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A STRONG VISION FOR THE FUTURE

ACEP President-Elect **Dr. Rebecca Parker** discusses issues facing emergency medicine

Part of ACEP's power as an advocate for emergency medicine comes from the strength and cooperation of its leaders. Last month, we interviewed ACEP President Jay A. Kaplan, MD, FACEP, about the challenges and opportunities ahead for emergency medicine. This month, Rebecca Parker, MD, FACEP, who was elected ACEP President-Elect in October 2015, shares her views on the key issues facing emergency medicine with *ACEP Now* Medical Editor-in-Chief Kevin Klauer, DO, EJD, FACEP.

KK: What do you think are the greatest challenges facing emergency physicians today?
RP: I think there are a couple of things. One is the implementation of PPACA, also known as the Affordable Care Act (ACA), and how that is going to impact emergency medicine. I think the ACA is also an opportunity for us to look at our current practice setting and where the opportunities are to improve it. I think that's the second challenge for us. It's harder and harder every day to be in the emergency department, and we are faced with fights and battles every single day. How can we use the challenge of the ACA as an opportunity to make our daily lives more enjoyable? It goes back to the joy of the practice instead of feeling like we're in a battle every day we go to work.

Dr. Parker speaking at the American Association of Women Emergency Physicians meeting at ACEP15

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A Call to Action

More female physicians need to join the emergency medicine workforce

by KATHLEEN CLEM, MD, FACEP

The evidence is in. We need more women emergency physicians.

There is a marked gender discrepancy in emergency medicine. Although females comprise 50 percent of medical school classes, they make up only 25 percent of EM-trained physicians (see Table 1). An even smaller percentage of women are in major leadership positions within EM (see Table 2).

While emergency medicine has made some progress in the quest to increase the number of women in the workforce, it has not succeeded at the rate the specialty needs nor has it reached anticipated outcomes based on the pipeline of women medical students.

Without the full participation of women in EM, the nation's ability to provide emergency care will be stretched even further. EM must attract and retain women physicians while concurrently addressing their unique needs in order for professionals to provide medical care for the millions of patients who annually visit the nation's emergency departments.

As the nation adapts to meet unprecedented challenges of health care, teams should include women physicians not only because more emergency physicians are needed within the medical community but

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PEARLS FROM THE MEDICAL LITERATURE

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ACEP Council Speaks Out

ACEP COUNCILLORS WERE ASKED A SELECTION OF QUESTIONS ON DIVERSITY AND DISCRIMINATION. **HERE ARE THE RESULTS:**

	NUMBER OF RESPONSES
1. Would you identify yourself as male, female, or transgender?	
Male	43
Female	30
Transgender	0
2. Are you heterosexual, homosexual, bisexual, or asexual?	
Heterosexual	70
Homosexual	1
Bisexual	2
Asexual	0
3. Select your ethnicity (federal definitions):	
Asian or Pacific Islander	2
Black, not of Hispanic origin	4
Hispanic	1
White, not of Hispanic origin	63
Other	3
4. Do you believe emergency physicians, regardless of gender, are treated equally in your group and hospital?	
NO	22
YES	51
5. Do you believe emergency physicians, regardless of ethnicity, are treated equally in your group and hospital?	
NO	10
YES	63
6. Do you believe emergency physicians, regardless of sexual orientation, are treated equally in your group and hospital?	
NO	7
YES	39
7. Do you believe your professional opportunities have been limited by issues related to your gender?	
NO	53
YES	20
8. Do you believe your professional opportunities have been limited by issues related to your sexual orientation?	
NO	69
YES	4
9. Do you believe your professional opportunities have been limited by issues related to your ethnicity?	
NO	45
YES	2
10. Have your co-workers treated others inappropriately based on ethnicity?	
NO	61
YES	12
11. Have your co-workers treated others inappropriately based on gender?	
NO	50
YES	23
12. Have your co-workers treated others inappropriately based on sexual orientation?	
NO	54
YES	19

SEND YOUR THOUGHTS AND COMMENTS TO ACEPNOW@ACEP.ORG

THE BREAK ROOM

EM Community Speaks Out on IOM Report

Editor's Note: *We received many responses to January's A New Spin article, "What's on My Mind: Should we focus on the diagnosis or the decision-making process?" by Kevin Klauer, DO, EJD, FACEP. Here are a few of the comments from the emergency medicine community.*

I HAVE SEVERAL THOUGHTS RELATING TO Dr. Klauer's excellent opinion piece in January's edition about the Institute of Medicine's report, "Improving Diagnosis in Healthcare." I share all of Kevin's concerns about the way in which the report alludes to emergency medicine and emergency physicians, but I think there are several additional issues deserving of mention.

Having entered the full-time practice of emergency medicine in 1973, my perspective has a long horizon. In the early days of our specialty, the expectation of the rest of the hospital's medical staff was for us to make an accurate "in" or "out" decision. Having the definitive final diagnosis was deemed nice but not mandatory. Assigning a weak tentative diagnosis was considered bad medical practice. Everyone accepted that there was a subset of emergency patients who clearly needed to be in the hospital because they were, in the emergency physician's judgment, *sick enough* to require the additional time and diagnostic resources afforded by inpatient status in order to reach a final diagnosis. Today, thanks to our irrational government health care programs, you can't admit someone with a diagnosis of "sick enough." In addition, since RBRVS [resource-based relative value scale] systematically short-changes the thinking doctors (as opposed to the proceduralists), the medical staff has come to expect that every patient arriving on the floor will have a completed comprehensive work-up and, insofar as possible, a definitive final diagnosis. One has to wonder what their true purpose, if any, has become. I thought this situation might change for the better with the advent of hospitalists, but I actually think they've made it worse in many cases by forcing the emergency physician to "sell" them on the admission, which, again, typically entails having a completed work-up and final diagnosis. The amiable internist who would admit whatever you asked him or her to do has faded into extinction.

The ED never was and never will be the appropriate setting in which to contemplate and confirm difficult-to-make diagnoses. Forcing it to function as such inevitably detracts from its primary purposes of being the entry point into the healthcare system for many and a provider of safety net and critical care. As Dr. Klauer notes, EMTALA assures a steady flow of high volume, uncompensated safety net care demand that the ED cannot off-load. In addition, many EDs already operate with only a fraction of their beds, the majority being tied up with extensive work-ups and borders. EMR's have deprived the emergency physician of relevant nursing history and physical findings to factor into the diagnostic thought process. Doing comprehensive work-ups in the ED also raises costs by making all ancillary testing "stat" and it must, of necessity, encourage over-ordering. Is it any wonder that emergency physicians are flocking to freestanding facilities and the more rational practice environments they afford?

—Ronald A. ("Ron") Hellstern, MD, FACEP(E), Colleyville, Texas

.....

EMERGENCY MEDICINE HAS ITS OWN language and culture. People who don't practice emergency medicine think it's just internal medicine in the ER. They picture us having the same leisures they have in how they manage patients, ie, linearly managing patients with known diagnoses. They will never learn our culture or language because they don't necessarily even recognize that there is a difference. Like most people, they don't go looking for things they don't know are in existence. As such, we will always be misunderstood, I fear. I have seen positive changes in the way we are perceived over my 20 years of practice, but there is still a way to go. I explain it as thus: Our job is to manage a community resource, the emergency department. Manage is the key word. Everybody else in medicine has the job of managing the patient's illness. We do that to the extent possible in the background of managing a community resource, but we are never relieved of our duty to first manage a community resource. We co-manage several patients at a time, providing safety for the downstream docs to do their work with major and unexpected medical conditions identified, treated, or ruled out...and, like, 5 minutes ago. We speak a language that nobody else in medicine speaks. Like anybody in that situation, we often can only shake our heads "yes" and move on.

—William Franklin, DO, FACEP Bakersfield, California

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OPINIONS FROM EMERGENCY MEDICINE

A NEW SPIN

Opinion: Are We Free?

The freedom of choice is not free from responsibility

by NICHOLAS VASQUEZ, MD

It's the political season again, and we're talking about liberty, freedom, and responsibility in public. It doesn't matter if you're Democrat, Republican, Independent, or apathetic; you've probably heard the noise from the debate. You've probably also heard it in your emergency department.

Usually it goes like this: "Why is this patient here?" Within that little question lies the entire debate about liberty and responsibility. These are patients who have exercised their freedom to seek care at a local ED for what appears to be a less-than-valid reason. For their troubles, they often get some "constructive" feedback:

- "Kid's got a fever? Did you try Tylenol? No? OK, let's try Tylenol."
- "No, I don't write notes for work."
- "No, I don't refill morphine ER scripts."
- "You're 18. Does your back really hurt you that bad? Let's try Tylenol."
- "No, the mole doesn't look any bigger in the time you've been here."
- "Yes, we do have a drug that starts with D. Lots of them. But let's try Tylenol."

During a string of night shifts recently I saw many of these patients. In my group, in conferences, in articles, and in online commentary, I have heard many people suggest these patients do not need to be in the ED. I don't disagree, but back to my original question, are we free? We have a system of government that allows people to self-determine. You can do almost anything you want without someone looking over your shoulder. Even illegal activities are possible if you want them badly enough. Want to do meth? How about drink alcohol all day? Eat junk food because it's the least expensive? Watch TV and sit on the couch endlessly? You're free to do all of that.

In fact, those of us in emergency medicine have a job because of these freedoms. I call them the "4 Bads": bad genes, bad habits, bad choices, and bad luck. (You could add bad policy, but I digress.) Most of our "don't need to be here" patients fall into one of these categories. Maybe it was the meth addict who was brought in by police after being up for three days. Or maybe it was the alcoholic guy who has been in your ED more times than you have. Or maybe it was someone who needed a note for work. Whatever it was, I'm certain there was a patient on your last shift who met these criteria. People who could have and should have known better. People who could have and should have sought treatment beforehand.

Often I've heard that "these people" should have the personal responsibility to take care of their issues. If they have primary care physicians, why don't they try to go to them? It turns out they're free to do whatever they choose, even if that's make bad choices. What they're not free from are the consequences. Every action, the saying goes, has a reaction. Every choice has an effect. Many of my colleagues have noted the choices made by patients have costs. "Your tax dollars hard at work," I hear. As if the prescription was to simply cut them off. As if the prescription was to erect a barrier or a filter so only the "right" people get seen.

My point is this: in this country, we're free to do as we please. Often these choices have consequences that reverberate beyond just ourselves. In fact, they often impact the community negatively. This is where our freedoms are supposed to end, but it's never that clean. There are only so many resources out there and not enough hospital beds for the population. EDs, for example, get very crowded (albeit for many different reasons), impacting everyone who works there and everyone who comes to that ED in need. So are we then to limit everyone's freedom to self-determine? Are we to tell people when they can and cannot decide it's an emergency? Or are we free to self-determine?

Some of you might rightly point out that we can't afford to let everyone utilize resources endlessly. That we all have a responsibility to the broader community to be a steward of resources and to not run our country into bankruptcy. That there are limits to freedom. You're probably right, but maybe we in medicine should be talking about those limits. The great majority of the cost in our health care system is spent on the sickest patients. The greatest source of our long-term debt in the country is the cost of health care. Maybe we in medicine have a responsibility to our country. However, I'm pretty sure that when sick patients show up in your ED, you do what I do and try to save them.

This is what we've trained and studied for. We get up for sick patients. I've heard nurses complain, "I'm bored. We need a good code." It sounds awful, but it's what we do. We like to treat sick people, not the "riffraff." Yet, those sickest people who we save, those septic 72-year-olds or diabetic 56-year-olds having strokes, those are the ones who cost the most. Hands down, no doubt about it, the sickest

CONTINUED *on page 6*

Are we free to choose an unhealthy life if, at the end of it, we help to bankrupt our country? Is it other people's business what you do on a daily basis, knowing that health is a set of habits you keep? In this country, people are free to choose as they wish, but it's often the broader community that cleans up after them.

ILLUSTRATION/PAUL JUESTRICH; PHOTOS SHUTTERSTOCK.COM

ACEP Wins Excellence in Education Award From AMA

ACEP has won the coveted CPT Excellence in Education Award from the American Medical Association (AMA).

ACEP was recognized for the material on the organization's website that advances the Current Procedural Terminology (CPT) code set and appeals to a broad audience far beyond the emergency medicine community.

"The American College of Emergency Physicians has assembled an impressive array of educational materials including books, courses, webpages, webinars, and other outreach programs designed for members of their specialty," according to Ken Brin, MD, PhD, chairman of the CPT Editorial Panel. "These efforts demonstrate considerable ongoing organizational commitment to excellence in education."

The award was conferred at the AMA CPT Annual Advisory Committee meeting in February 2016.

ACEP Reimbursement Director David A. McKenzie, CAE, center, accepts the CPT Excellence in Education Award from the American Medical Association at the AMA CPT Advisory Committee meeting in February. Ken L. DeHart, MD, FACEP, left, is the emergency medicine CPT advisor, and J. Mark Meredith III, MD, FACEP, right, is the alternate CPT advisor.

ACEP Reimbursement Director David A. McKenzie, CAE, was on hand to accept the award. ACEP's Coding and Nomenclature Advisory Committee and the Reimbursement Committee developed the content.

Nominations Sought for Emergency Medicine Longevity, Tenure Awards

The ACEP Section of Careers in Emergency Medicine is accepting nominations for two awards that will recognize physicians who have enjoyed long careers in emergency medicine.

The Longevity Award will recognize a physician with the longest active career in emergency medicine.

The Tenure Award is for the physician with the longest active career in the same emergency department.

Recognition will also be given to physicians who are still actively practicing emergency medicine after 20, 25, 30, and 35 years.

The deadline for applications is July 15, 2016. The award recipients will be recognized during the section meeting at ACEP16 in Las Vegas.

To be eligible for the awards, physicians must be current ACEP members and must have worked an average of 1,000 or more hours per year in emergency medicine practice or teaching. Hours for residency training and administration are not included.

Previous applicants may apply every year but may not win the same award within a five-year period. A full historical background must be included, along with a brief essay (300 words or fewer) about why the nominee made emergency medicine a career.

Nominations may be submitted to Tanya L. Downing, ACEP, P.O. Box 619911, Dallas, TX 75261-09911, or emailed to **careers.section@acep.org**.

ACEP Leaders Receive Awards From Gathering of Eagles

Several ACEP EMS leaders were recognized during a recent EMS State of the Sciences: A Gathering of Eagles XVIII Conference in Dallas.

- **Jim Augustine, MD, FACEP,** an ACEP Board member, received the Paul E. Pepe National Excellence in EMS Award.
- **Craig Manifold, DO, FACEP,** who serves as ACEP EMS Committee Chair and on the Board of the National Registry of EMTs, received the Michael Copass Leadership Award.
- **Sophia Dyer, MD, FACEP,** who is medical director for Boston Public Safety and associate professor of emergency medicine at Boston University School of Medicine, received the Corey Slovis Award for Excellence in Education.

The conference, held by the U.S. Metropolitan Municipalities EMS Medical Directors Consortium and others, was held in Dallas in February 2016.

A NEW SPIN | CONTINUED FROM PAGE 5

people cost the most. If you're worried about the cost of health care, then you're worried about this problem. Our country seems to be generating disease, like obesity, cancer, and diabetes, at greater rates. Are we going to treat all of them when they show up? Or can we turn that trend somehow?

Are we free to self-determine? Are we free to choose an unhealthy life if, at the end of it, we help to bankrupt our country? Is it other people's business what you do on a daily basis, knowing that health is a set of habits you keep? In this country, people are free to choose as they wish, but it's often the broader community that cleans up after them. We in emergency medicine are part of that community, often the business end of it. We may grouse about patients who abuse the ED, but all of us have the responsibility to make better choices. That could be how you treat your next patient or how you choose to manage the stress that comes from treating those patients.

I look at the ED as a public space, which can be used by anyone. In that public space are all the issues that our country has to offer. We can choose to make things better or worse each day, with each patient. We may not save a life each day, but we can touch one. In many of our EDs, we see the effects of poverty. Like many school districts around us, we will soon be asked to account for quality outcomes but not given credit for the effect that poverty has on those outcomes. Let us not assume that "these people" have some moral failing that they need to dwell upon. Let us not assume that "these people" deserve our scorn or our criticism. They need our help, not our judgment. I believe that we understand very little about the needs of the very patients who show up in our departments. We may assume they want drugs or free stuff, but have you ever asked? Has anyone ever studied it or taken a survey? What we have in our EDs is nothing less than a real-time, ongoing needs assessment for the community around the ED. "These people" who show up to the ED inappropriately are the very ones who, without intervention, will end up as the sickest patients we all trained for. I think it's in our long-term interest to take advantage of their presence and get a lot better at meeting their needs. In short, we need to better serve "these people" and seek to understand their problems.

Like many school districts around us, we will soon be asked to account for quality outcomes but not given credit for the effect that poverty has on those outcomes. Let us not assume that "these people" have some moral failing that they need to dwell upon. Let us not assume that "these people" deserve our scorn or our criticism. They need our help, not our judgment. I believe that we understand very little about the needs of the very patients who show up in our departments.

We in EM need to prevail on our leaders and on society in general to improve our country's health. If we cannot successfully address the bad choices and bad habits that lead to many of our patient's illnesses, there will be more sick patients than we can shake a stick at. While this is what I trained for, I don't believe this is good for our country. Whatever the solution, we will have to act more like a community and less like free individuals who have no connection to one another.

DR. VASQUEZ is an emergency physician who has been practicing for 10 years and currently serves as a medical director at a hospital in Arizona. In 2010, he served as president of the Arizona College of Emergency Physicians.

ZIKA UPDATE

What emergency physicians need to know about this latest disease outbreak

by DAVID E. HOGAN, DO, MPH, FACEP

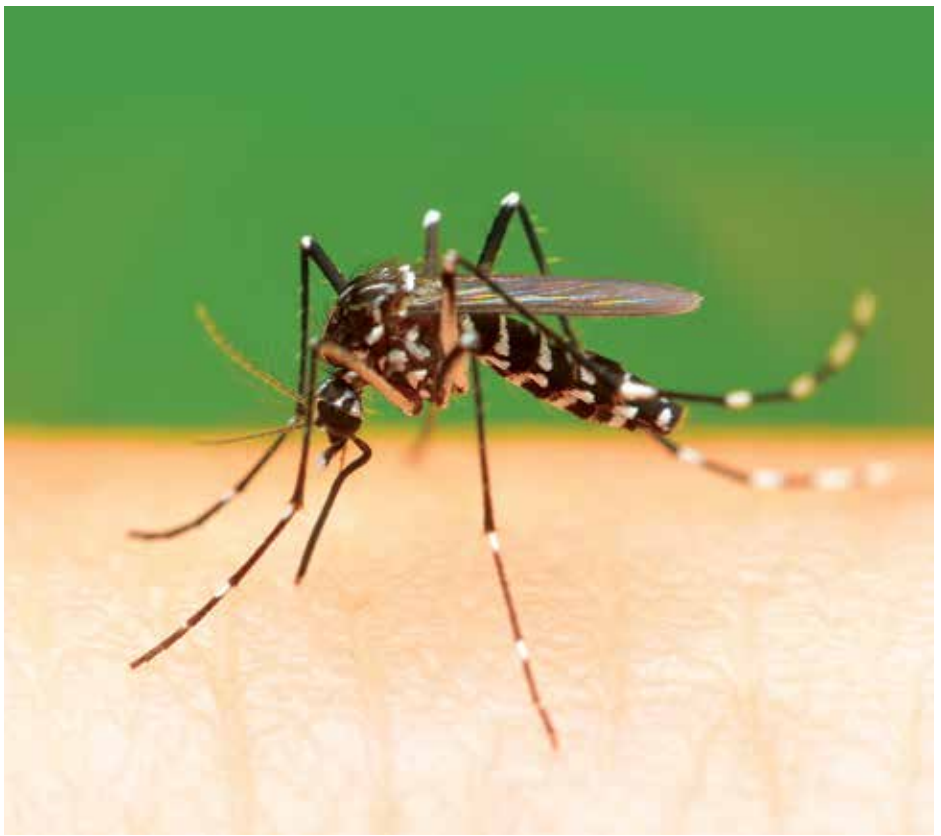
We just learned lessons about our preparedness (or lack thereof) in detecting and managing one virus in the form of Ebola, and now we have another? Now it seems, along with everything else, emergency physicians must function as frontline epidemiologists, identifying potentially dangerous infections. Welcome to the new millennium of emergency medicine.

ZIKA BASICS

Zika virus, a flavivirus transmitted mainly by mosquitos, is another in a line of emerging infectious diseases (EIDs) making new or return appearances in the United States. Zika can also be spread sexually (although the ease of transmission is not known) and through blood transfusions (a particular problem in outbreak areas). Most areas of South America, Central America, and Mexico are currently experiencing the largest known outbreak of Zika viral infection. To date, more than 150 cases of Zika have been detected in the continental United States. Current data suggest that at least nine of these cases (5.8 percent) are in pregnant women. All of these have been travel related in people returning from outbreak areas. About 107 endemic (locally transmitted) cases acquired by mosquito bites have been reported in Puerto Rico and the US Virgin Islands. In outbreak areas, the proportion of the population infected varies from 70 percent to 1.2 percent based on multiple factors. The vector mosquitos required to transmit Zika are already endemic in the South, Midwest, and Eastern United States. The World Health Organization predicts that Zika will likely be endemic in most of the United States within two years.

Zika is related to dengue, Chikungunya, yellow fever, Japanese encephalitis, and tickborne encephalitis. It usually causes a mild disease resulting in only rare hospitalizations or deaths. However, during the current outbreak, some very astute physicians in Brazil noted a sharp increase in the number of births with severe microencephaly.

The symptoms of Zika include macular or papular rash (90 percent), subjective fever (65 percent), arthralgia (65 percent), conjunctivitis (55 percent), myalgia (48 percent), cephalgia (45 percent), retro-orbital pain (39 percent), dependent edema (19 percent), and vomiting (10 percent). The presence of conjunctivitis and absence of hemorrhage are the most useful clinical indicators in differentiating Zika from dengue and Chikungunya infections (see Table 1). Zika causes minimal disease, with only one in five infected people developing symptoms. Other viral diseases such as dengue and yellow fever are also moving into the United States and are of much greater clinical concern, except for the question of pregnancy.



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Does Zika infection cause fetal malformations? In Brazil, the incidence of microencephaly is not clearly known. However, during the current outbreak, observations suggest a possible 20-fold rise in this malformation over previous years. Some of the children with microencephaly tested positive for Zika; some did not. Although there is no absolute confirmation of a link between Zika and fetal malformations, the latest report by the U.S. Centers for Disease Control and Prevention (CDC) greatly strengthens the theory. However, the circumstantial evidence is concerning enough that multiple agencies have issued alerts to people living in or planning to travel to Zika outbreak areas. Additionally, increasing incidences of Guillain-Barre syndrome have been reported in the Zika outbreak areas. The CDC is also investigating this potential association. No link has yet been confirmed, but as with any viral syndrome later developing neurologic findings, this entity should be considered.

TESTING AND TREATMENT

Treatment of Zika is entirely symptomatic. No vaccine exists for Zika. Vaccines for other flaviviruses (yellow fever, Japanese encephalitis, tickborne encephalitis, and dengue) are available but are of no benefit in Zika. Several companies are working on a Zika vaccine. Because the primary concern is in pregnancy, additional burden is placed on vaccine creators to ensure the safety and efficacy for the mother and fetus. It is probable that a vaccine is at least two years away, but it will likely be longer.

Testing is available for Zika through the CDC and should be performed based on the most current guidelines provided by that agency. Pregnant women who have a travel history to an outbreak area should be tested. All Zika testing is done through state or local departments of health and should be coordinated through those agencies. In settings where the clinician is considering testing outside of the above recommendation, consultation with the state or local epidemiologist on call is indicated. The assay is specific for Zika immunoglobulin M (IgM) antibodies. Such antibodies are detectable between four days and 12 weeks following infection. The results are available within one to two weeks. A positive test only means that the Zika IgM antibody has been detected. It says nothing about the clinical condition of the patient or fetus or the risk of a fetus developing a malformation. False-positive tests are possible after a recent infection with a related flavivirus or in people who have received yellow fever or Japanese encephalitis vaccines. This means that a positive Zika IgM test must be confirmed by other testing at the CDC. Any positive test is an indication for careful referral of pregnant patients to obstetrics/gynecology and patient counseling as outlined by the CDC.

According to news reports, several rapid assays are being developed for Zika. Some test for Zika RNA rather than IgM. Although there is enthusiasm in the lay press, substantial obstacles must be surmounted before rapid RNA testing for Zika can become a reality. Rapid tests historically have proven to be somewhat problematic, particularly once the test is released from study conditions and put in the hands of clinicians. In some scenarios, the presence of DNA or RNA of a particular virus or bacterium has little or no correlation with clinical disease. Getting a rapid result can reduce anxiety. However, it's likely that rapid results will need to be confirmed by other methods at the CDC. There is no specific treatment for Zika infection. Immediate results may be desirable but are not critical to Zika management. Much will depend on the cost and accuracy characteristics of rapid tests when they are developed.

As is true of most issues in medicine, the primary task for the clinician is educational rather than medical. This includes educating not just our patients but also ourselves and the staff at our facilities. EIDs will continue to be a serious issue for this and the next generation of emergency physicians. Although not as clinically dramatic, Zika represents a significantly greater risk to the health of our patients than the recent Ebola outbreak due to the risk of fetal abnormalities. Travel history outside of the United States or to specific outbreak areas should be a routine part of the ED intake process. The Zika virus outbreak is another opportunity for EDs to be educators, refine our approach to EIDs, and enhance the health of our communities.

Table 1. Differential Diagnosis Based on Clinical Presentation of Three Emerging Flaviviral Diseases

FEATURES	ZIKA	DENGUE	CHIKUNGUNYA
Fever	++	+++	+++
Rash	+++	+	++
Conjunctivitis	++		
Arthralgia	++	+	+++
Myalgia	+	++	+
Headache	+	++	++
Hemorrhage		++	
Shock		+	

Source: CDC: http://www.cdc.gov/zika/index.html

DR. HOGAN is director of the TeamHealth National Academic Consortium and director of education at the TeamHealth West Group.

A STRONG VISION FOR THE FUTURE

CONTINUED FROM PAGE 1

KK: What are your top goals for your presidency?

RP: My Council speech included two goals. The first one was to focus on emergency medicine becoming the nucleus of the acute care continuum. This includes continuing the work of the quality registry that has been started with the Clinical Emergency Data Registry; looking at how we can get financial data together to fight payers and their bad behavior, including how the insurance companies have been attacking us; looking at workforce issues; and looking at what a "physician-led team" means. Further on workforce, we're looking at graduate medical education and really being aggressive on that front. Graduates are starting to not have residency slots, and that is not acceptable. Finally, we're looking at wellness. We need to take care of ourselves. With the number of suicides we hear about and the number of people that have had tremendous pain in their lives, we need to support each other, value each member, and help people in their wellness journey.

The second piece of the puzzle is diversity. We're really more diverse than we've ever been. What does diversity mean from generational, gender, race, religion, LGBT, and geography standpoints? We need to pause, step back, and say, "How can we best support all of those different kinds of people?" We are hosting a diversity summit on April 14 to kick this off. We've invited about 20 emergency physicians from all different walks of life, many of whom have studied this or published on the topic within their vantage point. I think this is an opportunity for emergency medicine to lead the entire field and house of medicine.

KK: I think it's wonderful. Most should recognize that this is a serious and important issue. I think this is the right time, the right president, the right organization, and the right charge.

RP: Thanks, Kevin.

KK: What are your views on group democracy, particularly knowing that your career path has been to not work with a democratic group?

RP: That's actually a false statement. I don't know if you know that or not. I will tell you my story. I think that the term "democratic group" is a misnomer. Democracy is where people are voting on every single issue, and that is very hard to do in business. What I think we actually have are partnerships, like our legal colleagues have. You have people come up the chain to become partner. There are senior partners. There is a managing partner. That's the only way you can function in terms of governance and in terms of running a business. In the end when you look at democratic groups, what we really have are partnership groups. When you look at our groups, we have small, medium, and large groups. Then we have our multispecialty groups. They are multispecialty by design and not just hospital-based but outside of the hospital as well.

I actually have experience with a democratic group. I've really been interested in group formation since I was a resident. My first project on the EM practice committee was as a co-author of a paper on how to start a democratic group. I was two or three years out of residency, so I was a junior person on that paper. I learned quite a bit and contributed quite a bit as well. I had the opportunity to start a democratic group about 10 years ago when two hospitals here in the Chicago area were merging together. We wanted to start a new democratic group, we invited all of the physicians to join, and three physicians took up that option. I went through the whole process of taking out a loan and putting up my personal credit. My home was on the line of credit. What I would say about that experience is when you go into that type of group, it's a marriage. It's an intimate relationship, and it has that type of emotional connection. It takes the hard work that a marriage takes. In the end, the group did fail. I've worked for a single contract holder. I've worked for a regional group. I've worked as a hospital employee; that's actually my moonlighting job right now. I've worked at a Veterans Affairs hospital, and I've worked in academics. Right now, I work for a large national group. I have a gamut of experience, and in each of those different areas, I was part of the business side. I think in my role as president that brings a lot of value.

I actually have experience with a democratic group. I've really been interested in group formation since I was a resident. My first project on the EM practice committee was as a co-author of a paper on how to start a democratic group. I was two or three years out of residency, so I was a junior person on that paper.

KK: There's no reward without risk.

RP: Correct. My goal as President is to fight for all forms of practice so that in five years, when the dust settles, people have a choice on where they practice based on what's right for them.

KK: Along those same lines of group democracy, what would you say for those who don't know you well and would question how a physician from a large contract management group would be best suited to be the president of ACEP?

RP: They need to look at me as a person, and as I described, my practice setting has varied. As a person, I am a good choice because of those experiences. This is not the only type of group I've ever worked for. First of all, it comes down to the person.

KK: For those who are not aware of the need for an office building, how would you explain that to them?

RP: I think you start at how old our current building is. Really, it was built 40 years ago. We've been there a long time, and the size of the College is tremendously larger. We actually had to move our financial department to another building because they have no room in the building for them. We have outgrown our space. When we went through the process of figuring out what we need to do to enhance that space, we asked the team to investigate if we could expand and build onto the building we have now. We thought we could lease space where we have everyone together, and that was financially not the best option either. The good thing is that when we bought our property and started the process, we bought the property fairly early on. It's actually already increased in value; it's been a good investment. The portion of money that we put into the down payment was taken out of our savings. There was no dues increase; it was actually money we'd saved over time, and a good proportion of that will be dues money that's been saved up along with money from the Scientific Assembly, investments, etc. We financed the other portion of that so it's not all coming out of our reserves. I think in the end, it's going to set us up for the next 40 years. It's supposed to open in September, and we're going to be able to invite some of the original founders who put together the original building. Most of them are still alive, so that will be pretty neat.

KK: On a lighter note, what is your best ACEP memory while serving on the Board so far?

RP: That's a great question. One of the moments was being the first woman to have a baby while on the Board. The Board was very supportive. About two weeks before Jacob was born, they let me Skype into the Board meeting at the end of June. I was so pregnant, 37 weeks, and so I couldn't travel to Dallas. They essentially set up the computer like I was at the table. If I wanted to say something, I had to raise my hand, and they had me plugged into the overhead. They took care of me.

KK: Were there any contentious discussions that resulted in a few contractions for you?

RP: No, although I did deliver a week later.

Get Involved in the ACEP Pain Management Section

New section aims to increase pain management knowledge and tackle tough issues

by ALEXIS LAPIETRA, DO

Emergency medicine pain management can be painful, but it doesn't have to be. I recently finished a year-long emergency medicine–focused pain management fellowship, the first of its kind. I had the privilege of working with a variety of subspecialties in an effort to gain their perspectives on acute and chronic pain management.

As emergency physicians, our skills go far beyond Tylenol, Percocet, and Motrin. The problem is we get set in our ways and there is only so much time in the month to stay up to date. I have the answer. Join the newly formed ACEP Pain Management Section, a place where high-yield, cutting-edge pain management information can be made available, right at your fingertips.

ACEP PAIN MANAGEMENT SECTION

We can locate a patient's internal jugular vein on ultrasound. Why not move the probe over a few centimeters and instead inject local anesthetic around the brachial plexus? We are very comfortable pushing ketamine as an induction agent for intubation. Why not reduce the dose and give it for severe pain or chronic regional pain syndrome in lieu of opiates? It can even be given intranasally!

The Pain Management Section will serve as a venue to discuss relevant pain management topics such as multimodal nonopiate analgesia as well as novel and evidence-based approaches for the management of chronic pain and opiate addiction. The section will keep the College and its members up to date on cutting-edge pain management issues. Additionally, we will collaborate with the Ultrasound, Pediatrics, Geriatrics, and Palliative Care sections, as well as others in the College, to address controversial issues and help elevate pain management knowledge and practice.

In the current political climate, where opiates are a hot issue and compensation is directly related to patient satisfaction and pain relief, emergency physicians are caught in a bind. We are torn between traditional pain management modalities, concerns about not feeding addiction, and the desire to relieve pain. These are some of the issues the Pain Management Section will address.

Pain management does not have to be the unique province of a few fellowship-trained physicians. We all treat pain every day, but we can do it better by incorporating new medications and modalities and applying them in innovative ways. Our patients and our specialty will benefit enormously from these advances in our practice.

I invite you to join me and become part of this new and practice-changing section. ***Visit www.acep.org/painmanagement for more information.***

DR. LAPIETRA is medical director of emergency medicine pain management and fellowship director of the emergency medicine pain management fellowship at St. Joseph's Regional Medical Center in Paterson, New Jersey.

TWO NEW SECTIONS JOIN ACEP

The ACEP Board of Directors approved two new sections at the January meeting: Pain Management and Event Medicine.

The sections each drew the necessary 100 signatures and were quickly approved by the Board.

The Pain Management Section is designed to promote the subspecialty of pain management; evaluate and develop strategies to better manage acute and chronic pain in the emergency department, including finding ways to treat without opiates; provide discussion of novel protocols and current evidence regarding pain management in ED; and investigate whether to develop an ED-based pain management program.

The section also will advise ACEP on pain management issues, according to the prospective section goals outlined in the new section petition.

The Event Medicine Section aims to train current and future emergency physicians who will act as medical directors and practicing physicians during mass gathering events, according to the section's petition.

The section plans to develop standard operating procedures for event medicine; study the science behind limited-resource medicine, such as evaluating heat index complications, the type of event, and ratio of physicians and health care providers to spectators or participants; and legal implications for health practitioners.

THE BREAK ROOM

CONTINUED FROM PAGE 4

WHILE I DO AGREE WITH DR. KLAUER THAT it appears emergency medicine was unjustifiably singled out in this study, I would like to add a few observations from over 35 years of practicing emergency medicine.

It is an ideal situation if the ED physician is able to arrive at a diagnosis in an efficient and timely manner. Unfortunately, the human machine is not always willing to cooperate and in many cases a definitive diagnosis simply cannot be achieved in the ED within a reasonable timeframe. The next issue for the ED physician becomes "Do I admit or do I refer?" A physician who has listened to the patient's story—and I don't mean asked six or seven preconceived "Yes/No" history template questions that "best fit" (but don't EXACTLY fit) the patient's chief complaint—has done a focused physical examination—not just the now-ubiquitous "stethoscope tap" chest exam or "momentary palm touch" abdominal exam—formulated a differential diagnosis that is followed, has ordered appropriate lab and imaging tests based on his/her assessment of the patient, reviewed all tests results, and addressed any unexpected results is going to be much more secure in deciding whether a patient with an undiagnosed condition needs emergency admission or simply follow-up with their own physician or a referral to a specialist.

However, in the last 15 to 20 years I have noted a serious and progressive decline in the ability of the average emergency physician to perform a competent history and physical exam. In this day of the EHR, many patients have physical exams recorded that never took place. I recall (I'm semi-retired now) medical students and residents arriving for their emergency department rotations without even a stethoscope. I can't speak as to whether these same deficiencies apply to other specialties, though I suspect they do. We need to take a closer look at how medical students are being taught and instill in all new physicians and physicians-in-the-making that there is more to medicine than ordering a bunch of tests and then trying to explain away, or in some unfortunate cases, simply ignore the unexpected, for no other reason than it doesn't fit our preconceived notion of diagnosis and/or disposition.

—Jerry W. Jones, MD, FACEP, FAAEM
Houston, Texas

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I BELIEVE YOUR COMMENTS ARE RIGHT ON point with what we as a specialty need to be more outspoken of. The video that IOM created for laypeople (https://m.youtube.com/watch?v=fStBWT6fa3E) is a mockery to physician insight and perception that we would only favor one diagnosis and do not communicate with our patients throughout their hospitalization. The woman with left upper extremity pain that was apparently anginal in nature states that her long-term morbidity is associated to the delay in her diagnosis. However, they fail to mention if she may have reported any other symptoms to the emergency physician evaluating her on that given day that may have led him/her to believe that this could be acid reflux. Further, did her symptoms evolve over those two weeks and manifest into more obvious anginal symptoms? If we admitted every chest pain that would be considered clinically low risk, what are the long-term implications to our health care system? If we admitted every patient that stated they have a "high pain tolerance" and know that something is wrong, what do we further due to our growing narcotic epidemic? Yet, we find more ways to burden our specialty in reflecting on delays in diagnosis and pointing fingers for the growing narcotic epidemic.

We have all recently been asked to meet the CMS standards for severe sepsis in all of our patients. However, what about the patients in our respective institution that ultimately do not have sepsis? It may appear they could have an infection, but for fear of not meeting regulatory standards, still received the 30 ML per kilo bolus and broad-spectrum antibiotics. Maybe the patient even had a lactic acidosis and an interstitial infiltrate that could reflect pneumonia. What are the implications and long-term morbidity and mortality associated with these patients, that we now have been asked to ensure we hit all quality metrics within a three-hour window (just click the sepsis bundle and everything will be taken care of—but the patient)? Did we not learn from the pneumonia initiative, requiring initiatives such as these have negative implications? However, when a patient is negatively impacted because a physician attempted to use his critical decision-making and determine appropriate line of action, he immediately will be referred back to the CMS standards and the IOM initiative and be asked why.

I thought the best statement I heard made at SMACC was protocolized therapy makes stupid people stupider and smart people stupid. Yes, cognitive errors occur in every specialty and each specialty needs to be accountable. Better communication between physicians and physician subspecialties needs to occur, enhancement of our medical school education, etc. We need to stop focusing on certain hospital metrics. We need to allow an illness to manifest and focus on patient care!

—Hijinio Carreon, DO, FACEP
Des Moines, Iowa

First EM Doc in U.S. House Striving for Another First

Rep. Joe Heck has set his sights on the Senate

BY L. ANTHONY CIRILLO, MD, FACEP

In 2010, Joe Heck, DO, FACEP, became the first emergency physician elected to the U.S. Congress. He was elected to the U.S. House of Representatives to represent the Third District in Nevada and serves on the Committee on Armed Services, Education and the Workforce Committee, and Permanent Select Committee on Intelligence. Born in Queens, New York, but raised in Pennsylvania, he went to Penn State University and then the Philadelphia College of Osteopathic Medicine. (Joe is also the first DO ever elected to Congress.) After completing his EM residency at Albert Einstein Medical Center in Philadelphia, he moved to Nevada. After three terms in the U.S. House, Joe is now running for the U.S. Senate from Nevada for the seat being vacated by retiring Senate Minority Leader Harry Reid. In addition to his work in the emergency department until his election to the U.S. House in 2010, Joe was also a small-business owner, operating Specialized Medical Operations, which provided medical and tactical training to law enforcement and emergency medical services agencies.

In his "spare time" (like he really has any), Joe has been a member of the U.S. Army Reserve since 1991, and in 2014, he was promoted to brigadier general. After recently completing an assignment as the deputy commanding general of the 3rd Medical Command, he now serves as the deputy surgeon and director of reserve readiness on the Joint Staff. As part of his service in the reserves, Joe has been mobilized three times, including his last deployment to Iraq in support of Operation Iraqi Freedom.

ACEP Now *caught up with Joe to see how the campaign was going and how he feels about the future of politics and health care.*

LAC: What is the biggest difference between running for the Senate versus the House?

JH: The biggest difference, literally, is the geography. When you run for the U.S. House, you can really focus on just your district, which is geographically much smaller. Running for the U.S. Senate requires you to be present everywhere in the state. For a state like Nevada that has only three major population centers, that means traveling long distances to get to every small hamlet and town where the voters are. But that's what the election is really about: making sure that you let every voter know, no matter how small the town they live in, that they matter to you. The second difference is the amount of money that it takes to run for the U.S. Senate. The average U.S. House race costs about $2 million to run, but the average U.S. Senate race is five to six times that amount. Realistically, you can't raise the amount of money needed for a Senate race in just your home state. As a candidate, you have to do national fund-raising. During this campaign, I will do multiple fund-raisers in Boston, New York City, Dallas, and other "big" cities. These events are hosted by people who either know me directly or are willing to support me for my work in Congress. While it is nice to know that people outside of Nevada are willing to support my campaign, it does require a lot more time and logistical coordination. For some candidates, having to run a more national campaign means relinquishing some control of your campaign to key staff. Fortunately for me, I fall into the type A EM doc model and like to keep control over everything. Although I definitely delegate more in this campaign, I still have final sign-off on all messaging and events that take place.

LAC: What were the key determinants in your decision to risk your House seat for a Senate run?

JH: When I ran for the U.S. House in 2010, the major campaign issues and problems facing the country were national security, jobs and the economy, and health care. In 2016, those are still the same major issues/challenges facing the nation. While I am honored to serve in the U.S. House, there are 435 of us there, and there are limited chances to make major policy changes. With only 100 members of the U.S. Senate, there is the potential to have a greater impact on policy development, certainly at a national level and even somewhat back home on a statewide basis. I guess my hope would be that I would have the opportunity to do more good for more people if I'm elected to the U.S. Senate. The other factor that was important to me in deciding to run was that I felt that there were good candidates back home in Nevada that would potentially fill my U.S. House seat. Knowing that the people who had expressed interest in running to replace me were people who I trusted to take care of my district meant a lot to me. Lots of people have asked me what I will do if I don't win the election. That's simple—I will go back to being an ER doc. Every day in Washington, I remind people that I am an ER doc first and a member of Congress second. I have always known that at some point I was one election away from being back in the ED, something that I am totally OK with.

LAC: How can the house of emergency medicine be more supportive of EM docs who are interested in the political arena?

JH: Running for office is tough, especially when you run against an entrenched incumbent. My first campaign was for Nevada state senate in 2004, when I ran against a 20-year incumbent from my own party. At that time, that was not a very popular move with the Republican Party establishment, but I felt that the person had become "too comfortable" with their seat and wasn't representing the people anymore. Since running for office is hard, emergency medicine needs to do more to encourage docs to get involved earlier in the political process. It is a sad reality that most physicians, including most emergency physicians, are politically apathetic. In Nevada, back in 2004, lots of physicians supported my campaign for the state senate because there were no physicians in the state senate,

ILLUSTRATION/PAUL JUESTRICH; PHOTOS SHUTTERSTOCK.COM

the state was in the middle of our malpractice crisis, and the docs were all worked up on that issue. But the reality is that there are issues at the state and national level being decided every day that will affect the future of emergency medicine and how we care for patients. You can't wait until the last minute to voice your opinion on an issue and expect it to mean as much when you haven't been investing any time in the people representing you. Democracy is not a spectator sport; you have to participate in order to be an effective advocate. In order to do my part to help encourage EM docs to get involved, I am establishing internship programs in my office in D.C., and I believe Rep. Raul Ruiz has done that as well. Residents, or really any EM doc, that want to spend time in D.C. on the Hill can come and spend a month working with me on health policy issues. If docs can't get to D.C., then they should get involved with their state ACEP chapter or state or county medical society. The "where" you get involved isn't as important as just making the commitment to be engaged.

My first campaign was for Nevada state senate in 2004, when I ran against a 20-year incumbent from my own party. At that time, that was not a very popular move with the Republican Party establishment, but I felt that the person had become "too comfortable" with their seat and wasn't representing the people anymore. Since running for office is hard, emergency medicine needs to do more to encourage docs to get involved earlier in the political process.

—Joe Heck, DO, FACEP

LAC: What are you most and least proud of in your political career?

JH: In all honesty, what I am most proud of is the staff that I have working on my behalf serving the people of my district. Nothing gives me more pleasure than to be back home in Nevada at the supermarket and have someone come up and ask me if I am Representative Heck. Although that can be a little scary sometimes, it is almost always someone who just wants to say thank you for something that one of my staff helped them with. Whether it's a veteran who we helped get the benefits that he was having trouble receiving or someone dealing with a home foreclosure, my staff does amazing work in helping the people who live in my district. To me, being a member of Congress is not about passing bills in D.C.—it's about taking care of the people back home. On the "least proud" part of the question, I don't really feel there has been anything not to be proud of. I certainly have struggled with deciding how to vote on some issues. But for each vote, I try to weigh the positives and negatives of the bill and then make my decision. For the really tough ones, I ask myself if I believe that the bill would be good for my three kids and all the other kids in the state and the nation. I figure if it passes that test, then I can be at peace with the vote.

LAC: What do you see as potential solutions to the hyper-partisanship that exists within Congress?

JH: That's an interesting question because I don't believe that the Congress is really as partisan as it portrayed. Yes, the two parties will always have their differences on some major social and philosophical issues, but the Congress was able to pass very significant legislation in a bipartisan manner last year. We passed a five-year transportation bill, replaced the No Child Left Behind Act with the Every Student Succeeds Act, and passed the 54th consecutive National Defense Authorization Act. These are significant pieces of legislation that will affect the entire nation for years to come. Oh, and we also voted to do away with the Sustainable Growth Rate after 14 years—finally! My approach in Congress is simple. Rather than focusing on our differences, I try to find a member from the other side of the aisle that shares my concern on a specific issue. Maybe their district is facing the same problem that my district is, or they have a constituency or group that shares a concern with me, like health care. I will go and seek out that member and work with them to draft a bill that addresses the issue but is something that each of us can then take back to our respective parties and support. Focusing on the issue rather than party is a formula that I believe works well. That's why Raul and I can work together on health care issues; we share the common bonds of the emergency department and focusing on fixing problems.

LAC: How can EM docs find out more about your campaign?

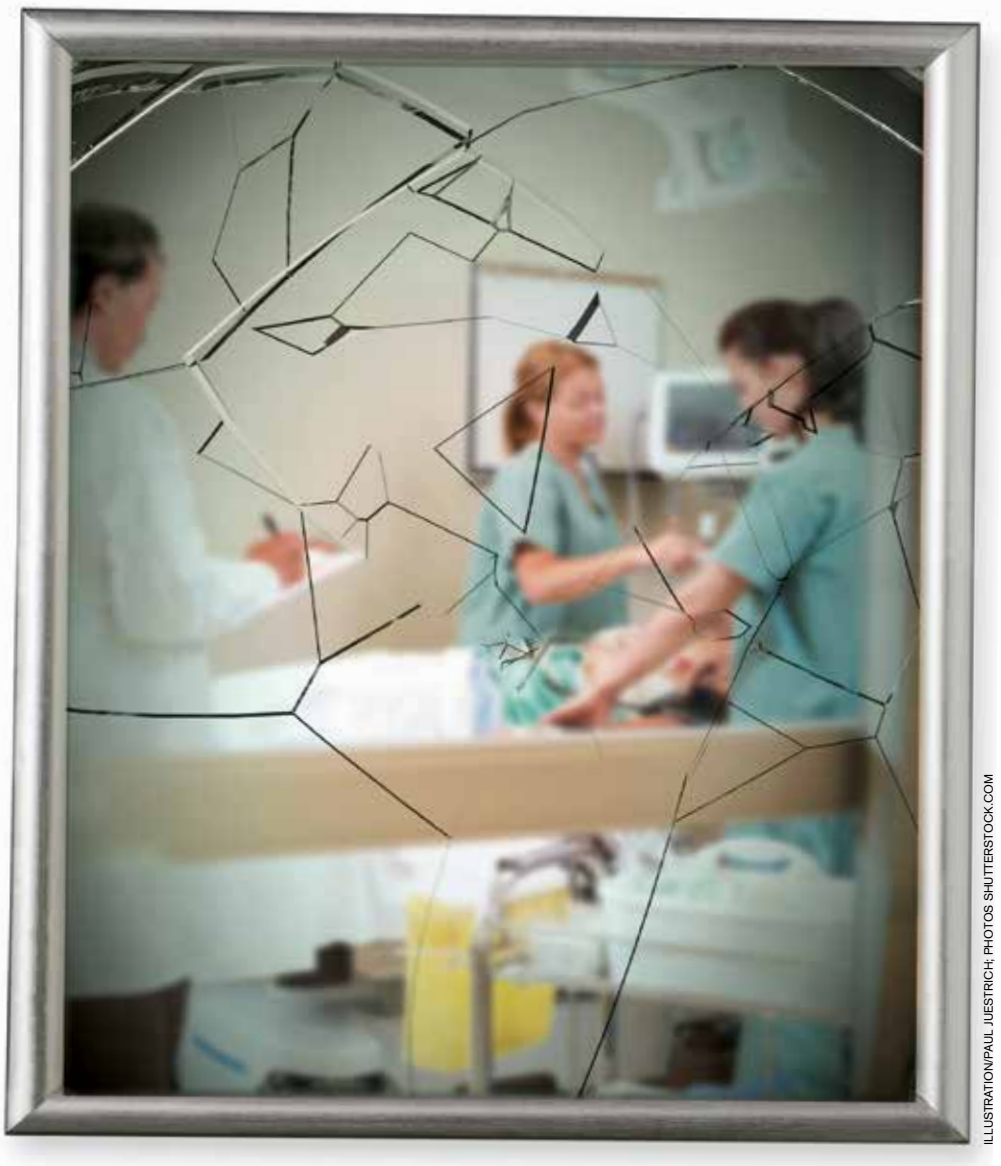
JH: The campaign website is www.heck4nevada.us. I would be happy to talk with any EM doc that wants to learn more about getting involved, running for office, or about any policy issues.

DR. CIRILLO is director of health policy and legislative advocacy for US Acute Care Solutions/EMP in Canton, Ohio.

Taking a Good, Hard Look in the Patient Satisfaction Mirror

I thought I was a good doc, but patient satisfaction scores taught me to be better

BY DAN GETZ, DO



ILLUSTRATION/PAUL JUESTRICH; PHOTOS SHUTTERSTOCK.COM

The hardest part of change is being convinced of its need. Patient satisfaction (experience of care) is a topic that rarely elicits positive emotions from providers. When tasked with improving my own scores, I began the journey with a great deal of skepticism. Before exploring how to improve, I had to first convince myself why this was necessary and worthwhile.

I felt I was doing a good job as a doctor. My patient satisfaction scores were low, but in my mind, they were unimportant and outside of my control. Surveys had poor statistical power. Patients had unrealistic expectations and were often drug seeking, and the nature of the emergency department prevented my success.

These, among numerous other fallacies, were preventing me from becoming a better physician. To quote Mark Twain, "It's not what you don't know that kills you, it's what you know for sure that ain't true."

As I challenged myself, many things surfaced that I had not considered.

Patient experience has direct financial implications for physicians. A tenet of good business is that consumers vote with dollars. One bad experience may influence friends, family, and, if documented on social media, even thousands of future patients.

Time spent at bedside does not equal better care. High-quality communication takes no additional time when interactions are focused and address patient expectations.

Physicians drive patient satisfaction. Skilled, empathetic communication influences experience greater than any single variable. Improved clinical outcomes and lower ED recidivism rates are valued dividends.

First Steps of Change

After several nights of fractured sleep, I scheduled a meeting with our service excellence manager to review my data. I learned that I was below the 30th percentile for the majority of metrics (see Table 1).

As a medical director, I could not effectively lead my department without improving my own practice, so I began to study the many variables that drive patient perception.

It became apparent that I was not communicating effectively. My unintentional lack of collaboration with patients made it impossible to deliver reassurance and emotional comfort and alleviate fear. Any effective approach must set reasonable expectations. We serve as clinicians and guides, helping patients navigate the terrifying and often foreign ED journey. Without providing context or framework for their stay, we inadvertently foster unrealistic patient expectations. This is the reason approaches such as AIDET work.

AIDET Method

Acknowledge and Introduce: This sets the stage for patient experience. Knock, and wait for permission to enter. Greet everyone in the room, and reciprocate with your name and title. Make routine eye contact, and use receptive body language. If they have waited, let them know their time is important by apologizing. I may be having an incredibly stressful shift, but my goal is for patients to feel that I am 100 percent focused on them at that point in time.

Always sit. Patients perceive that you spend more time when you sit, and it implies interest. Communication is a team sport. Utilize active listening, allowing patients the opportunity to fully describe their symptoms. Shared experiences or interests help to build rapport. Friendly conversation is a great tension diffuser.

Duration/Describe: Develop reasonable goals with patients, including a reasonable estimate of time they will spend in the department. Discuss conditions in your differential diagnosis, and inform them that your role is to exclude life-threatening illness. Initiate dialogue surrounding realistic pain management, engaging them as a partner in their care. For example: "Mrs. Jones, I know your pain is a 10 and reaching a 0 for you today is unlikely, but let's aim for a 4. We are going to get you more comfortable."

Discuss that they may leave the ED without a formal diagnosis; for many, we are the "what it ain't" department. Visit with your patients frequently, even if only popping your head in to update them on progress, results, or unanticipated delays. Patients with benign chest pain believe they are having a heart attack and will be reassured by their normal results. Don't make patients wait until the end of their stay to hear good news.

Explain and Engage: This is the most important part of the patient encounter. Using simple terminology, review with your patients what you have ordered, have or have not found, follow-up and treatment recommendations including symptoms of concern, and all new prescriptions. Finally, and this is the easiest to forget, provide everyone an opportunity to ask questions: "I would like to take a moment to try and answer any questions that you or your family/friends may have." As medical director at a 90,000-plus visit ED, I spend a fair amount of time in complaint resolution meetings, and I would estimate that nearly all of the complaints of merit could have been avoided if providers spent more time on this step.

Thank: At the end of the visit, take a moment to genuinely thank your patients for the opportunity to care for them. Patients should feel valued. I am humbled by the amount of trust patients place in my hands, and at the close of a visit, I want them to know that I am sincerely thankful for the opportunity to provide their care.

The Benefits of Focusing on Patient Experience

As I became better versed in these techniques, my job satisfaction unexpectedly and sub-

Table 1. Initial Scores, 2012

Providence Sacred Heart Medical Ctr — infoEDGE

EMERGENCY DEPARTMENT REPORT

Filter Definition

Filter	Choice(s)
Visit Date	From 01/01/2012 To 12/31/2012
IT ER_MDNAM	Getz,Daniel B

Providence Sacred Heart Medical Ctr — infoEDGE

EMERGENCY DEPARTMENT REPORT

Question Analysis

All Respondents

Section / Question	Top Box	n	All PG DB N = 1647 Top Box	All PG DB N = 1647 Rank	Large PG DB N = 914 Top Box	Large PG DB N = 914 Rank	Visits 60K-80K N = 111 Top Box	Visits 60K-80K N = 111 Rank
Std Doctors	58.6	58	65.4	19	64.9	17	62.7	28
Doctors	58.6	58						
Doctors courtesy	62.1	58	68.7	20	68.5	18	66.5	30
Doctor took time to listen	60.3	58	65.4	25	65.0	23	63.0	35
Doctor informative re treatment	55.2	58	63.3	15	62.7	14	60.3	25
Doctors concern for comfort	56.9	58	64.0	19	63.4	18	60.9	28

Table 2. Improved Scores, 2014 to 2015

Providence Sacred Heart Medical Ctr — infoEDGE

EMERGENCY DEPARTMENT REPORT

Question Analysis - Visit Date: 1/1/14 - 12/31/14

Visit Date 1/1/14 - 12/31/14 — All Respondents

Section / Question	Top Box	n	All PG DB N = 1886 Top Box	All PG DB N = 1886 Rank	Large PG DB N = 1072 Top Box	Large PG DB N = 1072 Rank	Visits 60K-80K N = 119 Top Box	Visits 60K-80K N = 119 Rank
Std Doctors	73.6	44	66.4	80	65.2	88	62.6	93
Doctors	73.6	44						
Doctors courtesy	79.5	44	69.8	88	68.9	93	66.7	98
Doctor took time to listen	74.4	43	66.6	82	65.4	89	63.0	93
Doctor informative re treatment	68.2	44	64.4	67	62.9	76	60.1	87
Doctors concern for comfort	72.1	43	64.7	80	63.4	87	60.6	95

Question Analysis - Visit Date: 1/1/15 - 12/31/15

Visit Date 1/1/15 - 12/31/15 — All Respondents

Section / Question	Top Box	n	All PG DB N = 1886 Top Box	All PG DB N = 1886 Rank	Large PG DB N = 1072 Top Box	Large PG DB N = 1072 Rank	Visits 60K-80K N = 119 Top Box	Visits 60K-80K N = 119 Rank
Std Doctors	73.5	27	66.4	80	65.2	87	62.6	93
Doctors	73.5	27						
Doctors courtesy	76.9	26	69.8	81	68.9	87	66.7	92
Doctor took time to listen	73.1	26	66.6	78	65.4	86	63.0	92
Doctor informative re treatment	69.2	26	64.4	72	62.9	81	60.1	91
Doctors concern for comfort	75.0	24	64.7	87	63.4	94	60.6	97

Table 3. Latest Scores, 2015 to 2016

Filter Definition

Filter	Choice(s)
Received Date	From 08/01/2015 To 01/31/2016
IT ER_NAME	GETZ, DANIEL

Question Analysis - IT ER_NAME: GETZ, DANIEL / Received Date: Total

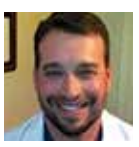
Received Date Total — All Respondents

Section / Question	Mean	n	All PG DB N = 1967 Mean	All PG DB N = 1967 Rank	Large PG DB N = 996 Mean	Large PG DB N = 996 Rank	Visits 60K-80K N = 111 Mean	Visits 60K-80K N = 111 Rank
Std Doctors	93.5	29	86.8	96	86.5	99	85.9	99
Doctors	93.5	29						
Doctors courtesy	96.4	28	89.0	99	88.8	99	88.3	99
Doctor took time to listen	92.9	28	87.0	93	86.8	98	86.3	99
Doctor informative re treatment	92.2	29	85.6	94	85.0	99	84.4	99
Doctors concern for comfort	92.0	28	85.8	93	85.4	97	84.7	99

stantially improved. Cookies were delivered to the department by sweet little old ladies. Notes of thanks began to come in routinely as well as requests to become a patient's primary care provider (a patient's highest form of praise). With a heightened sense of pride in my practice and continued efforts, I was able to obtain sustainable results.

Over the course of six months, my patient experience scores climbed from the 20th percentile to the 90th and have held steady for the past two years (see Tables 2 and 3). With myself as a case study, I was ready to engage my physician partners, many of whom also had been unaware they were struggling.

I am glad to report that our ED has made significant gains in patient experience and our providers continue to improve. More important, this has elevated the morale of everyone on our team. Enhancing patient experience does not need to invoke feelings of fear or hostility. It is simply better patient care.



DR. GETZ is ED medical director at Providence Sacred Heart Medical Center in Spokane, Washington; founder of Satisfaction Statistics, Inc., a patient satisfaction survey and patient experience consulting company; and adjunct clinical instructor for the department of emergency medicine at the University of Washington.

Meet the ACEP *Now* Team

ACEP *Now* CONTRIBUTOR

Ryan Patrick Radecki, MD, MS

- Author of the *Pearls from the Medical Literature* column, which takes a critical look at EM research, including:
  - tPA clinical policy
  - pediatric bronchiolitis guidelines
  - prescribing of antibiotics
- Blogs about EM research at **emlitofnote.com**
- Assistant Professor of Emergency Medicine at The University of Texas Medical School at Houston

Emergency Department Billing Under the Microscope in California

Anthem announces prepayment review on level 5 ED E/M Medicare claims

BY DAVID MCKENZIE, CAE

Anthem Blue Cross has announced that beginning January 2016, the plan will begin a prepayment review of selected ED visits billed with Current Procedural Terminology (CPT) code 99285 (professional service) or HCPCS code G0384 (ED facility service) under the Blue Cross Medicare Advantage Program. In other words, certain claims from these plans will not be paid until the medical record from the encounter has been reviewed by auditing the chart documentation to verify it meets, or exceeds, the requirements listed in the American Medical Association CPT book.

Anthem is targeting level 5 services that were not admitted to the hospital following the ED visit, reasoning that if the patient could go home after the ED treatment, extensive treatment wasn't required. Anthem is concerned that ED visit frequency distributions do not reflect a normal bell curve distribution, suggesting overuse of the higher-level codes.

ONLINE RESOURCES

ACEP has resources in the Reimbursement area of the web page found at **www.acep.org/reimbursement**, which include a paper offering valid reasons for the shift to a greater frequency of higher-acuity ED E/M codes and how to prepare for, and defend yourself from, payer audits.

CHALLENGE THIS PRACTICE

ACEP advises that this practice be challenged and that you should insist that frequency distribution comparisons be "apples to apples." In particular, Anthem should be comparing emergency physicians against other emergency physicians in similar practice locations rather than against claims from a different medical specialty or provider. Importantly, there are meaningful differences between high-acuity urban tertiary trauma centers and more rural emergency departments that often go unrecognized.

The increase in lower-cost alternative sites of service, ranging from "minute clinics" to urgent care clinics, has siphoned some of the lower-acuity volume away from emergency departments, which has likely resulted in the appearance, to payers, that a higher percentage of higher-level services in emergency departments are being claimed when compared to the frequency of lower codes. In fact, the acuity of the average ED patient is increasing regardless of whether they require admission.

Anthem has stated that it has implemented this process for its Medicare Advantage plans at this time, but we are watching to see if the policy spreads to Anthem commercial products as well.

Routine prepayment audits will create a significant financial hardship on practices with high Anthem exposure because the ED group will not be paid until after the reviews are complete. At best, this could cause a significant delay in cash flow for what is already a payment rate that is significantly discounted from usual and customary charges. At worst, if the claims are rejected or down-coded based on inappropriate "approved diagnosis lists," the payments can be reduced by as much as 40 percent or even paid at a nominal "screening fee" rate. There is an appeals process, but it is expensive and time-consuming, preventing timely payment for EMTALA-mandated services.

Although it is reasonable for Anthem, or any plan, to perform audits of claims received, widespread prepayment audits without indication of prior cause for concern seems unfair and presents a challenge to the fragile health care safety net the ED provides to the community and the managed Medicare population.

MR. MCKENZIE is reimbursement director for ACEP.

Diversity Executive Reception Promotes Sharing of Unique Perspectives and Ideas

The reception brings together emergency medicine leaders to focus on improving health care

BY SAVOY BRUMMER, MD, FACEP

Since ACEP13 in Seattle, medical directors, regional directors, members of boards of directors, vice presidents, chief medical officers, and chief executive officers of numerous national emergency medicine practice groups, hospital systems, academic institutions, and private-equity groups have attended the Diversity Executive Reception.

This annual private reception provides the opportunity for minority physician executives to network and discuss their unique professional accomplishments as well as providing the opportunity for higher-level discussions involving the business of emergency medicine. Annually, more than 50 senior-level executives of all cultural backgrounds meet to discuss how their roles and unique perspectives can promote the mission of their hospitals, physician organizations, and patients. Even Obama administration officials have come to this reception to hear from these diverse health care executives because they manage billions of dollars of health care revenue across the United States.

The reception has purposely remained informal to offer the most amount of time to network for the attendees. Wesley Curry, MD, chief executive officer of CEP America and one of the sponsors of the reception, felt like it was his responsibility to start such a group and maintain a relaxed atmosphere. "I feel that my 30 years of executive experience can be a very valuable resource for the next generation of physician executives," he said. "It's wonderful to mentor and converse with such a broad group of talented leaders."

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I have to take advantage of every year," he said.

The Diversity Executive Reception at ACEP has steadily increased its attendance numbers. It was originally designed for leaders at the level of medical director and above, and some executives have now brought select residents or assistant directors who are interested in administration so they can gain access to mentors and further their professional opportunities. It has been a rewarding experience for both junior and seasoned emergency medicine executive leaders.

The Diversity Executive Reception at ACEP has steadily increased its attendance numbers. It was originally designed for leaders at the level of medical director and above, and some executives have now brought select residents or assistant directors who are interested in administration so they can gain access to mentors and further their professional opportunities.

Reginald Nesbitt, MD, the previous chief integration officer of ApolloMD and now medical director of Alii Healthcare, has also found value in attending and has been coming annually since the group's inception. "The opportunity to meet with leaders driving new health care solutions in and outside of the emergency departments is something

Historically, there has not been a significant institutional drive to promote diverse executive leadership even though ethnic and racial minorities have experienced worse clinical outcomes across a broad spectrum of diseases, even when adjusted for income. We have known for some time that these health care disparities exist and cost U.S. taxpayers billions of dollars annually. Derek Robinson, MD, FACEP, is vice president of enterprise quality and accreditation for the Health Care Service Corporation and a past attendee of the reception. His role is to "ensure that his members receive the best care and provide optimal outcomes." He believes that there were few financial incentives for cash-strapped hospital systems and "hesitancy" for physician groups to move toward greater diversity in their executive ranks. The traditional fee-for-service model placed very little value on clinical outcomes or integrated delivery models for populations, and so the status quo persisted.

However, with the advent of population health and value-based reimbursement, hospital systems and physician groups are starting to take clinical outcomes much more seriously because they increasingly affect the hospital's bottom line. It clearly has been illustrated that provider diversity improves the quality of care and outcomes of both micro and macro populations. In his recently published textbook, *Diversity and Inclusion in Quality Patient Care*, Marcus Martin, MD, vice president and chief officer of diversity at the University of Virginia in Charlottesville, discusses how quality outcomes are affected by diversity of providers and leadership in emergency medicine. Having executive leadership that understands and directs the clinical operations that influence these disparities is a winning value proposition for hospital systems and patients. This reception hopes to address these issues.

Accordingly, the Diversity Executive Reception at ACEP underscores the need to facilitate and promote executive diversity in emergency medicine. It remains open to executive leaders of all backgrounds. If you feel that you or any member of your organization would benefit from attendance, email Savoy Brummer, MD, at savoybrummer@cep.com for more information. See you at ACEP16 in Las Vegas!

DR. BRUMMER is vice president and member of the board of directors for CEP America in St. Louis.

DR. MARCO is professor of emergency medicine at Wright State University Boonshoft School of Medicine in Dayton, Ohio.

Honesty Is the Best Policy

How to handle a medical mistake

Nathaniel Mann, MD, is a resident in the department of emergency medicine at the University of Cincinnati in Ohio. Jordan Celeste, MD, is an emergency physician in Florida.

by CATHERINE A. MARCO, MD, FACEP

Error in judgment must occur in the practice of an art which consists largely of balancing probabilities.—William Osler

As emergency physicians, we strive for perfection. We strive for quality medical care, diagnostic accuracy, patient safety, and patient satisfaction. However, medical errors are an inevitable reality in the practice of medicine. We focus attention on education and systems to reduce the incidence of medical errors and to manage outcomes after a medical error. Increased attention to medical errors resulted from the Institute of Medicine landmark report "To Err Is Human: Building a Safer Health System" in 2000.[1] In this report, an error is defined as failure of a planned action to be completed as intended (error of execution) or use of a wrong plan to achieve an aim (error of planning). Errors may be classified as *serious errors* (errors that cause permanent injury or transient but potentially life-threatening harm), *minor errors* (errors that cause harm that is neither permanent or potentially life-threatening), and *near-miss errors* (errors that could have caused harm but did not either by chance or by timely intervention).

Errors occur commonly in the ED environment.[2–4] A recent study showed that 56 percent of U.S. physicians have been involved with a serious error, 74 percent have been involved with a minor error, and 66 percent have been involved with a near-miss error.[5]

Patients strongly prefer disclosure of medical errors (up to 98 percent of patients).[6–8] It has been demonstrated that disclosure of errors to patients resulted in increased patient satisfaction, reduced likelihood of changing physicians, lower rate of seeking legal advice, reduced litigation, lower legal expenses, and lower jury awards.[7,9,10] At least 35 states have adopted apology/disclosure laws, which protect providers who disclose medical errors.

According to the American Medical Association ethics opinion "Ethical Responsibility to Study and Prevent Error and Harm," "physicians must strive to ensure patient safety and should play a central role in identifying, reducing, and preventing health care errors."[11] Physicians should be active in error reporting and disclosure to patients, but they should do so in collaboration with hospital risk management. In addition, The Joint Commission has required multiple safety standards including requirements of attention to safety, staff safety education, reporting systems, and disclosure of errors.

REASONS TO DISCLOSE MEDICAL ERRORS TO YOUR ATTENDING AND THE PATIENT

1. **Promote patient safety.** Disclosure of medical errors affords an opportunity to implement systemwide solutions.
2. **Build patient trust.** Patients want you to be honest with them. Honesty is the best policy!
3. **Improve your professional skills.** Disclosure to your attending physician affords a teaching opportunity. Your attending will help put the error in the proper perspective and develop an action plan to reduce future errors by you and other physicians.
4. **Integrity.** It's the right thing to do. It's as simple as that.
5. **Reduce your risk of litigation.** Studies have demonstrated that honest disclosure can reduce the risk of litigation related to medical errors.
6. **Being found out after hiding something is much worse.** The risks to you and your career are significant. Don't do it.

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ACEP POLICY STATEMENT ON DISCLOSURE OF MEDICAL ERRORS[12]

Revised and approved by the ACEP Board of Directors April 2010. Originally approved by the ACEP Board of Directors September 2003.

ACEP believes that emergency physicians should provide prompt and accurate information to patients and their representatives about their medical condition and its treatment. In the emergency department, as in other health care settings, patients may experience adverse events as a result of human error or of flaws in the health care system. Human or system errors can cause significant harm to patients or alter patients' needs for care. If, after careful review of all relevant information, an emergency physician determines that such an error has occurred in the care of a patient in the emergency department (ED), he or she should provide information about the error and its consequences to the patient, or if the patient is incapacitated, to the patient's representative in a timely fashion, in accordance with hospital policy on medical error disclosure.

ACEP recognizes that substantial obstacles, including unrealistic expectations of physician infallibility, lack of training about disclosure of errors, and fear of increased malpractice exposure, obstruct the free disclosure to patients of significant medical errors. In order to overcome these obstacles, ACEP recommends the following institutional, professional, and societal initiatives:

- Health care institutions should develop and implement policies and procedures for identifying and responding to medical errors, including continuous quality improvement systems and procedures for disclosing significant errors to patients.
- Medical educators should develop and incorporate into their curricula programs on identifying and preventing medical errors and on communicating truthfully and sensitively with patients and their representatives about errors.

BRINGING DATA TO THE BEDSIDE

BENCHMARKING ALLIANCE

DR. AUGUSTINE is director of clinical operations at EMP in Canton, Ohio; clinical associate professor of Emergency Medicine at Wright State University in Dayton, Ohio; vice president of the Emergency Department Benchmarking Alliance; and on the ACEP Board of Directors.

What's Ahead in Emergency Services

Surveys on industry trends help bring future improvements into focus

by JAMES J. AUGUSTINE, MD, FACEP

Emergency physicians and emergency department leaders face an important time in determining how to serve the needs of the communities in a changing health system. The trends that have driven the growth of emergency care have not been altered by government or payer policies to date. The National Hospital Ambulatory Medical Care Survey (NHAMCS) by the US Centers for Disease Control and Prevention (CDC) has detailed a continuous increase in ED visits since at least 1992, as has data from the Emergency Department Benchmarking Alliance (EDBA), and it's been confirmed in the experiences of most of the 4,800 EDs in the country.

The 1992 NHAMCS Emergency Department Summary stated that 89.8 million ED visits were made, about 357 visits per 1,000 population. Injuries were the cause of more than 35 percent of the visits. In 2011, visits had grown to 136.1 million, which calculates to 445 visits per 1,000 population.[1] Injuries accounted for 29 percent of ED visits, with the highest injury rates in persons age 75 and older. The CDC has not been able to produce visit estimates for 2012 and subsequent years, but it is likely that volumes have increased at a minimum of the 2.4 percent growth rate of the first 19 years of the study. Continuing a 2.4 percent growth rate means that 150 million persons had ED visits in 2015.

More important for predicting ED utilization, staffing, design, and processes are the types of patients visiting the ED. The ED population is aging, which is in line with the demographics of the country. Those persons age 75 and older in 1992 had 558 visits per 1,000 population. In 2011, that number increased to 682 visits per 1,000 population. Similarly, in those persons ages 65 to 74, the utilization increased from 314 to 369. These are the fastest-growing demographics in the country and will continue to grow for the next 20 years.

The EDBA has worked collaboratively with the CDC in producing useful data reports, which are needed for future planning. It hosted three summits that developed the definitions for the industry, the latest being published and used in the annual EDBA survey.[2] The 2014 EDBA survey used data from 1,142 EDs that saw 45 million patients. This report now has 11 years of data useful in the ED planning process.

EDBA data show a reduction in the mix of young patients (defined as under age 18), from about 22 percent to about 16 percent over the last 10 years. Ambulance transportation is a stable source of about 16 percent of ED patients, with patients arriving in this manner being admitted around 39 percent of the time. For the sicker or seriously injured patients arriving in the ED, the admission rates over the last 10 years are stable in a range between 16 and 18 percent.

Use of CT scanning appears to have reached a high of 22 procedures per 100 patients, but MRI and other special imaging procedures like ultrasound are used at an increasing rate. The other diagnostic tool that is increasing in ED use is the 12 lead ECG. From 2004 to 2014, ECG utilization increased from 17 uses per 100 patients seen to 26 uses. This trend is likely to continue.

There is a continuing growth in the percentage of overall hospital admissions presenting thru the ED. The EDBA data survey over the last five years finds that between 65 and 68 percent of hospital inpatients are processed through the ED. This reflects the role of the ED as the "front door" of the hospital.

There is a tremendous effort by many ED leaders to increase the flow of patients. ED providers have the greatest control over the flow of patients who are evaluated, treated, and released for outpatient follow-up. This represents more than 80 percent of the patients seen in American EDs. Patients managed completely in the ED represent the overwhelming majority of the flow. Despite increasing volumes over the last 11 years and increasing age and acuity of patients, the flow of patients has improved (see Tables 1 and 2). For all patients, the door-to-provider time has decreased from more than 40 minutes to about 28 minutes. (The 2011 NHAMCS study reports this number is 27 minutes.) Overall median length of stay for the complete spectrum of ED patients has decreased about 15 minutes, from about 190 minutes to about 175 minutes. Patients treated and released from the ED have been processed an average of 10 minutes quicker in 2014 than in 2008, from 160 to about 150 minutes. Flow improvements have resulted in an overall reduction in ED patient walkaways, from more than 3 percent to about 2.2 percent.

Data from the CDC and from the EDBA indicate that the emergency department is an important and valuable element of the health system, providing unscheduled care to an increasing number of patients over the last 23 years. The ED patient population is increasingly composed of older persons, a proud accomplishment indicating that efforts to reduce premature death from illness and injury are working.

KEY POINTS FROM NHMACS AND EDBA DATA

- The CDC NHAMCS study, which started in 1992, documents that American EDs are seeing about 2.4 percent more visits per year.
- More patients arrive with medical illnesses rather than injuries.
- More patients are elderly and arrive by EMS.
- Despite increasing volumes and acuity, ED flow improvement has occurred.
- There is a continued increase in the application of ECGs, MRI scans, and ultrasound in the diagnostic workup of ED patients.
- Admission rates are stable over the last decade at about 16 percent to 18 percent, and those patients represent about two-thirds of inpatient admissions to American hospitals.

Table 1. Critical Trends in 11 years of the EDBA Data Survey

YEAR	% OF PATIENTS UNDER AGE 18	% OF INPATIENTS PROCESSED THROUGH THE ED	NUMBER OF CT PROCEDURES PER 100 PATIENTS SEEN IN THE ED	NUMBER OF ECGS PER 100 PATIENTS SEEN IN THE ED
2014	16.0%	65%	20	26
2013	19.9%	68%	20	26
2012	21.5%	68%	20	26
2011	20.8%	67%	22	26
2010	21.3%	66%	22	23
2009	22.1%	65%	21	23
2008	21.5%	64%	22	22
2007	22.1%	62%	22	20
2006	20.5%	61%	22	19
2005	20.1%	61%	18	18
2004	22.5%	58%	Not studied	17

Table 2. Trend in ED Median Length of Stay, Time to Provider, and Walkaways

YEAR	MEDIAN MINUTES, DOOR TO PROVIDER	MEDIAN LENGTH OF STAY, PATIENTS TREATED AND RELEASED	PATIENTS WHO LEFT BEFORE TREATMENT COMPLETE
2014	28	150	2.2%
2013	30	147	2.3%
2012	32	147	2.2%
2011	30	146	2.0%
2010	33	143	1.9%
2009	35	146	3.2%
2008	41	160	3.0%
2007	Not studied	163	3.0%
2006	Not studied	157	2.9%

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tPA the Leviathan

Motivating factors behind the expanded use of tissue plasminogen activator

by RYAN PATRICK RADECKI, MD, MS

There are dueling laments between what could be called "the stroke industrial complex" and the physicians on the front line. Tissue plasminogen activator (tPA) for acute ischemic stroke, in so many words, is repeatedly touted by a handful of guideline-writing experts as simply having "proven benefit." Their primary lament is the paucity of acute stroke patients receiving tPA. Clinicians on the front line, however, see the perverse incentives wrought by such guidelines and mandates, including the detrimental impact on systems of patient care and costs of prioritizing "quality" targets. Our pragmatic concerns are for the safety of patients and of cautious concern regarding the appropriateness of therapy.

In order to protect our patients, many physicians, and the ACEP Clinical Policy statement, hew closely to the exclusion criteria.[1] These exclusion criteria are intended to maximize the safety margin for tPA by minimizing life-threatening intra- and extracranial bleeding. These absolute and relative exclusion criteria are quite conservative and have been under siege for quite some time by the proponents of tPA.

Most recently, the American Heart Association has issued a new update regarding the scientific rationale for inclusion and exclusion criteria for tPA in acute ischemic stroke.[2] This document reviews most of the historical exclusions for tPA and makes new recommendations for the use of tPA based on the accumulated evidence. Unsurprisingly, given the conflicts of interest pervasive in the stroke guideline genre, the recommendations are almost universally in favor of giving more tPA. Unfortunately, the authors compound the issue by grossly overstating the strength of the evidence supporting their recommendations.

For example, these authors address the use of tPA in the elderly population. Most trials excluded patients over age 80, and of the 1,711 elderly patients evaluated in clinical trials, 1,617 are from the open-label IST-3 trial. Despite the biases inherent to IST-3, tPA use did not provide a statistically significant favorable outcome at three months. No robust randomized trial data regarding death rates are available, but multiple observational series demonstrate increased risk of intracranial hemorrhage and death in the elderly compared with younger patients receiving tPA. Nonsensically, the authors state "intravenous alteplase administration within three hours is equally recommended for patients less than 80 and more than 80 years of age." This recommendation, in which limited and conflicting data are presented, is given their strongest Class I recommendation, based on the highest level of evidence.

Likewise, the authors comment on stroke severity in this guideline, noting the relative exclusion of both very mild and very severe strokes. Again, these authors recommend use of tPA for very severe strokes with Level A evidence while noting the National Institute of Neurological Disorders and Stroke (NINDS) enrolled "relatively few patients" and IST-3's adjusted odds ratio for good outcome with increasing the National Institutes of Health Stroke Scale (NIHSS) did not reach statistical significance.

More concerning is the authors' approach to mild stroke syndromes. The authors recommend tPA as "proven clinical benefit" for "mild but disabling" stroke symptoms with Level A evidence. They do so in the same breath as acknowledging, "Because nearly 3,000 such cases of ischemic stroke were excluded from the two NINDS trials for mild symptoms, any analysis of mild symptoms within the two NINDS trials is difficult to interpret." Furthermore, in a reversal from other recommendations touting favorable findings from IST-3, the authors of this section ignore the neutral outcomes of 612 patients treated with NIHSS 0-5 in that trial. These authors assured endorsement of use of tPA in mild stroke syndromes would seem to suggest its use is a settled question, even though Genentech is funding the Prevention of Relapses and Disability by Interferon beta-1a Subcutaneously in Multiple Sclerosis, or PRISMS, trial designed to investigate essentially this exact cohort.[3]

Rapidly improving symptoms are frequently cited as treatment exclusions. Transient cerebral ischemia, after all, is not an indication for tPA. In the section addressing this clinical scenario, these authors cite the work of The Re-Examining Acute Eligibility for Thrombolysis (TREAT) Task Force.[4] As if the acronym of this expert panel was not an apparent enough bias, support for this panel was received from Genentech. Participants in the meeting had all travel expenses paid by Genentech, and most of the panel representatives had some conflict of interest due to a relationship with Genentech. The foregone conclusion of this panel, reiterated in these guidelines, is that improving symptoms should not exclude patients from tPA.

Frankly, the general theme of this document is that tPA should be given or considered for most of the previous exclusion criteria. This includes such apparently concerning clinical scenarios such as recent major surgery, recent major trauma, a known left-sided heart thrombus, recent gastrointestinal or genitourinary bleeding, and known extra-axial neoplasms. These authors also recommend considering tPA for patients with dementia and end-stage malignancy and those already moderately disabled without substantially framing the question of appropriateness. Finally, these authors also implicitly endorse the slash-and-burn processes taking root in our emergency departments by stating the 2 percent incidence of intracranial hemorrhage in stroke mimics is safety margin enough to not delay tPA administration to make an accurate diagnosis.

One could assume an altruistic interest in patients as the motivating factor behind the expanded use of tPA. However, the underlying funding for much of the work cited by these authors comes from Genentech, whose stroke symposia are fixtures at annual meetings. The pervasive use of tPA, embedded in guidelines, quality measures, and reinforced by statements about the "standard of care," directly benefits its bottom line. Few statistics are available on the annual revenue derived from tPA since Genentech was purchased by Roche, but thrombolytics accounted for approximately $250 million in sales in 2008. Since then, Genentech has more than doubled the cost of alteplase from approximately $30/mg to more than $60/mg and, as these articles demonstrate, redoubled its efforts to expand indications.[5]

The original NINDS trials enrolled a few hundred patients each. Other rigorous trials, each with their own flaws and conflicts of interest, enrolled similar numbers. Now, 20 years later, rather than prove the safety and effectiveness of tPA for these expanded indications, these recommendations selectively overstate the quality of supporting evidence or simply use the absence of evidence to the contrary as justification.

It is frankly impossible to estimate any of the magnitudes of benefit or harms from the practices endorsed by this new guideline, but it is safe to assume the purported current benefit of tPA is certainly the ceiling. Likewise, as the original contraindications were intended to improve the safety margin of tPA, the anticipated harms must be greater. This is not the sort of work that improves the lives of our patients. We do not need to expand the use of tPA; rather, we ought to be pursuing research that helps us narrow the treatment cohort to those with the stroke syndromes and comorbidities with the ideal risk/benefit profile.

ILLUSTRATION/PAUL JUESTRICH; PHOTOS: SHUTTERSTOCK.COM

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A CALL TO ACTION

CONTINUED FROM PAGE 1

because the ideas, skills, interests, and creativity women bring are essential to the ongoing success of the specialty.

Women especially appreciate the need for work-life integration and have already provided guidance for the implementation of processes that support life "balance," and these concepts represent best practices for both men and women. In fact, millennials of both genders appreciate and agree on the need for work-life integration.

Investing in women physicians for the long term is key. Research shows that women may take off more time early in their careers but that they take off less time later in their careers as compared to men.

Table 1. Annual Number of Women in Emergency Medicine

ACGME				AAMC				AAMC			
YEAR	TOTAL EM RESIDENTS	# FEMALE	%	YEAR	TOTAL EM RESIDENTS/FELLOWS	# FEMALE	%	YEAR	TOTAL ACTIVE EM PHYSICIANS	# FEMALE	%
2013–14	5,743	2,077	**36.2%**	2013	5,599	2,097	**37.5%**	2013	37,210	9,497	**25.5%**
2012–13	5,590	2,053	**36.7%**	2012				2012			
2011–12	5,388	1,971	**36.6%**	2011				2011			
2010–11	5,190	1,927	**37.1%**	2010	5,069	2,035	40.1%	2010	33,955	7,983	**23.5%**
2009–10	4,950	1,828	**36.9%**	2009				2009			
2008–09	4,763	1,751	**36.8%**	2008				2008			
2007–08	4,546	1,608	**35.4%**	2007	4,494	1,744	**38.8%**	2007	30,718	6,596	**21.5%**

Improving Recruitment and Retention of Women Emergency Physicians

Fortunately, there is a lot that can be done. The list below is not exhaustive, but it provides a good starting place.

- Include positives about emergency medicine opportunities for work-life balance in recruitment.
- Ensure that maternity/paternity leave policies are in place.
  - –Include information regarding maternity/paternity leave, accommodations for pregnancy-associated needs, and family leave as a standard part of the recruitment package so applicants don't have to ask.
  - –When an emergency physician informs her group of pregnancy, the first response should be "Congratulations!" followed by assurance that maternity/paternity policies are available and that it is expected that they will be used.
  - –Remove any stigma associated with taking maternity/paternity leave.
  - –Monitor the use and advertise the utility of family-related policies to ensure that all employees feel comfortable using them without penalty.
- Ensure female involvement in recruitment, and when possible, pair women with female mentors for at least the first year after starting a new position.
  - –Be cognizant of the fact that women leaders are the best tool to improve recruitment and retention of women.
- Encourage involvement in Women in Medicine groups, such as ACEP's American Association of Women Emergency Physicians, Society of Academic Emergency Medicine's Academy for Women in Academic Emergency Medicine, Association of American Medical Colleges' Group on Women in Medicine and Science, and social networks like FemInEM blog and Physician Moms Group. Also encourage home institutional opportunities.
- Make it a point to highlight any recent progress made for women physicians at your place of work. Recognize and promote the added value women bring to the department.
- Work to improve work-life integration in your department/institution.
  - –Integrate and allow part-time positions for physicians who need this option.
- Experiment with changes in practices that are out of step with the realities of modern life and work to create environments that foster success for all the physicians in your group. (Yes, the emergency department has to be staffed for the present, but by making incremental adjustments now, you will help ensure the future staffing of the emergency departments of the future.)
- Conduct periodic audits to check for unjustified gender disparities in compensation.
- Implement family-supportive scheduling practices for all physicians. For example:
  - –Schedule critical departmental meetings and functions during hours typically covered by school/child care services, and allow meetings to be conducted and attended via phone or electronic media.
- Explore and consider implementing child care subsidy

CONTINUED *on page 20*

RESOURCES FOR FURTHER READING

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programs for all employees (eg, dependent care flexible spending accounts).

  – Explore and advertise options for emergency/backup dependent care for employees.

- Develop a policy that supports the needs of employees experiencing a significant life event. Such a program may include offering support surrounding devastating illness or death of loved one; guaranteeing physicians paid time off for family leave around the birth/adoption of a child; treating medical and family leave similarly in terms of paid time off, backup coverage, and flexible scheduling; offering graduated return to work after a significant life event; and offering job shares or flexible scheduling for the first six months after the birth or adoption of a child.
- Modify clinical staffing patterns and personal shift requirements (eg, set schedules) to minimize physical stress on pregnant staff. Consider taking pregnant women off overnight shifts during the third trimester.
- Provide clean, private non-bathroom facilities for lactation within or immediately adjacent to the emergency department. Ensure physicians are able to leave the department during their shift for lactation needs without compromising patient care.
- Create and implement supportive work policies and a stable income when physicians experience a significant life event (ie, family crisis, an increase in work burden at home, or an event such as pregnancy, birth, or adoption).

Be cognizant of the fact that women leaders are the best tool to improve recruitment and retention of women.

Bottom line: More women physicians in emergency medicine are needed. The consequences of neglecting to address the unique needs of women in emergency medicine will negatively impact the ability to recruit and retain emergency physicians and will ultimately affect the ability to provide medical care for the millions of patients who need emergency care.

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DR. CLEM is chair and chief of the department of emergency medicine and professor of emergency medicine and pediatrics at Loma Linda University in Loma Linda, California, and immediate past chair of the American Association of Women Emergency Physicians.

Table 2. Women in EM Leadership Positions

BOARD OF DIRECTORS	**16**	**0.94%**
Female	2	12.50%
Male	14	87.50%
CHAIRS	**42**	**2.48%**
Female	11	26.19%
Male	31	73.81%
COMMITTEES	**961**	**56.66%**
Female	270	28.10%
Male	682	70.97%
Unknown	9	0.94%
COUNCIL	**630**	**37.15%**
Female	169	26.83%
Male	454	72.06%
Unknown	7	1.11%
CHAPTER PRESIDENTS	**47**	**2.77%**
Female	9	19.15%
Male	38	80.85%
GRAND TOTAL	**1696**	**100.00%**

NEWS AND NOTES IN EMERGENCY MEDICINE

HOT OFF THE PRESSES

Routine Geriatric Consults Improve Elderly Trauma Care

by REUTERS STAFF

ROUTINE GERIATRIC CONSULTS IN OLDER trauma patients are associated with improved outcomes, researchers report.

Studies of older patients with orthopedic injuries have shown geriatric consultation to result in lower mortality, reduced readmissions, fewer complications, and shorter lengths of stay. Whether these benefits accrue in other settings has been unclear.

Dr. Olubode A. Olufajo and colleagues, from Brigham and Women's Hospital, Boston, assessed the processes of care and outcomes among older patients admitted to the trauma service before (n=215) and after (n=191) geriatric consults were mandated for all trauma patients 70 years old or older.

The proportion of patients who were do not resuscitate/do not intubate increased from 10.23 percent before geriatric consults became mandatory to 38.22 percent after implementation, according to the March 3 *Journal of the American College of Surgeons* online report.

Referrals for formal cognitive evaluation increased from 2.33 percent before to 14.21 percent after implementation ($p<0.01$).

There were also decreases in in-hospital mortality (from 9.30 percent to 5.24 percent), 30-day mortality (from 11.63 percent to 6.81 percent), and intensive care unit readmission (from 8.26 percent to 1.96 percent), but these changes fell short of statistical significance.

Hospital length of stay and 30-day hospital readmissions did not differ between the two groups.

"This study highlights the potential benefits of mandatory geriatric consults in routine patient care," the authors conclude. "Therefore, trauma services should consider adopting this approach to the care of their older patients."

Dr. Olufajo did not respond to a request for comments.

The authors reported no funding or disclosures.

CONTINUED *on page 22*

Benzodiazepine Prescriptions, Overdose Deaths on the Rise in U.S.

by MADELINE KENNEDY (REUTERS HEALTH)

EVEN AS OPIATE ABUSE HAS BECOME A growing problem in the U.S., overdose deaths involving sedatives and antiseizure medications in the benzodiazepine category have also risen steeply, according to a recent study. Prescriptions for benzodiazepines have more than tripled and fatal overdoses have more than quadrupled in the past 20 years, researchers found.

"Overdoses rose at a faster rate than prescriptions, suggesting that people were using benzodiazepines in a riskier way over time," said lead author Dr. Marcus Bachhuber, assistant professor of medicine at Albert Einstein College of Medicine in New York.

Benzodiazepines typically used to treat anxiety or depression include alprazolam (Xanax), chlordiazepoxide (Librium), diazepam (Valium) and lorazepam (Ativan). The benzodiazepine clonazepam (Klonopin) is used for seizures, while oxazepam (Serax) and temazepam (Restoril) are used for insomnia.

"Benzodiazepines have several known safety risks: in addition to overdose, they are conclusively linked to falls, fractures, motor vehicle accidents, and can lead to misuse and addiction," Dr. Bachhuber told Reuters Health by email.

The study team used data from the annual Medical Expenditure Panel Surveys between 1996 and 2013, which asked U.S. adults whether they had filled one or more benzodiazepine prescriptions. In those 20 years, the number of adults with benzodiazepine prescriptions grew by more than two thirds, from 8.1 million to 13.5 million, the researchers found. In 1996, around 4 percent of people surveyed had filled a benzodiazepine prescription, and by 2013, this had risen to 5.6 percent.

They also found that the amount of medication distributed had grown by three-fold. After standardizing doses of all drugs, they found that people with prescriptions received 1.4 times more medication in 2013 than 20 years earlier. Benzodiazepines were most often prescribed for anxiety disorders, mood disorders such as depression, and insomnia.

Based on data from the Centers for Disease Control and Prevention, overdose deaths involving benzodiazepines rose from 0.58 per 100,000 people in 1999 to 3.07 per 100,000 in

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2013, according to the results online February 18 in the *American Journal of Public Health*. This increase seemed to level off after 2010 overall, but among certain groups, including people over age 65 and certain minorities, there was no plateau and the rate kept rising, the study found.

Higher doses, more days of treatment and people combining their prescriptions with illegally obtained benzodiazepines may account for the increase in overdose deaths, the study team writes. Dr. Tae Woo Park told Reuters Health by email that deadly overdoses from benzodiazepines alone are actually rare.

Based on data from the Centers for Disease Control and Prevention, overdose deaths involving benzodiazepines rose from 0.58 per 100,000 people in 1999 to 3.07 per 100,000 in 2013, according to the results online February 18 in the *American Journal of Public Health*.

"Typically, overdose deaths occur when the benzodiazepine is combined with another sedating medication, such as an opioid or alcohol," said Dr. Park, a professor at the Alpert Medical School at Brown University in Providence, Rhode Island, who was not involved in the study. Dr. Park added that benzodiazepines are not recommended for older people because of the risk of falls.

Dr. Bachhuber said the public and doctors need to be aware of the dangers of combining benzodiazepines with other substances and should keep in mind alternative treatments including therapy or safer medications. "Benzodiazepine prescriptions are widespread, but their use may not be the smart choice for many patients," Dr. Bachhuber said.

"People should be cautious when taking benzodiazepines, particularly when combining them with alcohol or opioid medications," Dr. Park added.

Curb on Residents' Hours Linked to Changes in Trauma Care

by DAVID DOUGLAS (REUTERS HEALTH)

LIMITS SET BY THE ACCREDITATION COUNCIL for Graduate Medical Education on duty hours for residents may have changed aspects of trauma care, according to Rhode Island-based researchers.

"Most studies on the topic of duty hours have focused on the policy's effect on mortality and serious morbidity, and have identified no significant changes," said Jayson S. Marwaha, a medical student at Warren Alpert Medical School of Brown University, Providence. "However, our findings demonstrate that limiting duty hours may influence the quality of patient care when specialty-specific metrics are studied," he told Reuters Health by email.

Marwaha and colleagues, whose findings appeared online February 22 in *The Journal of the American College of Surgery*, studied trauma center data on more than 11,700 admissions from 2009 to 2013. Among provisions of the 2011 reforms for all U.S. residency programs are that first-year residents should have shifts no longer than 16 hours with at least eight off-duty hours between shifts. More senior residents with 24-hour shifts are allowed a maximum of four hours for transfer of care activities, and at least 14 off-duty hours between shifts.

Although the researchers found no significant changes in outcomes, including death, after adoption of the reforms, the length of hospital stay fell significantly from 7.98 days to 7.36 days ($p=0.01$). In addition, there was a significant rise in operating room and bedside procedures such as imaging and chest tube placement per admission (6.72 to 7.34, $p<0.001$) and in OR visits per admission (0.76 to 0.91, $p<0.001$).

Overall, there were an additional 9,559 procedures and 1,584 OR visits after the reforms. The most significant increases were in bedside procedures including lab and imaging. The mean number of consults per admission was also significantly higher in the post-reform group (1.42 vs. 1.02, $p<0.001$). The mean number of missed injuries per admission was significantly lower (0.40 vs. 0.68, $p=0.036$), but further evaluation indicated that the observed improvements in missed injuries were not associated with the reform.

The researchers note that, "Whether better metrics exist for examining the effects of work hour limitations on practice patterns and quality is uncertain; further study should be done to identify specific metrics affected by the reform." In fact, they suggest that "less-commonly studied areas of quality in the context of the 2011 duty hour reform, such as the cost of care, should be further studied."

Commenting on the findings by email, Dr. Anthony Yang told Reuters Health that although there was no change in patient deaths or complications, the reforms have had other consequences.

"Specifically," said Dr. Yang, of the Surgical Outcomes and Quality Improvement Center of Northwestern University Feinberg School of Medicine, Chicago, the study reveals "a previously unidentified pattern of increased use of healthcare resources in trauma patients. The new finding in this study adds more evidence and nuance to the debate over duty hour restriction policies for resident physicians."

Dr. Yang was not involved in the study.

WHAT ARE YOU THINKING?

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

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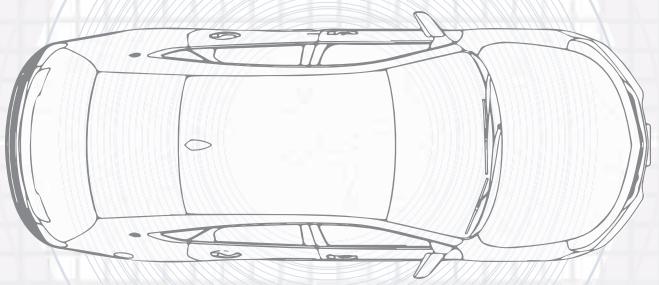

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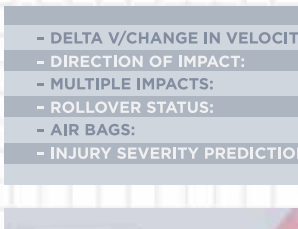

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- DELTA V/CHANGE IN VELOCITY:	45 MPH/72 KPH
- DIRECTION OF IMPACT:	SIDE
- MULTIPLE IMPACTS:	YES
- ROLLOVER STATUS:	NO
- AIR BAGS:	FRONT DEPLOYED
- INJURY SEVERITY PREDICTION:	HIGH

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