for people who might say, "Come on, seriously, what really are you trying to accomplish?" In addition to our enormously broad advocacy work and other things we do, we're going to try to do three big things, and these are part of a 10-year plan.

Hate is not too strong. People were walking around with pins on, like little campaign buttons, made with the red circle and the slash that said, "No MOC."

–Steven J. Stack, MD, FACEP

First, and this is not rank ordered, we're going to radically reform undergraduate medical education. Medical school has essentially the same structure it did 100 years ago when Abraham Flexner did his work and came up with a new model. It needs to be changed. We have new ways to teach, new ways to learn, new ways to assess, and a whole new collection of content—like business, finances, politics, population health, and legalities of medicine—that needs to be incorporated, which is not covered well in the current curriculum. However, you can't just keep putting more stuff in the container. You have to change the whole shape and structure of the container so that you can do it differently. The AMA put $11 million in a five-year grant program that is working with 11 medical schools in the country in a consortium to radically pilot and reconceive a medical education. I hope that a decade after that work has begun, we'll have a new model for medical education in the country that will serve the physicians of tomorrow better than the current model is serving them.

The second is to improve health outcomes for the nation by tackling big public health concerns. We are going to work on the proper diagnosis and effective treatment of hypertension. There are 70 million people in the country with hypertension and tens of millions of them who are either not diagnosed or not properly treated. They have preventable harm happen that we should not allow. The next is the diabetes epidemic. If we don't fix that, we're going to have an incredible burden of human illness and disease in our population, something that will be economically unsustainable and humanly intolerable. We know that if we institute lifestyle programs that sustainably alter people's diet choices, exercise choices, and activity choices, we can profoundly reduce the number of people who are in a prediabetic state who convert to diabetes. We are working with the Centers for Disease Control and Prevention, the YMCA of the USA, and others to come up with ways that, on a national level, we can catalyze the change that we all know needs to happen.

The third and final thing is that we are working doggedly to improve physician professional satisfaction and practice sustainability. We are trying to find out about things that make doctors happy and things that make them sad and frustrated. If those things are either directly within our sphere of control as individual doctors or the AMA and/or within our sphere of strong influence, we can intervene and make life better for physicians. I think the profession feels a bit downtrodden and run-over right now, with everyone shouting at us to do what they want us to do and nobody really supporting us in what we need to do.

SHOULD FAMILIES WATCH CPR? | CONTINUED FROM PAGE 12

Following policy development, staff education and preparation is essential. Training may include facilitator-training workshops to employ simulation with mannequins and/or actors portraying patients and families.[13–15] A designated supportive staff member (SSM) is important for a successful experience for families. The SSM may be a social worker, nurse, chaplain, or other dedicated personnel. The SSM should be trained and committed to the supportive process during resuscitative efforts. The SSM should initially communicate with family members prior to entering the resuscitation area. Family members should be given the option to be present and prepared for the visual and emotional stress of the clinical scenario. They should be instructed where to stand at the bedside to be close to their family member without interfering with the delivery of care. If there is uncertainty about crowd control or ability to function appropriately, or if there is suspicion of abuse, it may not be appropriate for family to be present. Ideally, there should be a designated area that provides adequate seating for the family as well as a direct line of vision to the patient and the delivery of care. Family members should be allowed to leave and reenter the room if they become uncomfortable with the situation. The SSM should be solely dedicated to the family throughout the resuscitative efforts and should provide appropriate education and communication regarding clinical status and medical interventions. Following unsuccessful resuscitative efforts, support of family through the bereavement process is essential. The health care team and the SSM should facilitate compassionate communication and support, which may include spiritual support, psychosocial support, and open dialogue about the events of the resuscitative efforts.

FWR Recommendations for Pediatric Patients[16]

1. Consider FWR as an option for families during pediatric procedures.
2. Offer FWR as an option if presence will not affect clinical care.
3. If family is not offered the option for FWR, document the reasons.
4. Consider the safety of the health care team.
5. Develop in-hospital transport and transfer policies and procedures for FWR.
6. Health care policies should undergo legal review.
7. Educate all health care providers.
8. Promote research into best methods for education; effects of FWR on patients, family, and staff; best practices for FWR; and legal issues regarding FWR, among others.

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ACEP's record-breaking Legislative Advocacy Conference and Leadership Summit in Washington, D.C., featured a new hotel, new format, and nearly 500 visits with lawmakers about issues related to emergency care. Next year's LAC is set for May 15–18. Don't wait to make your plans.

Highlights From LAC 2015

ACEP moves beyond the SGR fix

BY L. ANTHONY CIRILLO, MD, FACEP

The situation on Capitol Hill in Washington, D.C., in May was surreal. As we have been doing for more than 20 years, emergency physicians from ACEP made their annual trek to D.C. to meet with members of Congress and their staff and talk about the issues affecting the practice of emergency medicine during the ACEP Legislative Advocacy Conference and Leadership Summit (LAC). But for the first time in 14 years, something was different. Yes, for the first time in a very long time, members of Congress and staffers didn't have to sheepishly lower their eyes and again try to explain why they still hadn't fixed the flawed Sustainable Growth Rate (SGR) Medicare payment formula. Instead of more wringing of hands and gnashing of teeth, "thank you" and "you're welcome" were shared many times across the halls of the Capitol. After 14 years and 17 temporary patches, the flawed SGR formula was finally gone. Although I tend to be a little more reserved than most, I was tempted to go skipping down the halls of the Capitol, arm in arm with ACEP President Mike Gerardi, MD, FAAP, FACEP; Gordon Wheeler, ACEP associate executive director for public affairs; and Peter Jacoby, MD, FACEP, chair of the National Emergency Medicine Political Action Committee (NEMPAC) Board of Trustees, singing, "Ding-dong! The SGR is dead!" So with the SGR gone, what did we talk about with members of Congress? Real policy issues for a change! Now that the issue of Medicare payments is off the table (at least temporarily until we have to figure out this MIPS, or merit-based incentive payment system, thing), we could actually talk with Congress about addressing the day-to-day real-world challenges that affect how we practice our craft.

Although the conference didn't officially start until Monday, May 4, I want to give props to the Emergency Medicine Residents' Association (EMRA) and the ACEP Young Physicians Section (YPS), who really started the action on Sunday with their Leadership and Advocacy Essentials program. This half-day session included great presentations in a "rapid-fire" 30-minute format from Jasmeet Dhaliwal, MD, MPH, EMRA's legislative director who did an "Intro to Health Policy Basics talk;" Aimee Moulin, MD, who gave straightforward information with her "Stop the Madness! Treating Patients With Mental Illness in the ED" talk; and Paul Kivela, MD, MBA, FACEP, from the ACEP Board of Directors, closing the day with "The Roadmap to Getting Involved."

Of the 537 attendees at the conference, emergency medicine residents were, as always, very well represented, comprising 25 percent of meeting attendees. One last point about the residents: For those of us who have been going to LAC for a long time, it is easy to feel comfortable with D.C. and the advocacy process. For residents and other first-timers, going to Capitol Hill to speak with members of Congress can be pretty intimidating. However, there are always plenty of more-seasoned attendees to help guide you through the process.

Highlights From This Year's LAC

From a nuts-and-bolts perspective, this year's meeting was reformatted with the first two days retitled the Legislative Advocacy Conference and the last day focused on professional development as the Leadership Summit.

This year's meeting was full of informative presentations, including:

- "Quality Initiatives in the 21st Century—CEDR—ACEP's Clinical Data Registry"
- "Psychiatric Patient Boarding Problems in the ED"
- "Medicare Policy—Intersection of Observation, 2-Midnight, and 3-Day Stay Rules"
- "Leadership Diagnostics : Symptoms and Cures"
- "How to Succeed in an Evolving Health System," given by Steve Stack, MD who, in June, will become the first emergency physician to assume the Presidency of the American Medical Association (AMA)

Another new addition to the meeting this year was the Congressional Dine-Arounds. Sponsored by the NEMPAC, these were small dinners (only about 10 to 12 people) with members of Congress. Even with the House of Representatives not being in session, Jeanne Slade and the NEMPAC staff were able to arrange for dinners with the following members of Congress:

- Sen. Bill Cassidy (R-LA), who is a gastroenterologist
- Rep. Dutch Ruppersberger (D-MD)
- Sen. Ron Wyden (D-OR)
- Sen. Shelley Moore Capito (R-WV)
- Sen. Mark Kirk (R-IL)
- Sen. Chris Murphy (D-CT)

So with the Medicare Access and CHIP Reauthorization Act passed, the SGR formula gone, and MIPS coming, this year's Hill visits focused more on policy issues rather than payment. There were four major issues that we brought to the Hill:

1. Liability Reform

A continued push for support of the Healthcare Safety Net Enhancement Act of 2015 (H.R. 836/S.884). This bill would provide for federal protection under the Federal Tort Claims Act for all services provided in the emergency department under the EMTALA federal mandate. The Federal Tort Claims Act already provides similar protection to those physicians practicing in the U.S. Public Health Service, in the Indian Health Service, and at federally qualified health centers. The bill provides for management of claims in federal court, with the U.S. government becoming the defendant, rather than the individual physician. Although the cases would be adjudicated in federal court, the actual damages/payments that an individual plaintiff would be granted remain state-specific where the case occurred.

2. Mental Health

Support of legislative efforts to provide resources for patients with mental illness and stop the practice of psychiatric boarding in the emergency department. The ongoing challenge of finding appropriate inpatient beds and/or outpatient treatment resources for patients with mental health disease is certainly not new to anyone in the ED. There was great anticipation of a bill to be introduced by Rep. Tim Murphy (R-PA), a clinical psychologist by training, that would provide federal help in a number of ways. Rep. Murphy had introduced a bill last year with a number of key initiatives, and the hope was that his bill this year would contain many of the same initiatives:

- **a.** Improve research, data collection, and coordination of existing mental health programs by creating an Undersecretary of Health for Mental Illness at the Department of Health and Human Services.
- **b.** Remove regulations that currently prohibit same-day billing under Medicaid for treatment of physical and mental health for the same patient in the same location on the same day.
- **c.** Give states the option to receive federal matching payments for care of adult patients with mental illness.

3. Funding for Emergency Medicine Research and Trauma Systems

Requested support for appropriation of funds within the FY 2016 budget to support the Office of Emergency Care Research (OECR) at the National Institutes of Health (NIH) and for ongoing support of grant funding that supports research on regionalization of care and trauma systems. OECR was established in 2011 within NIH to coordinate research on the specialty of emergency medicine. However, the office has never been funded directly, significantly limiting its effectiveness in producing research to improve the practice of emergency medicine. Requests for support of OECR in the amount of $28 million were made to support the following programs that have been authorized by Congress but never funded:

- **a.** Regionalization of emergency care pilot projects
- **b.** Trauma systems planning grants
- **c.** Trauma care center grants
- **d.** Trauma service availability grants

4. Graduate Medical Education (GME) Funding

Expansion of GME funding amounts and number of residency slots. In 2006, the Association of American Medical Colleges began increasing medical school enrollments in an attempt to meet the medical needs of the U.S. population and minimize projected physician shortages. This has resulted in a 30 percent increase in the number of medical students, with just over 20,000 matriculants to U.S. medical schools in 2014. However, the number of Medicare-funded residency training spots, using Direct Graduate Medical Education funding, has been capped since 1996 resulting in a mismatch, with more medical school graduates than residency spots. In the 2015 match, there were 1,700 total U.S. graduates of allopathic and osteopathic medical schools who were unmatched and did not find a residency spot. The request to members of Congress was to fund an additional 15,000 residency slots over the next five years in order to expand the physician workforce in anticipation of the aging and growing U.S. population.

It is always great to see a few hundred ACEP members come to Washington, D.C., each year for an amazing few days. But being a leader in your ED and being an advocate for EM and our patients is *everyone's* responsibility. Next year's meeting will be May 15–18, 2016. Will you be there?

DR. CIRILLO is director of health policy and legislative advocacy for Emergency Medicine Physicians in Canton, Ohio, and chair of the ACEP Federal Government Affairs Committee.

DOGMA FEELS RIGHT UNTIL YOU STEP IN IT

SKEPTICS' GUIDE TO EMERGENCY MEDICINE

DR. MILNE is chief of emergency medicine and chief of staff at South Huron Hospital, Ontario, Canada. He is on the Best Evidence in Emergency Medicine faculty and is creator of the knowledge translation project the Skeptics' Guide to Emergency Medicine (www.TheSGEM.com).

Explosive Issue!

IV antibiotic–associated diarrhea

by KEN MILNE, MD

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Case

A 48-year-old man presents to your ED complaining of a two-day history of a warm, painful, reddened area on his right shin. It started with a minor abrasion earlier in the week. He has no significant past medical history and no known drug allergies. There is no evidence of an abscess on examination, and his labs and vital signs are normal. He is diagnosed with uncomplicated cellulitis, and you plan to send him home with a five-day course of cephalexin but are thinking about giving him a "one for the road" single dose of IV cefazolin before he leaves.

Question

What is the risk of emergency department patients developing antibiotic-associated diarrhea (AAD) with an IV dose of antibiotics prior to discharge?

Background

We all know that diarrhea is a common side effect of antibiotic therapy. The incidence reported in the literature is between 5 percent and 39 percent.[1] *Clostridium difficile* infection (CDI) is one of the most concerning types of AAD and has been increasing.[2]

A number of factors are known to increase the risk of AAD/CDI.[3] These include the type of antibiotic used and the duration of therapy. While almost all antibiotics can cause AAD and CDI, the cephalosporins, broad-spectrum penicillins, and clindamycin are more often the cause.

There are some patient factors also thought to be associated with AAD/CDI. These are age greater than 65 years, comorbidities, and a history of AAD.

Relevant Article

Haran JP, Hayward G, Skinner S, et al. Factors influencing the development of antibiotic associated diarrhea in ED patients discharged home: risk of administering IV antibiotics. *Am J Emerg Med*. 2014;32(10):1195-1199.

- **Population:** Adult patients from three EDs.
  - –Patients were excluded if they had diarrhea or *C. difficile* in the previous four weeks, had received an antibiotic in the previous four weeks, or were admitted to the hospital.
- **Intervention:** IV antibiotics as part of their ED visit and discharged home with a prescription for antibiotics.
- **Comparison:** Patients who were not given IV antibiotics as part of their ED visit and discharged home with a new prescription for antibiotics.
- **Outcomes:**
  - –Primary outcome was the development of AAD (three or more loose stools per day for at least two days).
  - –Secondary outcome was the development of CDI (AAD that led to a diagnosis of CDI confirmed by a positive *C. difficile* toxin A assay).
- **Authors' Conclusions:** "Intravenous antibiotic therapy administered to ED patients before discharge was associated with higher rates of AAD and with two cases of CDI. Care should be taken when deciding to use broad-spectrum IV antibiotics to treat ED patients before discharge home."
- **Key Results:** There were 247 patients included in the study. The most common infection being treated was a skin/soft tissue infection.
  - **–Primary outcome of antibiotic-associated diarrhea:**
    - ◆45/247 (18 percent) odds ratio 2.73 (95 percent CI, 1.38–5.43)
    - ◆25.7 percent IV group versus 12.3 percent oral group
    - ◆Absolute difference of 13.4 percent
    - ◆Number needed to harm=7
  - **–Secondary outcome of *C. difficile* infection:**
    - ◆2/247 (1 percent)

The rate of AAD increased with the duration of antibiotic therapy. Clindamycin, vancomycin, cephalosporins, penicillins, and macrolides were associated with the highest rates of AAD; quinolones and doxycycline had the lowest rates.

More than a quarter (28 percent) of patients who developed AAD stopped taking their antibiotic, and 16 percent had a follow-up health care visit because of diarrheal symptoms.

EBM Commentary

This was a small observational trial that demonstrated 26 percent of patients given IV antibiotics in the ED developed AAD. This was an absolute increase of 13 percent over those patients given oral antibiotics only and fits well into the range of 5–39 percent previously described in the literature.

The primary outcome was patient-oriented but didn't necessarily take into account all potential confounders (history of constipation and current medications that could have affected gastrointestinal motility or the development of diarrhea/constipation).

It was unclear if the primary outcome was accurately measured to minimize bias. Patients were asked about the development of AAD with a survey four weeks after finishing antibiotic therapy. This introduces potential recall bias.

Despite its limitations, this study provides important information about potential risks of an intervention that has yet to demonstrate any benefit in a patient population well enough to go home on a course of oral antibiotics.

In addition, if 28 percent of patients who develop AAD after a dose of IV antibiotics stop taking the antibiotics early due to the side effects, this could have implications for both the patient and may contribute to the eventual development of antimicrobial resistance.

Bottom Line

Giving IV antibiotics in the ED to patients well enough to go home on oral antibiotics is not without harm. This small observational study shows IV antibiotics are associated with an increased risk of AAD in this patient population.

Case Resolution

You decide not to give a dose of IV cefazolin and send the patient home with a five-day course of cephalexin for his cellulitis as recommended by the Infectious Diseases Society of America.[4]

Thanks to Meghan Groth, the emergency medicine pharmacy specialist at the University of Vermont Medical Center, for her help with this review.

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

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AVOID THE HAZARDS OF EM PRACTICE: FAQs FROM YOUNG PHYSICIANS

WHAT I WISH I KNEW...

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Don't Get Caught in a Moonlighting Trap

Top five things to consider before moonlighting

Nathaniel Mann, MD, is a resident in the department of emergency medicine at the University of Cincinnati in Ohio. Jordan Celeste, MD, is president of the Emergency Medicine Residents' Association and an emergency physician in Florida.

by ERIC SILMAN, MD, AND ESTHER H. CHEN, MD

In response to an EM resident's question about moonlighting, we present the following "Top Five" things we wish we had known about moonlighting.

1 Know the Rules of the Road

The Accreditation Council for Graduate Medical Education explicitly allows moonlighting in its program requirements for EM as long as the resident is able to achieve the goals and objectives of the residency program, does not violate duty hours, and is not a first-year resident. In addition, most institutions have their own graduate medical education moonlighting policy. Almost all residency programs require that residents meet specific criteria or be in good standing before they are allowed to moonlight externally. Dig into your residency program's policy and discuss your plans with your program director before you start because you will need the director's final blessing on any credentialing paperwork for the hospital.

2 Start Smart

Why do you want to moonlight? The two most common motivators are financial and educational. Many residents carry a high debt burden and make modest salaries. Moreover, working in practice settings that are different from the training hospital is a powerful educational experience that not only enables residents to see different types of cases but also to make decisions independently. You need to first develop your personal objectives for moonlighting so that you can ask the right questions and decide which practice setting is right for you. For example, do you want to see a high volume of low-acuity patients? Do you want more experience with pediatric patients or trauma patients? Do you prefer to work in a place with few consultants? Senior residents, recent graduates, or attendings who work in other institutions are great resources here. Finally, before you sign up, analyze the contract very carefully and review it with your program director. Most important, ask about the amount and type of professional liability (malpractice) coverage offered by the group or hospital and who is responsible for obtaining it and paying premiums. **Pay special attention to whether "tail coverage" is needed and who will pay the extra premium for this.** The Emergency Medicine Residents' Association offers more information about moonlighting, professional liability, and contractual issues on it's website (http://www.emra.org/Resources/Career-Planning), as does the American Academy of Emergency Medicine Resident and Student Association (www.aaemrsa.org) in the Resources section of its website.

3 Be a Paperwork Pro

Once you've decided on the practice setting, it's time to begin the application and credentialing process, which can take months. Here are some general tips:

- Maintain an updated CV and make sure it includes your current residency program information and any pertinent credentials such as advanced trauma life sup-

CONTINUED *on page 22*

ONE MORE REASON NOT TO ORDER AN X-RAY

SOUND ADVICE

DR. JOHNSON and **DR. LOVALLO** are in the department of emergency medicine at Alameda Health System's Highland Hospital in Oakland, California.

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Ultrasound-Guided Distal Sciatic Nerve Block in the Popliteal Fossa

The block can facilitate fracture reduction or abscess drainage or be used as an adjunct in a multimodal plan for pain control.

by BRIAN JOHNSON, MD, MPH, EMILY LOVALLO, MD, DANIEL MANTUANI, MD, MPH, AND ARUN NAGDEV, MD

The ultrasound-guided distal sciatic nerve block is the ideal block for patients with distal leg and ankle injuries (large lateral leg laceration, pain reduction from bimalleolar fractures, Achilles tendon rupture, lower leg burns, abscesses, etc.). Depending on the anesthetic used, the block can facilitate fracture reduction or abscess drainage or be used as an adjunct in a multimodal plan for pain control. Unfortunately, the superficial structures of the medial lower leg and ankle are not innervated by the distal sciatic nerve, and a saphenous nerve block (distal aspect of the femoral nerve) may be needed if a more complete analgesia to the lower leg is desired.

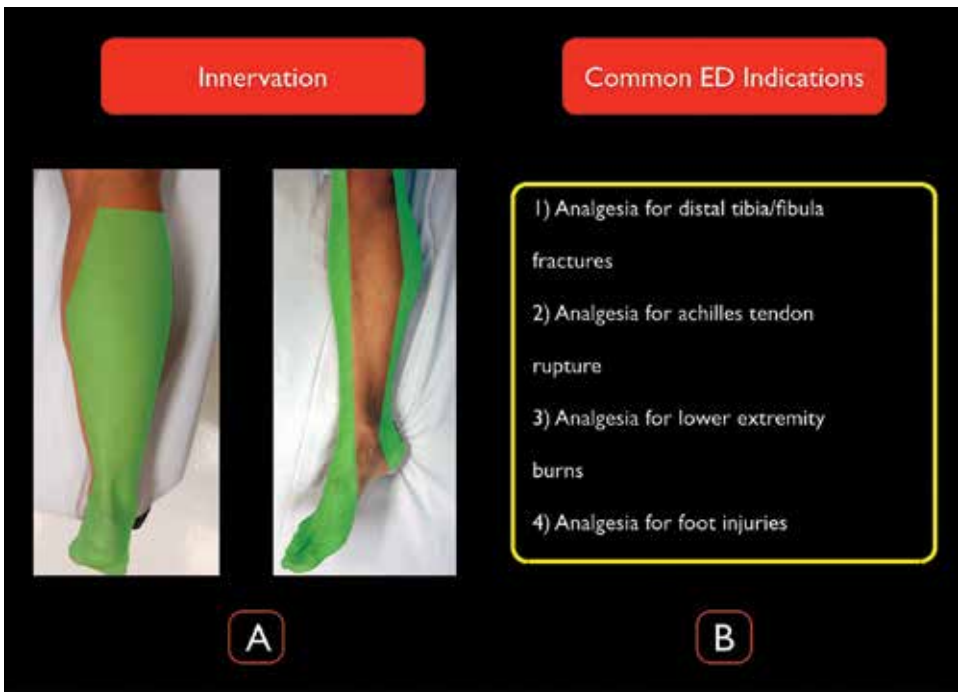

Figure 1. Distal sciatic nerve innervation and common ED indications for the block.

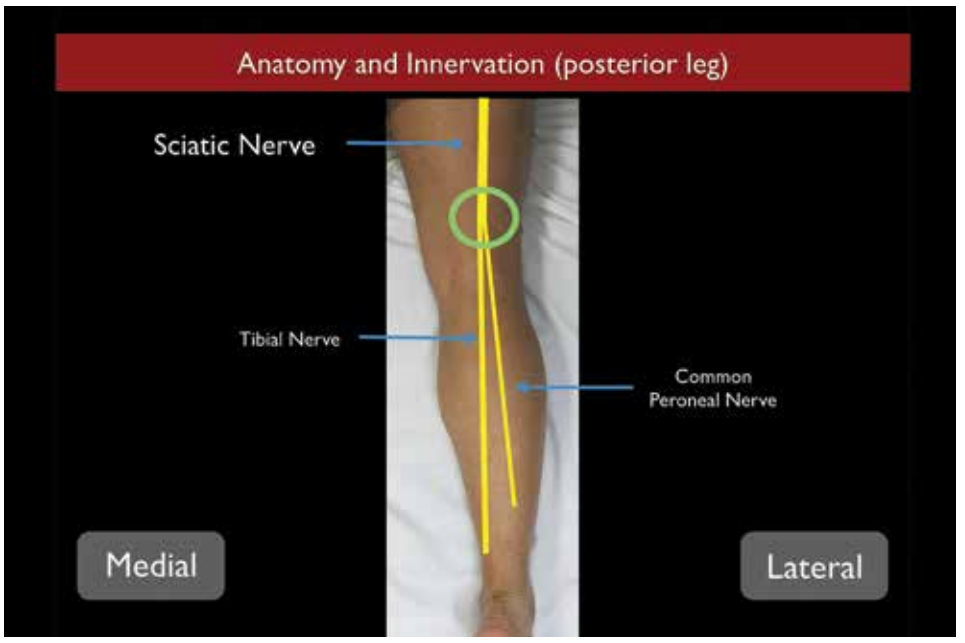

Figure 2. Sciatic nerve anatomy from the posterior aspect as it travels down the thigh into the leg.

Indications

The distal sciatic nerve innervates the majority of the lower extremity below the knee, making it an ideal block for ankle and distal tibial/fibular fractures and injuries to the foot (see Figure 1). It does not provide anesthesia to the medial aspect of the lower leg, which is innervated by the saphenous nerve (a distal branch of the femoral nerve).

Contraindications

Any injury that could potentially result in compartment syndrome is a relative contraindication to performing a distal sciatic nerve block. High-energy injuries such as a solitary tibial or mid-shaft tibial/fibular fracture are known to have high rates of developing compartment syndrome. Additionally, crush injuries or any injury with associated vascular compromise should trigger a detailed discussion with consultative services (orthopedics, trauma surgery, etc.) before an ultrasound-guided distal sciatic nerve block in the popliteal fossa is performed.

Anatomy

The distal sciatic nerve originates from the L4-S3 nerve roots of the lumbar-sacral plexus. The sciatic nerve initially runs deep in the posterior thigh, gradually becoming more superficial as it approaches the popliteal fossa. The large sciatic nerve bifurcates into the tibial (medial) and the common peroneal (lateral) nerves approximately 7–10 cm proximal to the popliteal fossa (see Figure 2). At this level, the sciatic nerve is bound by the semimembranosus and semitendinosus muscles medially and the biceps femoris muscle laterally. Although the sciatic nerve can be blocked at any location along its course, its superficial position in the region of the popliteal fossa makes this distal location ideal.[1,2]

Patient Positioning

If possible, the patient should be in the prone position, allowing easy access to the popliteal fossa and posterior aspect of the patient's lower extremity. In a patient who is unable to lie prone (cervical spine immobilization, etc.), the affected extremity must be elevated and supported with mild flexion of the knee. This is best achieved by propping the foot with blankets or pillows to allow the ultrasound probe to easily fit between the popliteal fossa and the patient's bed. Either position will allow the clinician to block the sciatic nerve in the popliteal fossa, with the prone position being technically much less difficult.

Equipment/Probe Selection

A high-frequency linear probe should be used to image the distal sciatic nerve in the popliteal fossa (see Figure 3). We recommend a 20- or 22-gauge, 3.5-inch (9 cm) spinal needle to reach the distal sciatic nerve because of its depth in the popliteal fossa. In addition, 20 mL of local anesthetic will be needed.

Survey Scan

To prepare for the block, start by placing the high-frequency linear probe with the probe marker facing the patient's right side at the popliteal crease and identify the popliteal artery and vein. The tibial nerve is commonly located just superficial to the popliteal vein and appears as a hyperechoic honeycomb-like structure (see Figure 4). If you are unable to locate the neural bundle, fan the probe caudal to cephalad to obtain the most perpendicular axis to the nerve, which

allows for better visualization (an ultrasound phenomenon termed anisotropy). Once the tibial nerve is visualized, follow the nerve proximally until it joins with the common peroneal nerve (lateral) to form the distal sciatic nerve (see Figure 5). The operator should mark this location and note the depth of the nerve and distance from the lateral thigh to ensure the appropriate length of needle prior to starting the procedure.

Procedure

The distal sciatic nerve is often 2–4 cm under the skin surface, making for a steep needle angle if entering the skin just adjacent to the ultrasound transducer (like most other ultrasound-guided nerve blocks). Instead, we recommend measuring the depth of the nerve during the initial survey scan and entering the lateral leg with a flat angle to ensure clear needle visualization. After placing a small skin wheal (on the lateral aspect of the thigh), fill 20 mL of local anesthetic in a syringe attached to a 20–22 gauge, 3.5-inch (9 cm) spinal needle. The more lateral approach and depth of the distal sciatic nerve often necessitate the longer needle for an in-plane distal sciatic nerve block.

Even though some experienced users may prefer the out-of-plane technique, we feel that the in-plane lateral to medial approach is both easier and safer for the novice sonographer. Slowly advance the spinal needle maintaining a nearly parallel angle to the probe with an in-plane technique (see Figure 6). Since the needle will be entering the lateral thigh, the needle tip will not be visualized immediately (like in other in-plane blocks), and the operator will often have to advance the needle a few centimeters until the tip will be seen entering the scanning plane. Attempt to place the needle tip on the superficial edge of the distal sciatic nerve without penetrating the nerve bundle (see Figure 7A). It is often difficult to determine whether the needle tip is either in the superficial tissue or the fascial plane of the nerve. Injecting small aliquots of either anesthetic or normal saline and visualizing its spread can be the discriminatory test to ensure that the needle tip is in the correct location. Once in the correct location, aspirate to confirm lack of vascular puncture, then slowly inject 2–3 mL aliquots of anesthetic until spread of anechoic fluid is noted to track around the distal sciatic nerve (see Figure 7B). Fanning the probe proximally and distally without moving the needle can be a simple method to confirm tracking of fluid in the fascial plane. We do not recommend novice sonographers place the needle tip on the inferior aspect of the nerve given its relative proximity to the popliteal vasculature. The sciatic nerve in the popliteal fossa has a significant complex fascial sheath. If there is difficulty visualizing anesthetic tracking along the nerve, the operator may need to place the needle tip through the complex fascial sheath, which can resemble epineurium. Often, the operator will feel a "pop" when puncturing the fascia. Using normal saline or very small aliquots of anesthetic under ultrasound visualization will then show a clear demarcation of nerve and fascia.[3,4]

Complications

Intravascular injection should be a concern because of the proximity of the popliteal vasculature and the distal sciatic nerve. A flat needle angle will allow for clear needle tip visualization and hopefully reduce chances of either local anesthetic systemic toxicity or peripheral nerve injury.

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ONLINE EXCLUSIVE

Watch the video clip showing how to perform an ultrasound-guided distal sciatic nerve block via the digital version of this article at ACEPnow.com.

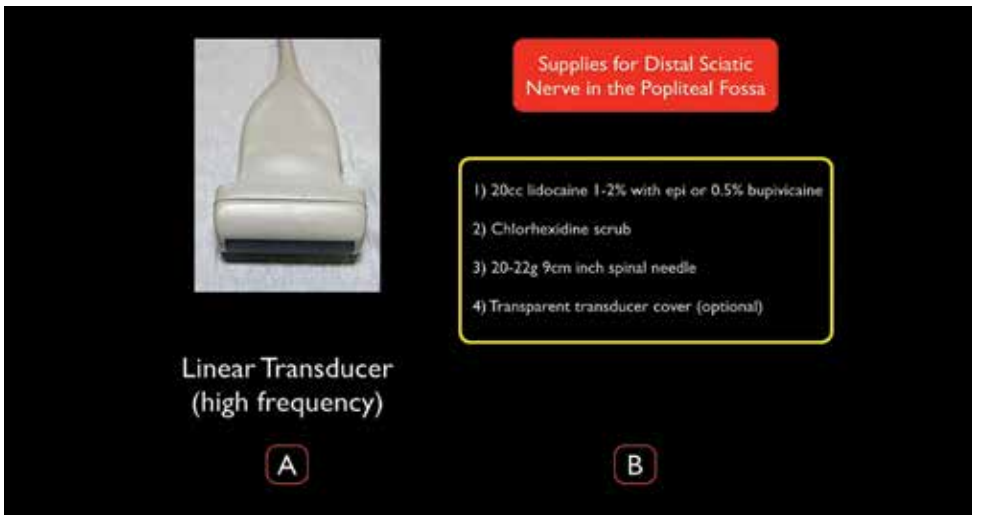

Figure 3. Transducer and supplies needed for ultrasound-guided distal sciatic nerve block in the popliteal fossa.

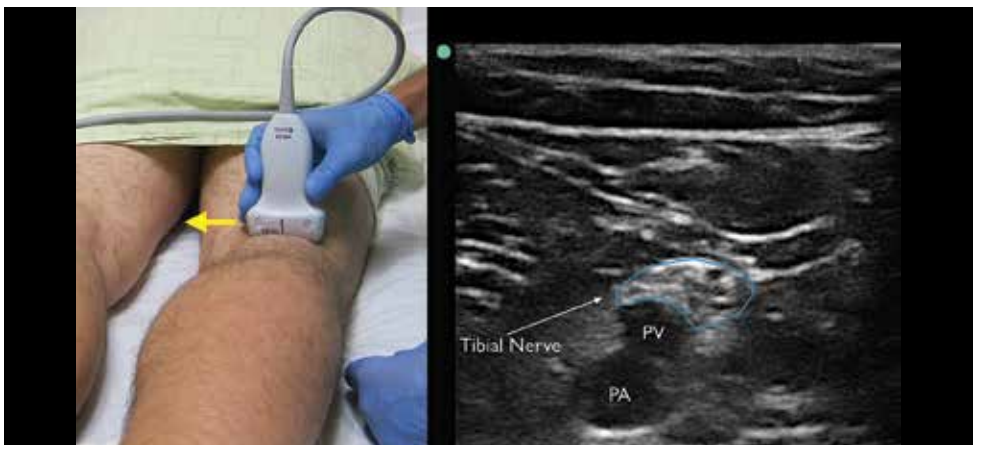

Figure 4. The tibial nerve sits just above the popliteal artery (PA) and popliteal vein (PV). Identification of this nerve is the first step in identifying the larger and more proximal distal sciatic nerve. Yellow arrow indicates direction of probe marker.

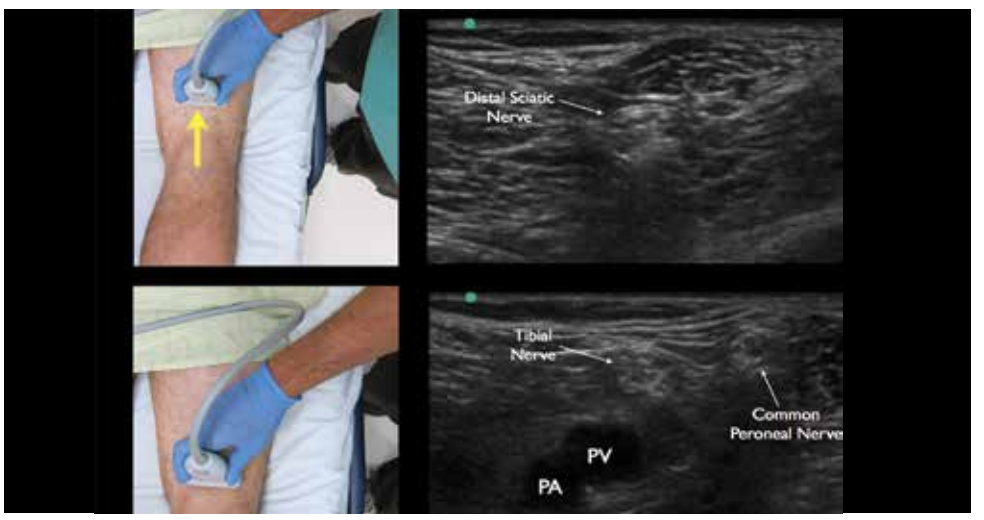

Figure 5. Appropriate movement of the ultrasound probe cephalad to visualize the joining of the tibial nerve with the common peroneal nerve forming the distal sciatic nerve. Note the common peroneal nerve approaching from the lateral aspect.

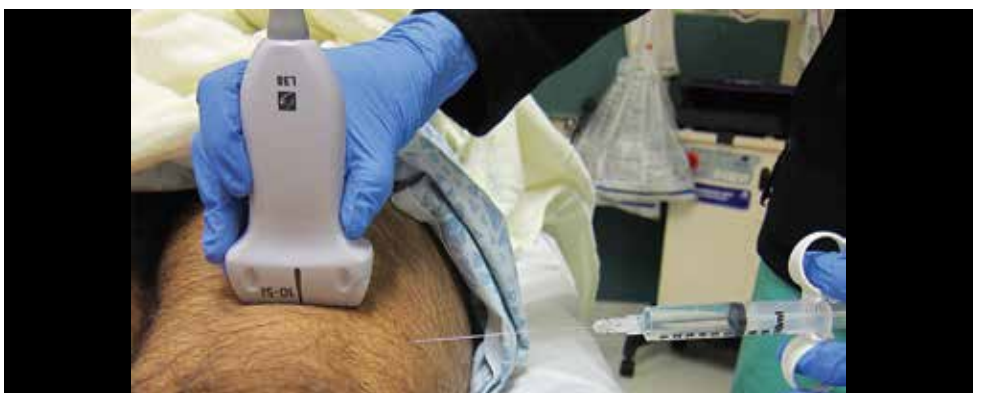

Figure 6. Ultrasound and needle placement for the distal sciatic nerve block in the popliteal fossa. Note the flat needle entry lateral to the transducer.

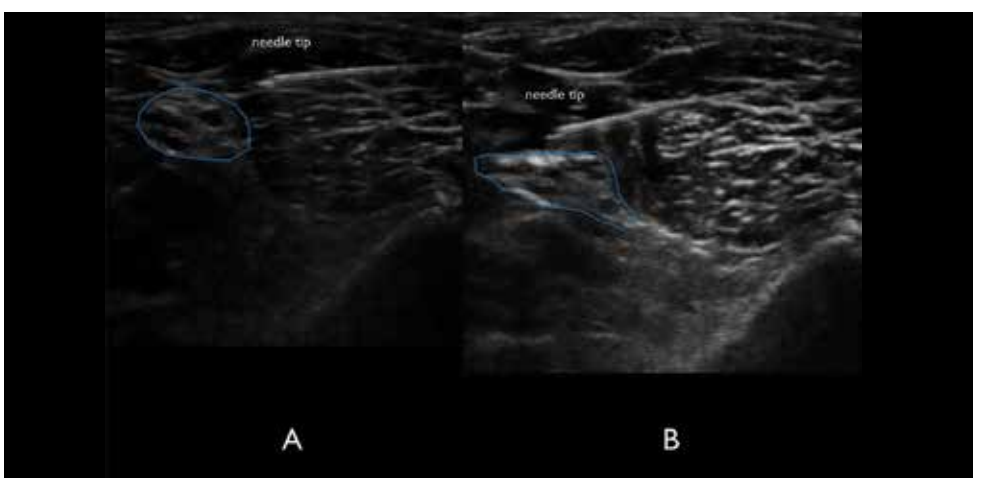

Figure 7A. In-plane lateral to medial approach of the needle. The needle tip is visualized clearly to ensure lack of nerve and vasculature puncture.

Figure 7B. Spread of anechoic local anesthetic surrounding the distal sciatic nerve indicating a successful nerve block.

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.

Behind in the Retirement Savings Game?

It's never too late to catch up

If you have a year-old BMW, consider selling it, purchasing a five-year-old Honda Civic, and adding the $50,000 saved to your portfolio.

by JAMES M. DAHLE, MD, FACEP

Question. ***I am a 61-year-old emergency physician. I am healthy and still enjoying my practice and make about $300,000 per year. However, for various reasons, I only have $300,000 saved for retirement. I would like to retire eventually but feel like I am way behind my peers. What can I do to still have a comfortable retirement?***

A: The first thing to realize is that you are not alone. Due to inadequate financial education, poor discipline, a late start, a divorce, and/or bad investment advice, many physicians arrive at retirement age with far less than they need to continue their current standard of living in retirement. While starting early obviously makes everything much easier, it is never too late to improve your financial position. Here are eight steps to help you make the most of your situation.

1. Cut Back a Little Now Rather Than a Lot Later

Unfortunately, there is no way, short of winning the lottery, for a physician spending most of his $300,000 salary to reproduce that entire salary with his investments in less than 10 years, particularly starting with such a small nest egg. The 4 percent rule indicates that to replace a $300,000 salary, you need $7.5 million. Social Security reduces that need somewhat, but there is no realistic way to get from here to there. Most physicians won't need to replace anywhere near their entire income to maintain their standard of living since they will not need to contribute to retirement accounts, fund college savings accounts, pay for work-related and child-related expenses, and pay premiums for disability and life insurance. Hopefully, their mortgage will also retire with them. However, if you have been spending nearly your entire income, you are in for a drastic reduction in income upon retiring. Your Social Security may provide $30,000–$50,000 per year, but that $300,000 portfolio will only contribute another $12,000 per year. While there are many people in America who retire quite comfortably on that size income, it will be a dramatic change from spending most of a $300,000 salary. The sooner you cut back on your current spending, the less dramatic the change at retirement will be.

2. Work as Long as Possible

The best solution to an inadequate nest egg is simply to keep working. This has numerous benefits. You have more time for your nest egg to compound. You also have more earnings to contribute to your retirement funds. Your Social Security benefits grow with more contributions. The longer you work, the shorter retirement will be, so the smaller the nest egg you will need in retirement. Even if you are only working part-time, you will still reap many of these benefits.

3. Delay Social Security

One of the best investments out there is to wait until you are age 70 to claim your Social Security benefit. If you are married, it may make sense to use the "file and suspend" technique for your spouse while waiting until 70 to take your benefit. Your Social Security benefit may be 85 percent larger at age 70 than it was at age 62.

4. Convert Nonincome-Producing Assets to Income-Producing Assets

Many physicians have inadequate nest eggs late in life because they have spent too much money on consumption items like expensive cars, boats, airplanes, and second homes. These assets can often be converted to income-producing assets. This is most commonly done by selling them and using the proceeds to purchase stocks, bonds, mutual funds, or investment real estate. However, many times the doctor can keep the asset and simply rent it out. Even if your vacation home is not the best investment, obtaining an extra $10,000 a year in income from it will help offset its costs. If you have a year-old BMW, consider selling it, purchasing a five-year-old Honda Civic, and adding the $50,000 saved to your portfolio.

5. Get Rid of Debt

A surprising percentage of the salary of a physician with low net worth goes toward servicing debt. This may be a mortgage on a primary home, a second mortgage, a mortgage on a second home, car payments, consumer debt, or even student loan payments. By paying off these debts, you may be surprised how little income you need to maintain your standard of living.

6. Downsize the House

Once the kids are out of the house, you may no longer need the 4,000-square-foot mansion. Downsizing may help you get out of debt and free up funds to add to the portfolio, but it will also reduce your ongoing expenses. Smaller houses have smaller bills.

7. Maximize Tax-Deferred Accounts

Let Uncle Sam boost the size of your nest egg. If your nest egg is small, relative to your current income, be sure to maximize your use of tax-deferred accounts as you will almost surely pull that money out of the accounts at a lower tax rate than you saved when you put the money in.

8. Take Advantage of Catch-Up Contributions

Older investors are actually allowed to save more in tax-protected accounts than younger investors. These catch-up contributions are $1,000 for IRAs and Roth IRAs and $6,000 for 401(k)s and 403(b)s starting at age 50. Health savings accounts (stealth IRAs) allow you to contribute an extra $1,000 per year starting at age 55. In addition, 457(b)s may allow you to double your contributions for the last three years prior to retirement age.

It is never too late to improve your financial position through education and discipline. If you find yourself approaching retirement with an inadequate nest egg, following these steps will still allow you to reach reasonable financial goals.

NEWS FROM THE COLLEGE

CONTINUED FROM PAGE 5

ACEP Honors Ebola, Disaster Preparedness Experts

David Pigott, MD, RDMS, FACEP, and Kristi L. Koenig, MD, FACEP, FIFEM, were honored by ACEP in May for their outstanding efforts to communicate about the 2014 Ebola scare as well as other national public health crises. The 2015 Spokesperson of the Year Award and the Communications Lifetime Achievement Award were presented during this year's Legislative Advocacy Conference and Leadership Summit in Washington, D.C.

"These two remarkable emergency physicians have served as voices for emergency medicine and for ACEP, providing critical information to the public at a time when our country needed it most," said ACEP President Michael J. Gerardi, MD, FAAP, FACEP. "They continue to educate the public and engage in developing policies to help protect people against outbreaks of infectious disease and in preparing our nation to respond effectively to disasters."

Dr. Pigott, professor of emergency medicine at the University of Alabama and an infectious disease expert, was named 2015 Spokesperson of the Year. Dr. Pigott became ACEP's point person for talking to the news media about the recent Ebola crisis this past fall. He handled scores of media calls during the height of the Ebola scare, including with Fox Business News, *The Wall Street Journal*, *Chicago Tribune*, *Houston Chronicle*, *Los Angeles Times*, *Newsweek*, Discovery News, and the Associated Press, among others.

Dr. Pigott also spoke with dozens of reporters at ACEP's annual conference in Chicago in October 2014. Many of them were registered at the conference and specifically went to cover two Ebola-related courses that he taught.

Dr. Pigott provided invaluable help in developing ACEP's public messages regarding Ebola and set a gold standard for rapid-response crisis communications.

Dr. Koenig, professor of emergency medicine, director of public health preparedness, and director of the Center for Disaster Medical Sciences at the University of California, Irvine, took home the 2015 Communications Lifetime Achievement Award. For more than a decade, she has served as ACEP's expert when national crises, such as the 2001 national anthrax scares, the SARS epidemic in 2003, bird flu in 2006, and the most recent 2014 national Ebola crisis, have occurred.

In 2014, Dr. Koenig spent hours at ACEP's national meeting in Chicago conducting interviews about biologic and chemical weapons, including anthrax. When Ebola became a significant news issue recently, Dr. Koenig offered her expertise to assist in developing ACEP's talking points and do press interviews leading up to and during ACEP14. She conducted interviews with all the local Chicago news media, usually against the backdrop of InnovatED, and she handled press calls with news organizations, including *The Washington Post*, *The Dallas Morning News*, and Bloomberg News.

THE BREAK ROOM

CONTINUED FROM PAGE 4

that ECGs are unreliable for diagnosing ACS. ECGs alone, their specific abnormalities, and the presence or absence of those abnormalities are unreliable in exclusively ruling in or ruling out ACS. Thus, they are an important part of the evaluation but could never be used in isolation for risk stratification.

My intent was to draw a bright line between reliability and usefulness. It appears we agree on two things for certain: "the mere presence of any kind of nystagmus does not help to differentiate peripheral from central causes of the acute vestibular syndrome," and that, when present, the quality of nystagmus does have utility, particularly when a detailed assessment can be performed, as you have adeptly outlined in your letter.

Thank you for the instruction and valuable input.

—Kevin M. Klauer, DO, EJD, FACEP
Medical Editor-in-Chief, ACEP Now

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WHAT ARE YOU THINKING?

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port (ATLS), advanced cardiovascular life support (ACLS), basic life support (BLS), and pediatric advanced life support (PALS).

- Ask two to three faculty members in your home institution if you can list them as your references for your moonlighting position.
- Draft a cover letter that highlights your patient care, professionalism, and interpersonal/communication skills.
- Scan or make several copies of your state medical license, Drug Enforcement Administration (DEA) certificate, driver's license, immunization records, and other pertinent documents.
- Ask whether your current license and DEA certificate are appropriate for the institution. For example, DEA certificates for county hospitals may not be used for private institutions.

While many residents feel that this unsupervised practice facilitates their growth as an EM physician, it is also a risky undertaking.

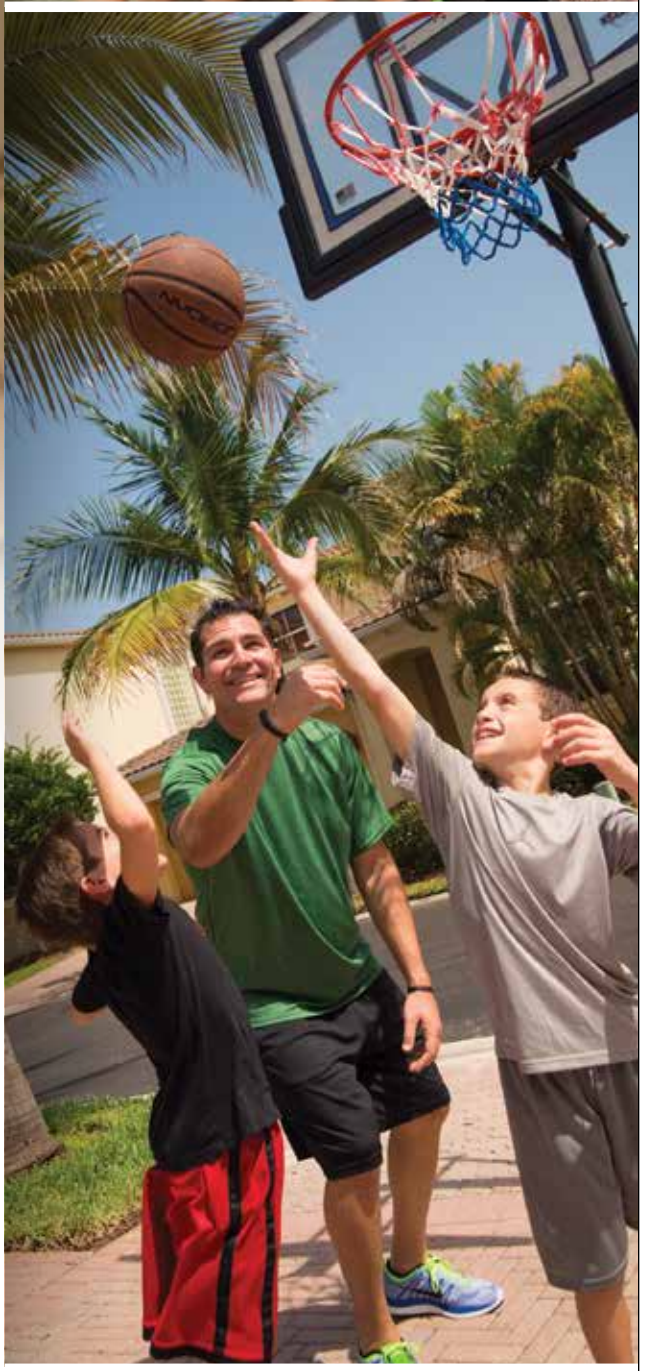
4 The Buck Stops With You

Practicing outside of your training institution means that you are practicing under your own medical license with minimal to no attending supervision. You have the sole responsibility for all aspects of patient care, including accurate and appropriate documentation both for medical care and billing. Do not sacrifice high-quality, thoughtful patient care and education at the expense of efficiency and throughput. Your attending won't be there to fill in the holes in your documentation or make sure that patients understand their discharge planning. While many residents feel that this unsupervised practice facilitates their growth as an EM physician, it is also a risky undertaking. A single-coverage practice setting is probably not the best place for a first-time moonlighter. Always remember that the faculty in your home institution is available for you to ask questions, so it's OK to call and discuss cases with the attending on shift if you are ever unsure.

5 Get the Most Bang for Your Buck

All moonlighting residents should take an active role in maximizing the educational benefit of the moonlighting experience. Here are some suggestions:

- Actively seek feedback from patients, nurses, colleagues, and physician leadership. Your colleagues can provide valuable suggestions for improvement. Use this opportunity to identify your weaknesses and focus on improving those areas.
- Many groups provide patient care information, such as productivity, patient satisfaction, and compliance with guidelines and benchmarks, to providers. If you don't receive this information, ask for it.
- Perform frequent patient follow-ups, via chart review or phone, to "calibrate" your clinical judgment (eg, how many of your admitted chest pain patients rule in for acute coronary syndrome or if the patient you sent home with vague abdominal pain returns with acute appendicitis).
- Ask for help if you're unsure. Remember that patient care should always come first, and asking for help is not an admission of weakness or ignorance.
- Log all major procedures (eg, intubations, chest tubes, central lines, procedural sedation). Although they do not count toward residency requirements, they can be used for future credentialing.
- Do not forget to maintain a healthy work-life balance. Your primary job is to finish residency, not to moonlight.



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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

Chair, Department of Emergency Medicine

The University of Texas Medical School at Houston seeks a dynamic physician leader to serve as Chair of the Department of Emergency Medicine. The medical school is a part of The University of Texas Health Science Center at Houston (UTHealth), a comprehensive academic health science center located in the Texas Medical Center (https://med.uth.edu/wp-content/blogs.dir/1/files/2012/05/utms-annualreport-2011.pdf). UTHealth is composed of six schools (Dentistry, School of Biomedical Informatics, Graduate School of Biomedical Sciences, Medicine, Nursing and Public Health). Over 4,000 students are enrolled in its various programs. The organization has over one billion dollars in assets. UTHealth is one component of the Texas Medical Center which includes two medical schools, two level one Trauma Centers, the Texas Medical Center Library, a regional affiliate of the NLM, and multiple hospital and educational programs. Houston is the fourth largest city in the US with one of the most diverse populations and growing and vibrant economy.

The UTHealth residency program in EM is one of the larger programs in the US and recently celebrated its twentieth year of EM residency training. The Department of Emergency Medicine has 50 faculty and 24 Advanced Practice Providers. Its educational program includes 54 residents (PGY1-3), 7 clinical fellows, and one third-year and three fourth-year medical student electives. The department has $600K in annual research expenditures, $8M in clinical revenue, and an annual operating budget of $27.8M. Clinical services are provided at two primary teaching hospitals, and two community hospitals. The Chair also oversees a growing hospitalist program with 24 faculty and staff physicians. The department offers a vibrant and diverse working environment characterized by an atmosphere of supportive, interdisciplinary collaboration. Additional information about the department may be found at: https://med.uth.edu/emergencymedicine/

The candidate should be of national/international stature, recognized for his/her accomplishments in academic Emergency Medicine and should possess outstanding leadership qualities. He/she must have demonstrated success in promoting excellent teaching, faculty development and scholarship, as well as implementing outstanding research and clinical programs. The candidate should also have the skills necessary to lead a diverse organization and to work collaboratively with colleagues and administrative teams.

The successful candidate must be board certified in Emergency Medicine and meet the requirements for a senior faculty appointment at the University of Texas Medical School. He/she must hold or be able to obtain an unrestricted medical license in the State of Texas. Minorities and women are strongly urged to apply.

Review of applications will continue until the position is filled. Interested candidates should confidentially submit electronic application materials using the following link: **http://jobs.uth.tmc.edu/applicants/Central?quickFind=102730**

UTHealth™
The University of Texas Health Science Center at Houston

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CHA Cambridge Health Alliance

HARVARD MEDICAL SCHOOL TEACHING HOSPITAL

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.challiance.org

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