JARON CHRISTIANSON, MD, MBA, FACEP

Last year, my wife and I put our 1-year-old daughter into daycare for the first time. She developed an upper respiratory infection and passed it along to me. Despite Tessalon Perles, albuterol, and a variety of over-the-counter remedies, I had a hacking, bronchospasm-type cough for a few days. At one point, I was at home watching a sitcom and started laughing and coughing at the same time, which resulted in a twinge in the left side of my neck. I didn’t have any pain but noticed that I would reflexively hold my neck whenever I coughed.

Early the next week, I was in a meeting and developed a left occipital headache. Nothing major but enough to make me take some Tylenol when I got home. The next morning, the headache was back and now was associated with a sunburn-like sensation to my left frontal and parietal scalp. I would also develop a headache in that region whenever I pushed on my neck at the base of my scalp. The pain would go away when I stopped. That night at dinner, I noticed that the sniffing position was now quite uncomfortable for me. Tylenol, Motrin, and Robaxin didn’t help, but lying on my side (either side) and either ice or heat did help. I had an early shift the next morning, so figuring I pulled something while coughing, I slapped on some ice and went to bed.

The next day at work, the symptoms persisted. I spoke to one of my colleagues, who commented that his brother had something very similar and it turned out to be shingles. That sounded reasonable, so I started Valtrex and prednisone and went about my business. We were leaving for Hawaii the next morning for a friend’s wedding, so I popped over to the barber after work. The pain from the comb through my hair was quite uncomfortable as was the pain from wear-
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BY THERESA HSIAO, DO

It was a typical Friday night: The trauma bay was full, patients were lined up in hallway beds 1 through 6, and we were 50 deep in the waiting room. Within an hour of starting my shift, I had a chest pain in Room 4, a pregnant vaginal bleeder in Room 6, an old lady with belly pain in the neighboring room, and a colostomy malfunction in Room 13. These descriptions were exactly how I attempted to remember them. I had systematically hit all the right questions for each patient and put in the necessary orders, imaging was obtained, charts were being typed up, and the attending physician had been notified and had agreed with all my plans. Feeling like I had things under control, I called over to the nurse. “Hey, can you please check on the vaginal bleeder to see how she’s doing?” The nurse stared at me blankly and responded, “You know she has a name, right?”

I was immediately taken aback. To me, she was “Room 6,” 35-year-old female G3 P 0111, newly pregnant with a few days of spotting, mild abdominal cramping, no rebound or fever, guarding, rule out ectopic, and confirm a live fetus. We mechanically run codes, fly through the codes, often fall prey to practicing cookbook medicine. We forget that we are the privileged few who patients trust with their secrets and stories—what a humbling honor.

I walked back in, this time more aware, no longer consumed with everything else, I honestly became flushed and warm, and my voice stuttered. I was unsure how to respond. I had been so consumed with everything else, I honestly hadn’t even glanced at her name. Like a good resident, I had checked on her a couple of times to ensure her abdominal cramping had resolved. I gave her ice water and updated her on the wait time for her ultrasound. Once all items were marked off my checklist, I went on my way. The nurse proceeded to ask me, “Did you know she and her husband have been trying for a year? That she’s had a prior miscarriage and is worried it might happen again?”

My face was now beet red and my heart thumping out of my chest from my embarrassment from the unintentional reprimand. As busy physicians, we get so caught up with our endless tasks and algorithms that we often fall prey to practicing cookbook medicine. We mechanically run codes, fly through procedures effortlessly, and transition from room to room, chugging through the never-ending emergency department tracking list. With the practice of medicine becoming so mechanical, we forget that, on a daily basis, we meet patients who are having the worst day of their life. They divulge to us private details not even their best friends and families are aware of. We forget that we are the privileged few who patients trust with their secrets and stories—what a humbling honor.

“Most physicians, my illness is a routine incident in their rounds, while for me it’s the crisis of my life. I would feel better if I had a doctor who at least perceived this incongruity.” —Anatole Broyard, from “Doctor Talk to Me,” The New York Times, Aug. 26, 1990

Thank you to my Room 6, future mom of two, fellow foodie, and wife of her high school sweetheart. Thank you for reminding me that when I chose to go into medicine, I made the commitment to connect with all patients, to be their advocate, to bring compassion to those who are vulnerable and scared in their most vulnerable moments. Thank you for reminding me that the woman in Room 6 has a name.

“New Spin” is the personal perspective of the author and does not represent an official position of ACEP Now or ACEP.
The expanded Observation Care ‘17 conference is the premier national event for mastering topics surrounding observation medicine. Designed for hospital leaders and clinicians alike, and organized by national experts in observation care, the three-day symposium will cover the most critical issues and best practices for implementation, staffing, and management of an effective observation unit.

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JEFFREY WRIGHT, MD  
President of Summa Emergency Associates

KK: Tell us about the background and history of your group.

JW: Our group is private and independent, owned and run by the physicians. We’ve been around for 40 years or so, and we have run the residency program at Summa Health System since 1980.

KK: How challenging was that for you to begin a training program in emergency medicine, knowing that Akron General was already in place just down the road?

JW: Both are very good programs. Both have won international awards, do well recruiting each year, and put out a very good product, well-trained residents. We have residents go all over the country every year. We have 10 residents a year; it’s a three-year program.

Our residency director and core faculty were willing to continue to educate the residents and even provide a weekly conference without getting paid until a transition was laid out. That was never taken up.

KK: The program has a great reputation and provides great training. What really happened, from your perspective, with this transition?

JW: Basically, our most recent contract [with Summa Health System] was a three-year contract started in 2013. At that time, there was an RFP because Summa wanted one group for six emergency departments. One has since closed, so now it’s five emergency departments. It was us and many other groups vying for that contract. We won the contract in 2013 and picked up three other emergency departments within the system.

KK: Was this negotiation in 2016 different?

JW: We had dealt with similar administrations for multiple years. Some members of the new team have been here for one to three years. The negotiations didn’t get started, unfortunately, until mid to late November. We saw the first contract on Nov. 26. It was about an 80-page contract. The biggest issue was that it was never about quality, timeliness of service, or meeting any metrics. We do fantastic on the metrics. The residency does very well on the medical education side. When we won the RFP three years ago, we picked up three new emergency departments within Summa. All three are underperforming other financially and/or by volume.

Two weeks before we took over the Wadsworth contract, the hospital decided to get rid of inpatient beds; it took out 36 percent of the volume within that ER. The groups that were in there before us had asked for stipends or assistance. We did those contracts for three years and lost between $8 million and $9 million. It cost us more to staff them, bill them, and malpractice them than we were receiving in revenue. There was nothing to cut from our end. We offset the losses with other departments that we run.

Five senior residents this year wanted to stay with the group. All five had to sign with competitors because I could not offer them the type of package needed for them to pay back the $500,000 in medical student loans.

KK: So the math is simple. You can’t compensate people and pay your bills if they’re more than you can bring in revenue.

JW: Correct. I’ve been head of our group for 15 years, and even before I was president of the group, we never had any financial assistance from the hospital, but those in residency kept graduate medical education money. In our counterproposals to Summa, we didn’t even ask for financial assistance. We said, “Can we get out of two of these three ERs? Can we close them? Can we make them urgent cares?”

KK: Was there anything extraordinary beyond meeting your losses with the stipend you were looking for?

JW: No. Initially, we didn’t even want a stipend, but when it was discussed, it was actually significantly less than what we were losing. Basically, our group, doctors, and corporation were giving [Summa] a stipend the last three years, and my doctors were taking less.

KK: In effect, you were subsidizing the hospital. Did you decide to withdraw, or did they terminate your contract?

JW: The contract was over Dec. 31 at 11:59 p.m. I had requested face-to-face meetings with emails saying, “Guys, let’s get together and get this worked out.” We got the contract on Nov. 26 or 28. Our first and only face-to-face meetings did they terminate your contract?

KK: In effect, you were subsidizing the hospital. Did you decide to withdraw, or did they terminate your contract?

JW: Correct. We have staffed three of the five Summa facilities in the past. We staffed two of them for over a decade prior to them becoming part of Summa, and one was a new build, free-standing, that we started staffing when they built it. We staffed them up until about three years ago when the system put out an RFP and consolidated all five sites into one ER contract [awarded to SEA].

DS: Correct. We have staffed three of the five Summa facilities in the past. We staffed two of them for over a decade prior to them becoming part of Summa, and one was a new build, free-standing, that we started staffing when they built it. We staffed them up until about three years ago when the system put out an RFP and consolidated all five sites into one ER contract [awarded to SEA].

KK: I think people may not be aware that you’re located right in Akron-Canton, Ohio, and have had business relationships with Summa before. Could you speak to your history with Summa? It didn’t just start Dec. 31.

DS: We have staffed three of the five Summa facilities in the past. We staffed two of them for over a decade prior to them becoming part of Summa, and one was a new build, free-standing, that we started staffing when they built it. We staffed them up until about three years ago when the system put out an RFP and consolidated all five sites into one ER contract [awarded to SEA].

KK: Getting into some of the controversial topics, did the hospital contract with you prior to the end of their agreement with SEA? Some have raised the question of whether or not Summa had already contracted with USACS.

DS: No. Let me give you the timeline. Their contract, from what I understand, was never terminated. Their contract expired at midnight on New Year’s Eve, and it sounds like they had been negotiating with the hospital for some time. There was never an RFP or any sense that we were going to be involved in a transition or that there would be a turnover of this group. We fully expected that SEA would renew. Until we got a call on Dec. 24, we knew nothing about this.

DS: Their contract expired on the 31st. They first reached out to us on the 24th. On the 27th, they said, “We would like a proposal for how you would take over on the 31st if you can,” and they sent that proposal to two other national groups.

KK: From your perspective, do you think they were still negotiating in good faith with SEA at that point?

DS: Absolutely. From what it said in the papers, there were offers to SEA as late as the afternoon of New Year’s Eve. What was reported in the paper last week was that they were offered a five-year contract or an extension to continue to negotiate, and SEA refused both and walked out at midnight. On the 29th, Summa told us, “If we have to do this, we’re going to do it with you.” They told us verbally they would work with USACS if they still couldn’t negotiate, but they were still negotiating. It wasn’t until the 31st that they said, “SEA has refused our offer of extension and has refused the contract terms that we’ve given to them. You guys need to start tonight.”

KK: How would you respond to the criticism that you, as a large group, came in and displaced one of the few remaining independent groups in the area?

DS: We would have wanted to do it differently. We encouraged the hospital to continue to try to get an extension for the sake of the residency and the rapidity of the transition and the disruption that could cause, fully knowing that doing so might have led to SEA working it out. I really don’t see us as having displaced them. I see us filling a void. They left, and there was no one there if we didn’t go in.

KK: What resources or expertise does your group have to run or support a residency program?
The contract was going to expire at mid-
night; it just expired.

JW: The contract was going to expire at mid-
night; it just expired.

KK: It sounds like they may have had a
backup plan in place.

JW: We had one part-time physician who is
now working for the new group, but the other
65 are not.

KK: I assume none of them have taken
the offers.

JW: We had one part-time physician who is
now working for the new group, but the other
65 are not.

KK: Well, I admire your solidarity, that’s
for certain. Some people have been critical
on both sides about the transition of
the training program. Tell me, from your
perspective, what transition plan you
had in place to protect the residents.

JW: That was one of our biggest concerns.
The residents [250 residents] within Summa
had all of the shifts covered, and we have
qualified physicians. Some of the low-acuity
patients experienced slightly longer waits be-
cause the physicians weren’t as facile with the
EMR, but there were no patient safety issues.
Within two days, all of the wait times were
back to baseline.

KK: Did you ever have to use a different
documentation system other than the
EMR system that was in place?

DS: The first two days, the hospital used their
downtime procedures, which do involve the
physician documentation being on paper. The
nurses were using the EMR for some of their
charting, but they did use their downtime pro-
cedures for the first approximately 40 hours.
They didn’t have enough trainers to do the
transition that quickly, but within 40 hours, we
were back on the EMR. This was the hos-
pital’s plan for the transition.

KK: There’s been a lot of conversation
and discussion about the optics of con-
flict-of-interest with friends or family
members who may or may not have been
involved with some of the negotiations.
Any thoughts or comments?

DS: We all know in medicine that there are
conflicts of interest at times. The issue in my
ATTENDING THE 2017 PRESIDENTIAL INAUGURATION LEFT THIS POLITICAL JUNKIE DISHEARTENED

by L. ANTHONY CIRILLO, MD, FACEP

As a self-professed political junkie, I will admit that attending a presidential inauguration has been on my bucket list for a long time. As I “approach” middle age at the age of 56 (my definition of middle age) and since inaugurations only happen every four years, I decided that this would be the year to head to Washington, D.C., to attend the inauguration of Donald J. Trump as the 45th president of the United States. I will admit that, given the unconventional nature of the entire presidential campaign and the controversy that surrounds President Trump, I drove to D.C. with my son Connor and with a mixed emotional bag of excitement and trepidation. The weekend experience in D.C. was enlightening, but honestly, it was more disheartening. When I left D.C. and headed back home to Rhode Island, I kept asking myself, “Who is America?” While in D.C. and in the days since I got back home, I keep feeling that I am not part of the America that I saw at the inauguration or at the Women’s March on Washington the following day. Since I have been involved in politics and advocacy for a while, I was not naive enough to believe that everyone in D.C. was going to sing “Kumbaya” just because it was inauguration weekend. On the other hand, I did not expect to witness Americans disrespecting the office of the president, the United States as a nation, and mostly one other.

Inauguration Morning

We took the Metro and made it to Union Station by 8 a.m. Upon leaving Union Station, there were already protests happening, but given the presence of law enforcement everywhere, we felt very safe and walked up to the Capitol. We were fortunate and had been given seated tickets by U.S. Rep. Jim Langevin (D-RI). I will give kudos to Sen. Roy Blunt (R-MO), who served as chair of the Inauguration Committee, and the entire team of folks who did the planning and logistics for the inauguration. Despite the complexity of the event, this was well choreographed and orchestrated.

“A New Spin” is the personal perspective of the author and does not represent an official position of ACEP Now or ACEP.

So if the day was so easy, then when I did get so disheartened? Well, it wasn’t the official ceremony part of the whole day but, honestly, the people there. Look, I had no illusions that this wasn’t going to be a pro-Republican and pro-Trump crowd. If you made the trip to the inauguration, you were probably on the “right” side of the aisle in terms of political leanings. I get that. However, the people around us weren’t just happy about their guy winning. They actually seemed to revel more in taunting and jeering the outgoing president, the first lady, and, of course, Hillary Clinton, who could have taken a pass on the whole day and avoided the crowd. There was real vitriol and disdain for people who had served the nation, which went beyond disagreeing with a political point of view. I was really taken aback by this. Maybe I am naïve, but an important part of politics for me is separating someone’s issues from that person’s value as a human being. In all my years in politics and advocacy, I have yet to find a politician or policymaker who I agreed with on every issue. That’s why you don’t fall on your sword on any one issue because tomorrow is another day, another issue, and another vote. That’s why you build relationships based on mutual respect and finding common ground rather than focus on what divides us. In all honesty, the crowd really took something away from the importance and significance of this event, which has happened only 58 times in the history of our nation.

The president’s speech was, in a word, “Trumpian.” He was very clear that under his administration things were going to be different and that the old ways of doing things weren’t going to continue. He spoke about the inauguration being about giving power back to the people, which seemed a little unusual for a man who pretty much has never been a man of the people. I would have to imagine that his comments were also awkward for all the current members of Congress and all the ex-presidents who were in attendance (Jimmy Carter, Bill Clinton, George W. Bush, and Barack Obama). The crowd certainly got excited by President Trump’s speech, but the enthusiasm quieted quickly as people left.

After the actual swearing in ceremony, we got back to the place we were staying only to find that every—and I mean every—news channel was covering the “anarchists” in the streets of D.C. Even though this was a small group of about 100 people, they got, essentially, all the news coverage of the day. It was disappointing that the media made breaking windows and setting a few trash cans and newspaper machines on fire more important than discussing the importance and significance of this event, which has happened only 58 times in the history of our nation.

The Women’s March

Then came Saturday, which was the day of the Women’s March on Washington. Again, from my political junkie perspective, I give kudos to Teresa Shook, Evvie Harmon, Fontaine Pearson, Bob Bland, and others who created the concept on Facebook and worked to make it happen. The Women’s March was a weekend experience in D.C. that the media made breaking windows and setting a few trash cans and newspaper machines on fire more important than discussing the importance and significance of this event, which has happened only 58 times in the history of our nation.

CONTINUED on page 20
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A Diverse Future for Emergency Medicine

More than a year ago during its retreat, the ACEP Board of Directors discussed the importance of diversity and inclusion and agreed that making improvements in these areas would be a multi-year project. The Board made one of the 13 objectives within ACEP’s strategic plan to “promote and facilitate diversity and inclusion and cultural sensitivity within ACEP.” ACEP President Rebecca Parker, MD, FACEP, hosted a summit in April 2016 and appointed the diversity and inclusion task force, led by Aisha Liferidge, MD, to welcome this generational shift in diversity, which is directly tied to ACEP’s future success. Here are a few initiatives ACEP is currently undertaking:

- *Annals of Emergency Medicine* has published “Why Diversity and Inclusion Are Critical to ACEP’s Future Success,” written by Dr. Parker; Steven J. Stack, MD, FACEP, an emergency physician and past President of the American Medical Association; and Sandra Schneider, MD, FACEP, director of EM practice at ACEP. This “burning platform” paints the current landscape of diversity in emergency medicine and its patient populations, describes how studies show that embracing diversity and inclusion can improve patient care, and outlines research that shows inclusive benefits organizations and even companies. Read the article at www.ann-emergmed.com.

- ACEP and its chapters are taking a hard look at ensuring that the faculty members at our educational conferences represent a variety of races, religious affiliations, cultural identities, sexes, gender identities, and other forms of diversity far beyond the obvious visual distinctions. Expanding the opportunities for faculty and course topic selection improves the well-being and resiliency of members while also improving patient care.

- A Diversity Leadership Task Force, led by Dr. Stack, will help broaden the diverse representation among ACEP leadership. This approach will potentially attract, retain, and engage new members; develop new leaders; and build upon the expertise of current members. Diversity and inclusion of leadership positions will help many to overcome collective biases and nurtures creativity of thought, collaboration, and problem solving.

- Dr. Liferidge’s task force has developed objectives to guide its activities over the next several years. The task force has identified five focus groups: age, gender, race/ethnicity, sexual orientation, and religion. It recognizes there are additional groups to pursue in the future. The task force has outlined three objectives:
  - Engage the specialty of emergency medicine on diversity and inclusion.
  - Identify obstacles to advancement within the profession of emergency medicine related to diversity and inclusion and develop ways to overcome those obstacles.
  - Highlight the effects of diversity and inclusion on patient outcomes and identify ways to improve those outcomes.

This task force is developing tactics to accomplish each of these objectives. Upcoming projects for the task force include ongoing conference calls and an in-person meeting during the ACEP Leadership & Advocacy Conference in March, as well as the development of proposals for consideration by the ACEP Board and Council Steering Committee, a webinar on bias and cultural competence, a social media campaign, and more.

INauguration | CONTINUED FROM PAGE 8

A worldwide event. Effective advocacy is all about tapping into passion, and the coordinators of the march did so extremely well. It was impressive to see the diversity of issues that were being championed. Reproductive rights, immigration reform, religious discrimination, LGBTQ rights, gender and racial inequalities, workers’ rights, and environmental issues were all part of the official platform. Although not part of the official platform, there was an anti-Trump sentiment that pervaded the event. Signs saying “Not My President” were some of the nicer ones. Madonna’s “F-bomb” rant and talk about blowing up the White House went beyond exercising one’s right of free speech and into a realm of hate and intolerance, which is what the protest was supposed to be rallying against.

Today I am not sure that I belong to either of the Americas that I witnessed in D.C. I am not far right or far left on any issue. I believe that I am part of the true majority in this country, those who live somewhere within two standard deviations on the bell curve of social and economic issues. I know that effective democracy and debate can’t just about talking—there has to be a listening part, too. This nation was founded by people who disagreed about many things, including whether we should have even become a separate nation. However, through all of our troubled times, we have remained one nation, one America, even after being nearly torn apart by a “civil” war. Our greatest moments in history have been realized when we put aside our differences and faced our enemies and challenges together. I am concerned that we are now becoming a “pendulum nation,” swinging wildly back and forth to political extremes as politicians in both parties attempt to garner the support of the loyalists on either side. The media, which should be a voice of reason and a vehicle for education, has become a morass of pandering sound bites, trying to win the “gotcha” arms race. America is not strengthened by rhetoric and name-calling by anyone on either side of a political issue. America will prosper when we listen to and respect each other as people, as Americans.

Dr. Cirillo and his son Cayden at one of the unofficial inaugural balls.

Dr. Cirillo is director of health policy and legislative advocacy for US Acute Care Solutions in Canton, Ohio, and chair of the ACEP Federal Government Affairs Committee.
he International Liaison Committee on Resuscitation (ILCOR) appointed a task force in 2013 to prepare recommendations regarding first-aid care by trained or untrained rescuers. The recommendations were released with the 2015 American Heart Association Guidelines Update for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care. The goal was to provide an evidence base for the initial care provided by laypersons, EMS, and physicians outside of the office or hospital setting.

ACEP Now has partnered with three emergency medicine residency training programs (Wake Forest School of Medicine, Winston-Salem, North Carolina; Mayo School of Graduate Medical Education/Mayo Clinic, Rochester, Minnesota; and Warren Alpert Medical School of Brown University, Providence, Rhode Island) to review 15 of these recommendations following the PICO (Population, Intervention, Comparison, and Outcomes) analytic format utilized by the recommendation authors.

Panel Commentators
- Howard Mell, MD, MPH, CPE, FACEP, assistant professor, Wake Forest Baptist Medical Center, Department of Emergency Medicine
- Jessica L. Smith, MD, FACEP, associate professor (clinical), Warren Alpert Medical School of Brown University, and program director, Emergency Medicine Residency
- Jason Stopyra, MD, FACEP, assistant professor, Wake Forest Baptist Medical Center, Department of Emergency Medicine
- Matthew Sztajnkrycer, MD, PhD, FACEP, associate professor, Mayo Clinic, Department of Emergency Medicine


**OPEN CHEST WOUND (FA 525)**

**Recommendation Author:** Anuradha Ganapathy, MD

Dr. Ganapathy is a member of the emergency medicine residency training class of 2018 at the Warren Alpert Medical School of Brown University.

**QUESTION:** Among adults and children with open chest wounds outside of the hospital (P), does use of occlusive dressing (I) compared to non-occlusive dressing (C) change outcomes (O)?

**Results:** One animal study (deemed very-low-quality evidence) addressed the PICO question of use of occlusive versus non-occlusive dressings in open chest wounds for respiratory arrest and to improve oxygen saturation. Vented and unvented chest seals were placed serially on open chest wounds in eight pigs, and onset of tension pneumothorax and deterioration of respiratory parameters were measured upon serial air injections into the pleural cavity.

**Outcomes:** There was benefit from use of non-occlusive devices for the outcomes of respiratory arrest, oxygen saturation, tidal volumes, and respiratory rate. There was no significant benefit in terms of mean arterial pressure, survival, or cardiac arrest.

**Discussion:** Tension pneumothorax is a life-threatening complication in open chest wounds. The task force recognized the limited evidence addressing this but noted that both evidence and the medical practice of treating a tension pneumothorax by creating an open wound to allow communication between it and the ambient air justified the benefit of non-occlusive dressings in open chest wounds. Further research into non-occlusive dressings is required due to the concern that they may inadvertently occlude open chest wounds, causing life-threatening complications.

**Recommendation:** First-aid providers should not apply occlusive dressings or devices in patients with open chest wounds.

**Note from Dr. Smith:** In the first-aid setting, occlusive dressings should not be placed on open chest wounds due to the possibility of doing harm by creating a tension pneumothorax.

**HYPOGLYCEMIA (FA 795)**

**Recommendation Author:** Derick D. Jones, MD

Dr. Jones is a member of the emergency medicine residency training class of 2018 at the Mayo School of Graduate Medical Education/Mayo Clinic.

**QUESTION:** Among adults and children with symptomatic hypoglycemia (P), does administration of dietary forms of sugar (I) compared with standard dose (15–20 g) of glucose tablets (C) change time to resolution of symptoms, risk of complications (eg, aspiration), blood glucose, hypoglycemia, or hospital length of stay (O)?

**Results:** Three randomized control studies and one observational study that addressed the PICO were identified. All four studies were downgraded for risk of bias and imprecision. The three randomized studies were deemed low-quality evidence, while the observational study was deemed very low quality.

**Outcomes:** No study showed that any form of dietary sugar or glucose tablets improved the blood glucose before 10 minutes. The observational study showed fewer diabetic patients demonstrating a 20 mg/dL increase in blood glucose level 20 minutes after treatment when treated with dietary sugars compared to glucose tablets. Pooled data from the three randomized trials showed a slower resolution of symptoms 15 minutes after diabetic patients were treated with dietary sugars compared with glucose tablets. No studies assessed the risk of complications or assessed hospital length of stay.

**Discussion:** The current analysis evaluated glucose supplementation from glucose tablets...
QUESTION: Among adults who are with symptomatic hypoglycemia, glucose
gives dietary-equivalent glucose tablets were iden-

tified as the best first-aid option based on four
studies, lack of availability should not deter
the use of other sugars, despite the weak rec-
ommendation, in a symptomatic hypoglyce-
mic patient who is conscious, able to follow
commands, and able to swallow.

OXYGEN USE IN FIRST AID (FA 519)
Recommendation Author: Shannon Mum-
ma, MD
Dr. Mumm is a member of the residency train-
ing class of 2018 at Wake Forest School of Medi-
cine.

QUESTION: Among adults and children who exhibit symptoms of shortness of
breath, difficulty breathing, or hypoxia outside the hospital (P), does adminis-
tration of oxygen (I) compared with no administration of oxygen (C) change sur-

dival outcomes, time to resolution of symptoms, or therapeutic endpoints (Q)?

Results: One retrospective study presents
very-low-quality evidence that there is no ben-
efit of supplemental oxygen administration for reducing death, the need for assisted ventila-
tion, and respiratory failure for patients with
acute exacerbation of chronic obstructive pul-
monary disease. One randomized controlled

trial presents low-quality evidence showing
the benefit of supplementary oxygen admin-
istration for treatment of shortness of breath in
cancer patients with dyspnea and hypoxemia.
A meta-analysis and four randomized con-
trolled trials present low-quality evidence of
no benefit for advanced cancer patients with dyspnea without hypoxemia for shortness of
breath. Oxygen administration was found to
have a positive effect on oxygen saturation.

Outcomes: No evidence was found for or
against routine administration of supplement-

ary oxygen by first-aid providers. Supplement-

ary oxygen administration has been found to be
of some benefit in specific circumstances,
including advanced cancer patients with dysp-
nea and hypoxia as well as individuals with
decompression injuries. Oxygen provided to
patients with hypoxemia helped them reach
normal oxygen levels.

Recommendation: No recommendation.

Note from Dr. Mell: Providing supplemental oxygen does not appear to improve outcomes
for patients with dyspnea. Emergency physi-
cians do not need to routinely carry oxygen as
part of first-aid kits.

AEC P Clinical Policy on Acute Carbon Monoxide Poisoning

by STEPHEN J. WOLF, MD, FACEP

In October 2016, the AEC P Board of Direc-
tors approved a clinical policy on the eval-
uation and management of adult patients
presenting to the emergency department with
acute carbon monoxide (CO) poisoning.
There are approximately 50,000 ED visits per year
as a result of CO poisoning. Acute poison-
ings have extremely varied presentations, from
minimal symptomatology to unrespon-
siveness, hypotension, severe acidemia, or
acute respiratory failure. CO poisoning is also
known to be associated with longer-term mor-
bidity and mortality.

CRITICAL QUESTIONS AND RECOMMENDATIONS

QUESTION 1: In ED patients with suspected acute CO poisoning, can noninvasive car-
boxyhemoglobin (COHb) measurement be used to accurately diagnose CO toxicity?

Patient Management Recommendations

• Level B: Do not use noninvasive COHb measurement (pulse CO oximetry) to di-
agnose CO toxicity in patients with sus-
pected acute CO poisoning.

QUESTION 2: In ED patients diagnosed with acute CO poisoning, does hyperbaric ox-
yn (HBO2) therapy, as compared with normobaric oxygen therapy, improve
long-term neurocognitive outcomes?

Patient Management Recommendations

• Level B: In patients with moderate to severe CO poisoning, obtain an ECG
and cardiac biomarker levels to identify
acute myocardial injury, which can pre-
dict poor outcome.

Dr. Wolf is an associate professor and
vice chair for academic affairs in emer-
gency medicine at the University of Virginia School of Medicine in Charlottesville.
SUING UP TO COMBAT CONCUSSIONS

Emergency physician attempts to reduce football-related head injuries by changing the rules

From pee wee leagues to the NFL, football is a national obsession in the United States. However, recent research into football-related injuries is starting to illuminate the grave neurologic toll the sport can take on its players.

Paul S. Auerbach, MD, MS, FACEP, MFAWM, FAAEM, Redlich Family Professor in the department of emergency medicine at Stanford University School of Medicine in California, and coauthor William Waggoner decided to combine the current research on sports-related concussions with their knowledge of football to suggest a series of rule changes that could help protect players’ brains.

ACEP Now Medical Editor in Chief Kevin Klauer, DO, EJD, FACEP, recently sat down with Dr. Auerbach to discuss what inspired him to write this opinion piece and what he hopes football organizations will take away from it. Here are some highlights from that discussion.

KK: Let’s talk about your very provocative, interesting, and forward-thinking editorial about concussions that came out Sept. 27, 2016. What prompted you to write this?

PA: I got interested in this largely because of my experience as a team physician for a local high school and observing a lot of concussions in football players. I also want to give credit to my coauthor, Bill Waggoner. He was a high school coach and an outstanding collegiate player.

A few years ago, I was involved in a study to look at a noninvasive device to diagnose concussions. We discovered that it took a minimum of four to six weeks for the concussed players to get back to a baseline measurement. I discussed this finding with other investigators in the field who had used other methods to diagnose concussions and who had found the same result. That flew in the face of what commonly occurs with players, who get returned to play anywhere from 24 hours to about a week. That exposes them to what is commonly referred to as second-impact injury, which most people believe is far worse than the initial injury.

Tom Talavage, PhD, at Purdue University and other investigators have highlighted the fact that, with objective MRI techniques, subconcussive injuries—meaning injuries in which players don’t become clinically symptomatic in the same way that do persons who have an acute injury altered enough to be recognized at that moment—are prevalent. There is an enormous number, reasonably in the range of 10 to 20 percent, of players who are being injured.

KK: I love the quote from your article, “With orthopedic injuries, athletes, players, and coaches readily accept a four- to six-week recovery period. It is astonishing that they show so much less respect for the brain.” Do you have some statistics regarding football and concussions that you can share with readers?

PA: Yes. There is beginning to be a bit of a surge of a response. I’ve gotten communications from the National Collegiate Athletic Association (NCAA), from independent writers, and from researchers who are interested in this field, and the consensus is that commentaries like we published will hopefully ignite activity to prevent these injuries. I’ve also received responses from parents citing their distress at what’s going on with children.

There are statistics that I’ve seen from the years 2002 to 2012; there was a 200 percent increase in the number of emergency department visits for concussions among 8- to 13-year-olds and the number of reported concussions of children 14 to 19 years old. In 2012, emergency departments treated 325,000 teens for concussion. That is just the tip of the iceberg because those are the patients that seek care. The Centers for Disease Control and Prevention published statistics on the number of children who take part in some sports in the United States, and we’re talking about tens of millions of adolescents.

CONTINUED on page 15
ing a baseball cap.

Over night, the headache worsened and settled into a persistent pre-orbital pain along with my neck pain. It was still better when I was on my side. The shingles rash that I was expecting had yet to materialize. I was having no other symptoms. By the afternoon, I was becoming a bit more concerned and called my emergency department and spoke with a doctor. If I came in, based on what I’m saying, would she do any imaging? She didn’t think so, and in her shoes, I wouldn’t either. I still figured I pulled something while coughing, though I couldn’t really link that to the neuralgia symptoms. That evening, I was texting with another emergency physician, and she matter-of-factly diagnosed me with a vertebral artery dissection (VAD). Thanks, I said, but I’ll stick with rash-less shingles and muscle strain with secondary neuralgia.

Emergency Department Workup

At the emergency department, I had a normal exam, and everyone agreed that this was muscular. My colleague even found a nice trigger point that exacerbated my symptoms. He suggested a trigger point injection, which I was agreeable to on the condition that I would get a CT angiogram of my neck if it didn’t help. Deal. I got the injection; it didn’t help. I got the CT angiogram, and about 30 minutes later, I was in an ambulance to our neuro tertiary care center for my long-segment VAD. No Hawaii for me.

The overnight stay in the neuro ICU was pretty uneventful. I got a little morphine, more for the cough than the pain. I was started on Plavix and aspirin. My MRI of the brain was normal. Transcranial Doppler showed no emboli. I pulsed up a dose of Norco, but otherwise, the night was uneventful. After seeing the intensivist, neurologist, and neuroradiologist, it was decided that I would lay low for six weeks, continue the antiplatelets, and start lisinopril and Lipitor.

Little did we know that the day I left the hospital was the first day of boating season in Seattle, and our route home was from one side of Lake Washington to the other. After about an hour in the car (for a 10-mile drive), I was carsick and made it within a half mile of my house before I vomited. This led to a marked increase in the headache that was not improved with position. Zofran, or tramadol. Of course, my wife thought I was doing fine, so she popped over next door to chat with the neighbors. When she got home, apparently I looked like death, so back to the emergency department we went. I guess the nurses agreed with my wife’s assessment; they put me in a resuscitation room. Now my blood pressure was 210/120, and I was dripping in sweat. Fortunately, a repeat CT angiogram showed no change in the dissection, and I did not have a subarachnoid hemorrhage. After about eight hours in a room, two liters of Ruid, IV Dilaudid, Zofran, Compazine, Benadryl, and Ativan, I was as good as new.

Long Road to Resolution

Sadly, I spent the next three weeks on my back, needing narcotics and benzos to control the pain. I finally went in to see the neuroradiologist who wasn’t thrilled that I was incapable of sitting upright in the waiting room. He promptly got the neurinterventional from next door, who sent me down to interventional radiology and performed a diagnostic angiogram, which showed a pretty ragged artery with lots of thrombus. The options were: 1) stay on Plavix and hope for the best, or 2) sacrifice the artery that I really didn’t need anyway. I chatted with a few people, but it was pretty clear that the second choice was the best option. The next day, I had a second angiogram and had six platinum coils placed. As an aside, it was noted that I had some extravasation of blood into the soft tissue. I went home that evening with a Medrol dose pack, and by the next morning, I was nearly pain free and have been so since. I was back at work and feeling great at my six-month follow-up for angiogram number three. To my dismay, this showed that the extravasated blood had managed to work itself into a dural arteriovenous fistula (AVF). The recommendation was to do a fourth angiogram and squirt a little surgical glue (Onyx) in there and just be done with it. The downside of a persistent dural AVF is myelopathy, which is obviously best avoided. This sounded like a fantastic plan until the physician told me that the risk of the procedure was the glue going where it shouldn’t, causing an immediate spinal artery stroke and quadriparesis. I spoke to my neurosurgeon and then a colleague neuroradiologist who both thought an open approach, if even needed, was better, so I got an MRI (normal) and saw a specialist outside of the system who did these for a living. He wanted to wait another six months, repeat the MRI, and then do his own angiogram. The repeat MRI was normal. His angiogram showed decreased blood flow through the AVF. Apparently, a few of these just slow down and shut off on their own. It was decided to wait a year and repeat the angiogram. If the flow remains low, then there won’t be much more to do. If there is still a problem, then the next step would be a multilevel spinal fusion—which definitely beats a spinal artery stroke!

In the meantime, I feel great and have no symptoms. I’ve diagnosed a good number of VADs in the meantime, and my group’s CT utilization rate has skyrocketed. I have come to the conclusion that VADs are not that uncommon.

DR. CHRISTIANSON
is program director of emergency services at Group Health Permanente in Seattle.
**WRIGHT | CONTINUED FROM PAGE 7**

Health System wrote a letter to us, and the Residents Council wrote a letter to the board of directors with a vote of no confidence in the hospital leadership. Our biggest concern was the continued education of our residents. Our residency director and core faculty were willing to continue to educate the residents and even provide a weekly conference without getting paid until a transition was laid out. That was never taken up.

KK: We’ve heard that you sent the residents home to take a month off. Can you speak to that decision?

JW: No. The residents are back in the department. Our concern was with the staffing levels and the credentials of the new physicians (never shown to either us or our residency director). The residents (those only on an ED rotation) did not work for two or three days. They were put on an administrative elective, basically a study month for their in-service exam. They have since gone back to their normal routine.

KK: Who told them to come back to work?

JW: They were pressured by (two members of Summa Health System’s senior leadership) to return. They were told that they could potentially lose their jobs if they didn’t come back into work.

**SCOTT | CONTINUED FROM PAGE 7**

mind is how they are dealt with. In this case, the conflict had been disclosed in the past and was well-known. The person that we’re talking about, (the wife of the USACS CEO), has been on the board of [Summa] hospital in the past, and she’s the CMO currently. That conflict had been disclosed. She was recused from any part of this decision making. In fact, there was no decision. As we said, we didn’t get notified until the 24th, so the idea that this was some type of a plan just simply isn’t true. She was recused from the negotiations and any part of that conversation. Clearly, the hospital knew that this was an issue that would be brought up, and they handled it as any large organization handles potential conflicts. I don’t have any concerns about it.

KK: Are you fully staffed, and what does your staffing plan look like?

DB: We have fully staffed all of the shifts. We have a group of partners with us who travel. We’re using them. We have a lot of volunteers from our partners across the country, and we’re actively hiring. We also are actively staffing the residency program. Scott Felton is the interim program director. We have Chris Lloyd as the associate program director. We have the rest of the core faculty named, some of whom are interim; we continue to look for permanent core faculty.

**THE ACEP BOARD OF DIRECTORS WEIGHS IN**

Understanding the importance of this issue to our members and our specialty, the ACEP Board of Directors met on Jan. 19, 2017, and discussed this topic extensively. We are committed to protecting the interests of our specialty, patients, members, residents, and training programs. Your input as we develop supportive resources is welcome. We will continue to communicate with you on this and other important issues.
THE END OF THE RAINBOW

JAMES M. DAHLE, MD, FACEP

Is there any value to hiring a financial adviser?

A. Many emergency physicians wonder if they should spend their hard-earned money on financial advisory fees. The answer to this question, like much in life, is, “It depends.”

The key is comparing the value received from the adviser to the price you pay the adviser. When hiring a financial adviser, it is absolutely critical, despite the difficulty of doing so, that you get good advice at a fair price.

Many doctors hire a financial adviser because they are too busy and would rather pay someone else to deal with the hassle. The impression might be that it isn’t worth the doctor’s time and is similar to hiring someone to take care of the lawn and clean the house so you can spend your time making the big bucks practicing medicine. Unfortunately, the truth is that doing financial planning and managing your investments is likely the very best use of your time.

Consider a typical financial advisory relationship for a doctor. Perhaps the doctor is paying an “industry standard” 1 percent of AUM “industry standard” level of fees given how many good financial planners choose to be their own financial planner and investment manager is the substantial cost of hiring someone to do it for them, especially considering the ease of doing so compared to learning to practice medicine safely. You see, whereas an emergency physician needs to know almost everything about emergency medicine and a competent, experienced financial adviser ought to know almost everything about financial planning and investing, if you are functioning as your own adviser, you need only understand the portions of personal finance, investing, and the tax code that actually apply to you, which is a small fraction of what an adviser needs to know.

Just because real financial advisers are very expensive, many advisers are actually commissioned salespeople in disguise. Chances are good that competent, low-cost advisers can provide more value than their cost, especially early in your career.

First, consider the costs. There is little reason to pay the “industry standard” or “average” level of fees given how many good advisers out there are willing to do it for less. Many advisers working under an Asset Under Management fee model will work for less than 1 percent, especially as the size of your portfolio grows. However, you can also simply pay an hourly rate for your initial financial planning and investing plan design and then a flat, relatively inexpensive (a few thousand dollars per year) ongoing asset-management fee. If you are spending a five-figure amount on advisory fees each year, chances are very good you can lower your cost while maintaining or even improving the quality of your advice, service, and after-fee investment performance.

Second, consider the many ways in which an adviser can add value. The most useful thing an adviser can do for you is to help you develop an initial financial and investment plan. That means educating you on what matters when it comes to finances, helping you better define your goals, and generating a written plan on what you should do with the money you have now and will earn in the future in order to maximize your happiness and reach your goals. Even after the plan has been designed and implemented, the adviser serves another important function: helping you stick with the plan. Investors, especially physician investors, are notorious for performance chasing and behavioral biases that cause self-inflicted financial catastrophes, such as buying high and selling low. In addition, the adviser can function as a financial coach, reminding you of your goals and encouraging you to save enough of your income to reach them. Of course, the adviser also takes care of the necessary portfolio chores, such as opening accounts, typing buy and sell orders into the computer, and generating periodic reports about asset allocation, investment performance, and progress toward goals. Finally, an adviser provides an important backup function. For most couples, one person is far more interested in personal finance than the other. The presence of an adviser provides a bit of insurance that if something happens to the interested partner, the financially naive partner will have someone to ensure the finances are managed in some reasonable way.

Each of these functions that a competent, low-cost adviser can provide has significant value. However, that value is different for every investor. For an investor who already has a written financial and investing plan and has the interest, knowledge, and discipline required to maintain the plan, that value is likely to be much lower than the substantial cost. However, an investor who has none of those things can easily justify paying significant fees to a financial adviser as money well spent.

Even the least competent physician investor who desires to fully rely on a full-service financial adviser needs to learn a few things. These include understanding what a fair price is for advice as well as learning what high-quality financial advice and portfolio management look like. I know of no better way to find out whether your adviser is giving you good advice than to get a second opinion from another experienced, fee-only adviser at a separate firm. That second opinion may be the best financial advisory fee you will ever pay.

In summary, a competent, low-cost adviser can provide substantial value, but whether that value is more than the price depends both on the price and on how ready and willing you are to function as your own financial planner and investment manager.

TECHINT NOTE: The necessary financial planning and investing plan design and then a flat, relatively inexpensive (a few thousand dollars per year) ongoing asset-management fee. If you are spending a five-figure amount on advisory fees each year, chances are very good you can lower your cost while maintaining or even improving the quality of your advice, service, and after-fee investment performance.

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2017 Course Topics

Topics Updated & Revised!

- Acute and Chronic Back Pain in the ED
- BRUE in Low Risk Infants: AAP Guidelines
- Sepsis, SOFA, So What?
- Sore Throat: 2017 State-of-the-Art
- Imaging in Chest Trauma
- Myths in Emergency Medicine
- Poisoning / Overdose 2017
- ED-Related “Choosing Wisely” - Part 1
- ED-Related “Choosing Wisely” - Part 2
- Gastrointestinal Pearls
- ACLS Literature Update - Part 1
- ACLS Literature Update - Part 2
- Unusual Antibiotic Side Effects
- The Dilemma of PE Overdiagnosis
- The Challenges of Physician Variability
- Assessing Suicide Risk
- TIA’s in the ED
- Clinician Burnout: 2017 Update
- Getting to Know Tranexamic Acid
- Management of CPR Survival - Part 1
- Management of CPR Survival - Part 2
- SAH Ongoing Diagnostic Challenges
- Minor Head Trauma: Special Cases
- Ongoing Challenge of Managing Pediatric UTI
- Steroids: Uses and Misuses in EM
- Topics in COPD 2017: Is Anything New?
- Visual Diagnosis Challenges - Part 1
- Visual Diagnosis Challenges - Part 2
- Important Recent EM Literature - Part 1*
- Important Recent EM Literature - Part 2*
- Diagnostic and Therapeutic Controversies*
- Challenging ED Scenarios*

*Topics listed with an asterisk (*) are 90-minute faculty panel discussions; all other topics are 30 minutes.

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For Complete Details and to Register, Visit www.EMAcourse.com or Call 800-458-4779 (9:00am-4:30pm ET, M-F)
EM Docs has gone global. Our 10,800-plus members are teaching and learning from other physicians practicing emergency medicine in some areas with extremely limited resources. We have quite an international reach! Our members are living and practicing on every continent (except Antarctica). We are represented in North America in the United States, Puerto Rico, and Canada; in South America in Chile and Honduras; in Africa in Egypt; in Asia in India, Japan, Saudi Arabia, Taiwan, and Singapore; in Australia in Australia and New Zealand; and in Europe in Sweden, United Kingdom, and Norway, among others.

We Are EMPOWR’d

We are empowered by other EM Docs. Practicing emergency medicine is hard. It has always been and will always be hard—that is the reason most of us chose it! We have disruptions to our sleep with odd shift times. We sometimes see people at their worst as they yell and blame and call names. We finish a code, deliver terrible news to a family, and walk into the next room with a plastic smile and the lingering knowledge of what just happened. We cover the “code brown” after the disimpactions with deodorizers and cover our heartaches after we lose the ones who came in too late. We compartmentalize our lives so we can function inside and outside the emergency department. Occasionally, we realize our family is saying, “Are you listening?” as our mind drifts to the 15-year-old with a gunshot wound. We work with empty stomachs and full bladders. We drive home with the images of broken anatomy and aching souls. How do we answer our families when they ask, “How was your shift?”

We titrate our own emotions to a professional level and manage our own frustrations despite the fact that we are human. To deal with the unrealistic expectations on us, some use sarcasm and dark humor or alcohol. Many of us exercise and get outdoors! EM Docs tend to have an amazing sense of adventure and love for extreme sports.

We empower each other. We understand each other like no one can. We speak the same language and share the same culture of caring like a tribe. We have always been the safety net for our communities. Now EM Docs are the safety net for their colleagues. Working a holiday or a nightshift seems a little more bearable when we know so many of our colleagues are also out there doing the same. On EM Docs, we have a night shift/holiday shift “roll call” to identify colleagues working that shift, and we share favorite songs that we play on the way in to a shift or that we sing in our minds when we walk into a shift or when the “brown stuff” hits the fan. “Welcome to the Jungle” seems to be a favorite, along with “I Gotta Feeling,” “Highway to Hell,” and “Crazy Train.”

We share and discuss cases. We inspire one another to stay current on evidence-based medicine. We laugh at ourselves and each other. “JAFERD” is a nickname that some EM Docs have taken on as an inside joke after one member told a story of a patient who was angry with her for refusing to fill his opioid prescription. She said that this unnamed patient walked out and said to her, “You are just another P**ing ER doctor.” She abbreviated it to JAFERD and stuck, “Own it,” many said. Another member told a story of a patient who was angry with him for his car license plates. He made T-shirts, and some even put it on their car license plates. We step among ourselves on some issues, but we stand up for our profession and for each other. We are out of isolation and have a united voice now.

Heated Discussion

EM Docs survived the election with mostly respectful discourse. There continue to be occasional heated discussions that allow us to learn from one another on (usually) divisive topics such as abortion, gun control, gender issues, and the Affordable Care Act. Some members participate in the discussions, and many more follow it. Even when the discussions get a little dramatic, all sides are heard.

The connection and communication between the bedside physicians and our professional organizations are faster now. It helps the fiercely passionate bedside physicians be heard, and it helps our trailblazers in leadership know our most pressing struggles so that emergency medicine can better address our challenges right away.

Metrics

One EM Doc, who will remain anonymous, posted about doctor-to-doctor time, door-to-disposition time, patient satisfaction scores, and similar measures, stating that these metrics have unintended consequences such as “encouraging physicians to sign up before they are really ready for a new patient just to stop the clock,” which “does nothing to actually improve patient flow.” The member discussed how patient satisfaction scores “can lead to inappropriate medications and tests. Performing to timed metrics may lead to poor charting and increased risk for errors. The end result is physician dissatisfaction and fewer EM Docs willing to serve in leadership positions.” “Time to take back control of our profession,” another EM Doc said, but from whom—the Centers for Medicare & Medicaid Services, government intrusion, third-party payers, corporate medicine?

One commented that door-to-doctor time was originally designed to assess adequate ED coverage, not measure individual physicians. Times for individual physicians can be affected by the shifts they work. Wait times go up, and satisfaction scores go down. Physicians are frustrated by nonclinical leadership that sees only multicolored charts and graphs that do not represent what truly happens at the bedside. One EM Doc cited a New York Times article from January 2016, “How Measurement Fails Doctors and Teachers.”

One argued that “to improve, we must...”
Regulatory Twitter
Tweets of a different tone

by JEREMY SAMUEL FAUST, MD, MS, MA

In the past few years, major hospitals, health organizations, and prominent leaders in health care have hopped onto Twitter. Now, just about every major healthcare and medical entity, from the New England Journal of Medicine (@NEJM) to the Mayo Clinic (@MayoClinic), has an official Twitter feed. For the most part, tweets that are officially representing a prestigious organization or prominent person in the field tend to reflect that fact. Translation: The tweets are usually boring. No one takes a stand. No one says anything interesting. For the most part, official Twitter accounts associated with medicine and health care organizations are echo chambers for well-established ideas that are not interesting to medical professionals. Sure, there’s the occasional tweet about some medical innovation or recent event. However, those are usually self-promoting and not ready for prime time. At worst, even well-respected medical centers’ Twitter accounts are in the habit of tweeting out poorly written health and medicine stories from local and national mainstream media or, regrettably, spouting pseudo-wisdom from celebri-docs and self-styled health and medicine gurus who are more style than substance. Part of the problem is that these accounts are frequently not managed by medical professionals but rather by young public relations professionals just entering the medical field who don’t distinguish between Vivek Murthy (the much-beloved Surgeon General of the United States, @Surgeon_General) and Deepak Chopra (decidedly not the Surgeon General of the United States, Twitter handle withheld.)

Enter Andy Slavitt. Mr. Slavitt has been the acting administrator of the Centers for Medicare & Medicaid Services (CMS) since 2015. While Mr. Slavitt has come under some scrutiny from some conservative news outlets and other critics for his work while at the helm of CMS, his personal Twitter feed is simply awesome. Mr. Slavitt (@ASlavitt) brings a refreshing honesty to the medium. Yes, he’s partisan, but he owns it. He’s also not afraid to mix it up with random people and accounts online. Usually famous or “well-known” people on Twitter ignore snarky comments from “normals” (ie, everyday people without any particular claim to fame trying to bait a prominent person into a Twitter battle). Not Mr. Slavitt! He’s just as apt to tweet official news about major government initiatives, such as MACRA, as he is to dispel rumors and myths about the Affordable Care Act (ACA) put forth by everyday tweeps (ie, you and me). One anonymous but politically tied Twitter account accused Mr. Slavitt of not knowing the difference between getting insurance and obtaining real medical care, a critique of the ACA. Most government officials at Mr. Slavitt’s level would let a tweet like this slide and simply ignore it. Instead, Mr. Slavitt swung back, tweeting that “unnamed people often lob clichés at you in the job … highest rates of regular [doctor] visits, script fills, and avoided deaths, notwithstanding.”

In fact, Mr. Slavitt’s Twitter persona is not random. It’s part of a plan. Mr. Slavitt has said that his Twitter presence is specifically being cultivated in order to demystify the large and often opaque government agency that he runs. Doing so, he says, “scare[s] the crap out of my colleagues” at CMS, who aren’t used to such a frank and occasionally brusque approach to online PR. This reflects precisely why Mr. Slavitt’s tweets are so informative. When a government agency has a real person responding in real human ways, things may indeed get a little messy, but people feel like they can be a part of the process. Even critics are more likely to engage. The 12,000-plus followers Mr. Slavitt has amassed in just a few months seem to agree.

Also in agreement is health care reporter Dan Diamond (@DDiamond) of Politico.com, who invited Mr. Slavitt to be the first guest on his new weekly podcast, “Pulse Check,” which is available online or on iTunes. In that first interview published in April 2016, Mr. Diamond somewhat affectionately branded Mr. Slavitt as “remarkably liberated to weigh in on
Pushing Fast Forward in the ED

The Miriam Hospital’s FAST FORWARD program regains lost patient flow efficiencies

by SHARI WELCH, MD, FACEP, FACHE

The Miriam Hospital is a 247-bed community hospital affiliated with the Warren Alpert School Medical School of Brown University in Providence, Rhode Island. The emergency department sees 68,000 visits annually in its 61 treatment spaces, which include 21 lounge chairs for vertical flow. The emergency department has had a long reputation for efficiency and service quality. The ED physicians and staff have always been proud of their performance metrics and empty waiting room. However, after crossing the 60,000-visit volume band, the department began to falter operationally, and its wait times increased. The new normal included an often full waiting room. The emergency department, which effectively operates as a geriatric emergency department (more than 30 percent of its patients being older than age 65), often found itself with Emergency Severity Index (ESI) 2 patients being placed back in the waiting room, a situation that did not please staff.

Hospital President Arthur Sampson and ED Medical Director Gary Bubly, MD, decided to undergo a comprehensive ED operations assessment conducted by an objective third party. The assessment identified opportunities for improvement. The leaders were committed to improving the emergency department but needed a road map of where to start. After the assessment, Dr. Bubly, along with his associate director, Ilse Jenouri, MD, and his nursing counterparts, Denise Brennan, nurse director of emergency services, and Bob Ross, clinical manager, decided to trial a change package with a set of complementary improvements that would commence simultaneously.

Using data, interviews, and observation, the ED operations experts argued that the emergency department had the space and personnel to manage the volumes. Their assessment revealed that intake was cumbersome, with many delays as most steps were conducted in series. Further, though the Miriam emergency department had just begun patient streaming and treating patients in chairs, there was no improvement in wait times because the streaming was not decisive and most geographic zones were mixed-acuity service lines. This made it hard to move low-acuity patients through the system quickly. Other patient flow and housekeeping issues were identified. Using data the leadership team developed, the emergency department implemented the flow model in Figure 1 using the major care/minor care concept used in Great Britain.

The leadership team cleverly dubbed the
change package “The Miriam: FAST FORWARD>>.” It connotes the overarching theme of trying to regain lost efficiencies. The changes included:

1) Team triage, which made the most of the physical layout.
2) A patient flow coordinator (PFC) to monitor flow into the department and, where possible, load-level the various zones.
3) Low-acuity patient streams (fast track and vertical flow), which place lower-acuity patients into cohorts depending on resource need.
4) A housekeeping improvement initiative to rectify the problem of empty but dirty rooms.

The leadership crafted a new triage process that has many steps now happening in parallel (see Figure 2).

The physician contact is now very early in the ED encounter, and lab testing is initiated at the ED encounter, and lab testing is initiated at the most appropriate for the patient, but the PFC assigns the room.

The PFC is a role that is growing in popularity, especially in emergency departments seeing more than 50,000 visits per year. The PFC manages incoming ambulances and has the 30,000-foot view of the workload in each area. As emergency departments get busy with increased numbers of geographic zones, an overview is lost unless someone is dedicated to monitoring and managing flow. This role works best when it is in addition to the charge nurse role, which was becoming unmanageable in terms of scope of duties. The charge nurse and PFC work as a team and are in constant communication (cellphones with speed dial) to share information for flow management. The charge nurse now focuses on one area with attention to outflow, admissions, and discharges. The charge nurse can inform the PFC as to workload in the back, the status of patients, and which patient is likely to be moving next. Together, they manage overall patient flow.

Patients were grouped according to acuity work in positive results. After four rapid-cycle tests of change, the leaders and stakeholders had ironed out the bugs and were ready to turn on their new ED processes for good. Compare their results where they were undergoing relative to the Academy of Administrators in Academic Emergency Medicine and Emergency Department Benchmarking Alliance cohorts before and are now top performers (see Table 1).

There are some take-home messages that are important to all ED leaders and managers reading this story. You will need to change your processes as your volumes grow. In particular, as you jump a volume band, what has worked before no longer works at the increased volumes. Parallel processing, patient streams that segment patients according to the time and resources they will need, and pushing the provider to the front of the encounter are all forward-thinking ED flow strategies. For The Miriam Hospital emergency department, this change package helped get its mojo back! Once again, the ED members are top performers in their system. From now on, they will continue moving their patients fast forward and achieving higher levels of performance and great success!

### Table 1: Miriam’s Performance Before and After Intervention Compared to Benchmark Data

<table>
<thead>
<tr>
<th>PERFORMANCE METRIC</th>
<th>THE MIRIAM HOSPITAL BEFORE</th>
<th>AFTER</th>
<th>AAEM 60-80K</th>
<th>EDBA 60-80K</th>
</tr>
</thead>
<tbody>
<tr>
<td>PPD</td>
<td>182</td>
<td>198</td>
<td>193</td>
<td>164</td>
</tr>
<tr>
<td>D2D</td>
<td>41</td>
<td>17.7</td>
<td>30</td>
<td>33</td>
</tr>
<tr>
<td>LOS Overall</td>
<td>264</td>
<td>232</td>
<td>300</td>
<td>201</td>
</tr>
<tr>
<td>LOS Admitted</td>
<td>341</td>
<td>326</td>
<td>486</td>
<td>336</td>
</tr>
<tr>
<td>LOS Discharged</td>
<td>228</td>
<td>189</td>
<td>264</td>
<td>181</td>
</tr>
<tr>
<td>LOS Fast Tracked</td>
<td>N/A</td>
<td>118</td>
<td>N/A</td>
<td>128</td>
</tr>
<tr>
<td>LBTC</td>
<td>4.72%</td>
<td>1.8%</td>
<td>4.4%</td>
<td>3.1%</td>
</tr>
<tr>
<td>LWBS</td>
<td>2.9%</td>
<td>.61%</td>
<td>2.6%</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Definitions: PPD, patients per day; D2D, door-to-doctor time; LOS, length of stay; LBTC, left before treatment completed; LWBS, left without being seen; AAEM, Academy of Administrators in Academic Emergency Medicine; EDBA, Emergency Department Benchmarking Alliance.
Forensic photography for emergency medicine

by RALPH J. RIVIELLO, MD, MS, FACEP

The Case: You are called to testify in court for a domestic violence assault case. You saw the patient three years ago; she had sustained multiple bodily injuries. In addition to providing medical care, you took photographs of her injuries. While on the stand, you are shown the picture in Figure 1 and are asked to describe the location and size of the wound. How would you answer that question?

Discussion

In the case, the photograph does not allow the viewer to accurately know which body part is being depicted. Also, the size cannot be described. Photography has become an important tool for injuries. It is used in documenting child abuse, elder abuse, domestic violence, sexual violence, and assault cases. In some departments, forensic nurse examiners (FNEs) are called upon to take photographs and document the findings. However, a FNE may not always be available, requiring the emergency provider to take the pictures. A few helpful hints will allow you to take photographs that actually represent the finding you identified.

Forensic photography supplants the medical forensic history and physical findings. It allows the viewer to see the injuries and the provider saw at the time of evaluation. The advent of digital photography has had a great impact on forensic photography.

Several advantages of digital image capture include instant review of photos for quality and composition, no need for film or film development, and ease of storing and transfer of images. Prior to taking photos, there should be a department policy addressing the use of photographs. The policy should cover topics including consent, secure storage of images, and transfer of images. Risk management, information technology, and the medical record departments should be involved in policy development.

Patients should consent to have their photographs taken. A separate photographic consent form should be used. Patient have the right to refuse image capture of certain injuries or body parts. Also, the consent should address the release of images to law enforcement and/or district attorney’s offices. Images should be stored on a secure server and/or within the electronic health record.

The medical record should reflect that photographs were taken as well as the number taken and how they were stored. Transferring the images to a CD-ROM and storing the CD with the medical record or in a separate secure location or using a separate memory card for each patient are acceptable. Photographs depicting genitalia should be stored with particular sensitivity.

Some Photographic Tips

Equipment: Expensive equipment is not necessary. A good-quality point-and-shoot camera takes sufficient images. The camera should capture images of at least six megapixels and have macro lens capabilities. Macro lenses allow for close-up imaging of injuries.

Figure 1 (Left): Suboptimal quality photograph of an injury from a domestic violence assault.

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low close-up shots and are represented by the “tulip” icon on most cameras. A built-in or separate flash is also required. Other essentials include spare batteries, memory cards, computer-readable reference scales for measuring length, cleaning supplies, and the camera manual. A tripod or monopod may also be helpful.

For most applications, the camera can be kept in automatic mode, which will choose the correct settings and capture desirable images. For close-ups, the mode dial should be set to macro setting. For initial settings, file format should be set to JPEG, image quality to best, and image size to largest.

Prior to taking photographs, a picture of the patient’s identifying information should be taken. This should include the patient name, medical record number, date, and time. A hospital ID sticker is ideal. Next, a picture of the photographer’s ID should be taken. A facial image or full-body image can be taken to identify the patient. When taking pictures of an injury or other finding, a “forensic series” of images should be taken:

- Overview (includes two anatomic landmarks for orientation)
- Mid-range (closer, includes one anatomic landmark)
- Close-up (one with and one without a reference scale)

The overview and mid-range shots may include more than one finding. However, the close-ups should each include a single injury. A reference scale should always be used. The most popularly used scale is the American Board of Forensic Odontology scale (ABFO-2). Image of showing the distortion of the photograph. If an ABFO scale is not available, a small ruler or coin can be used. The scale should not obscure the finding(s) and should be positioned on the same plane as the finding and at an equal distance from the camera.

Make sure your camera is oriented 90 degrees to the injury. This ensures the most accurate representation of the injury. Also, make sure the background is free of clutter.

Take as many pictures as needed to best represent the finding. Never delete a picture no matter how bad it is. Also, photographs should not be manipulated, and if photographic software is used to enhance an image, the original image should be saved, and for each altered image, documentation of how it was altered should be provided.

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Bay Medical Center (Panama City)
Gulf Coast Regional Medical Center (Panama City)

CENTRAL FLORIDA
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Englewood Community Hospital (Englewood)
Midwest Regional Medical Center (Ocala)
Emergency Center at TimberRidge (Ocala)
Oak Hill Hospital (Ocala)
Poinciana Medical Center (Orlando)
Bradenton Regional Emergency Center (Plant City)
Fawcett Memorial Hospital (Port Charlotte)
Bayfront Punta Gorda (Punta Gorda)
Centerpoint Medical Regional Hospital (Sanford)
Doctors Hospital of Sarasota (Sarasota)
Brandon Regional Hospital (Tampa Bay)
Citrus Park ER (Tampa Bay)
Medical Center of Trinity (Tampa Bay)
Northside Hospital (Tampa Bay, FL)
Northside Hospital (Tampa Bay, FL)
Assistant Medical Director
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Can I bill for my interpretation of ECGs and X-rays?

Answer: Yes, you are permitted to bill for interpretation of ECGs and X-rays, but certain criteria must be met. First and foremost, an “interpretation” is different than a “review.” If you independently visualize or review a diagnostic test, this work is incorporated into the level of medical decision making. If you perform an interpretation, the written report should be similar to what a specialist in the field would prepare. It must be your interpretation, not someone else’s. Medicare and some other payers have stated that they will pay for interpretations that contribute to the diagnosis or treatment of patients but usually only one interpretation. Some payers do reimburse for both contemporaneous and final (QA) readings. Therefore, you might consider having discussions with other services that may want to bill for concurrent or delayed readings. Some institutions require credentialing in order to “officially” interpret certain studies. For more information, see ACEP’s FAQ on this topic at www.acep.org/content.aspx?id=32164&list=1&fid=2292. Brought to you by the ACEP Coding and Nomenclature Committee.

GET PAID FOR YOUR INTERPRETATION
by HAMILTON LEMPERT, MD, FACEP, CEDC

Question: Can I bill for my interpretation of ECGs and X-rays?

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Editor’s Note: Cutting through the red tape to make certain that you get paid for every dollar you earn has become more difficult than ever, particularly in our current climate of health care reform and ICD-10 transition. The ACEP Coding and Nomenclature Committee has partnered with ACEP Now to provide you with practical, impactful tips to help you navigate through this coding and reimbursement maze.

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South Carolina

Rapid expansion in Greenville, SC due to new EM Residency Program starting 2017 and community hospital growth.

Greenville Health System (GHS) seeks BC/BE Emergency Physicians to become faculty in the newly established Department of Emergency Medicine. Successful candidates should be prepared to shape the future Emergency Medicine Residency Program and contribute to the academic output of the department. GHS is the largest healthcare provider in South Carolina and serves as a tertiary referral center for the entire Upstate region. The flagship Greenville Academic Department of Emergency Medicine is integral to the patient care services for the:

- Level 1 Trauma Center
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- STEMI and Comprehensive Stroke Center
- Emergency Department Observation Center
- Regional Ground and Air Emergency Medical Systems
- Accredited 3 year Emergency Medicine Residency Program

The campus hosts 15 other residency and fellowship programs and one of the nation’s newest allopathic medical schools – University of South Carolina School of Medicine Greenville.

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Greenville, South Carolina is a beautiful place to live and work. It is one of the fastest growing areas in the country, and is ideally situated near beautiful mountains, beaches and lakes. We enjoy a diverse and thriving economy, excellent quality of life, and wonderful cultural and educational opportunities.

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GHS does not offer sponsorship at this time. EOE
the issues of the day” on Twitter (said with a chuckle). In other words, he said Mr. Slavitt was really off on being unexpectedly “real” on Twitter. Mr. Slavitt agreed and acknowledged that it was part of a plan to get ahead of problems and to have a “good offense” when it comes to policy rollout at the federal level. Whether you agree with CMS policy, I believe the strategy has been effective. Thanks to Mr. Slavitt, and the medium itself, I do not believe there has ever been a time when average people had more access to a high-level government administrator.

Speaking of Mr. Diamond, his health care coverage on Politico has gotten enormous and well-deserved attention lately. His daily blog, “Politico Pulse,” is becoming must-read material for anyone looking to keep up with what is happening in the world of health care policy, politics, and business. Each day, Mr. Diamond gives updates on public health (eg, the latest on Zika) and what’s going on in Washington (eg, will Medicare expand or collapse in the incoming administration?), and he tracks major movements in the pharmaceutical industry, with recent special attention to mergers and what they mean. Finally, Mr. Diamond’s brief list of “what we’re reading” provides daily links to important medicine, science, and health care policy articles in the mainstream press as well as online.

Do you have other must-follow Twitter accounts and blogs? Let me know, and I’ll highlight some of them here on “The Feed.”

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Those interested in a position or further information may contact Dr. Dick Kuo via email dckuo@bcm.edu or by phone at 713-873-2626. Please send a CV and cover letter with your past experience and interests.

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The department has a well-established, three-year residency program and an Emergency Ultrasound fellowship. The department is seeking physicians who can contribute to our clinical, education and research missions.

Qualified candidates must be ABEM/ABOEM certified/eligible. Salary and benefits are competitive and commensurate with experience. For consideration, please send a letter of intent and a curriculum vitae to: Robert Eisenstein, MD, Interim Chair, Department of Emergency Medicine, Rutgers Robert Wood Johnson Medical School, 1 Robert Wood Johnson Place, MEB 104, New Brunswick, NJ 08901; Email: Robert.Eisenstein@rutgers.edu; Phone: 732-235-8717; Fax: 732-235-7379.

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FEBRUARY 2017 ACEP NOW 27
WHAT IS CULTURE AND WHY DO I NEED IT?

WHAT IS CULTURE?
Like an iceberg, culture is largely invisible. If you ask your nursing or medical staff to describe your hospital’s culture, they’d probably have a hard time. However, it's likely that everyone in your organization shares an unspoken understanding of the rules and their place in the pecking order.

“Culture represents your organization’s core, its true self.”

It’s expressed continuously by what your people do and say. For this reason, it can’t be faked or changed through directives. It has to be changed through hearts and minds.

CULTURE IS MISSION CRITICAL
Developing and maintaining a positive culture probably isn’t in your job description as a leader. But make no mistake, it’s one of the most important things you can do.

Culture touches everything in your organization. It influences behavior, relationships, decisions and ultimately, effectiveness. A survey of top supply chain executives found that they viewed culture (or lack thereof) as the number one barrier to business success. Culture has elevated many ventures — and crushed many more. On the positive side, the best and the brightest minds compete to work for culture-conscious companies like Google, Twitter, Facebook and even the fully unionized Southwest Airlines. On the negative side, we have the culture of unchecked greed that tanked Enron. Glaring cultural differences made the $35 billion Sprint Nextel merger a disaster.

CULTURE & HEALTHCARE
Let’s talk about what this all means for hospitals and health systems.

As a vice president and former regional director of CEP America, it’s been enlightening to work with dozens of hospitals over the years.

Very often, when a department is struggling, team members will point out why their department is different. Maybe they’re in a part of the country where recruiting top-notch providers and staff is difficult. Maybe the facilities are outdated, cramped and uncomfortable. Or maybe they have high patient volumes, high acuity or a challenging population.

Granted, these difficulties are real. But I also think these departments are underestimating the role culture plays.

In my day, I’ve seen hospitals with every advantage struggle with staff retention, patient satisfaction and quality. And I’ve seen hospitals with stark disadvantages excel at all of the above.

Performance areas directly impacted by culture include: Patient Satisfaction, Provider Satisfaction, and Medical Staff Alignment.

To read more about the importance of culture and how CEP America enacted change, visit: go.cep.com/yourculture
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For additional information, please contact:
Susan B. Promes, Professor and Chair, Department of Emergency Medicine, c/o Heather Peffley, Physician Recruiter, Penn State Hershey Medical Center, Mail Code A590, P.O. Box 850, 90 Hope Drive, Hershey PA 17033-0850, Email: hpeffley@hmc.psu.edu OR apply online at www.pennstatehersheycareers.com/EDPhysicians

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Founded by ESP, ERGENTUS, APEX, TBEP, MEP, EPPH and EMP
measure.” Many said that most of the metrics are not under our control. One said that some of the most important things we do in emergency medicine—practice compassion and empathy—cannot be measured nor should they be. There are only demerits given for “lost efficiency” when spending time with grieving families. Some of the most important parts of what we do include reassurance for the souls who come to us scared and hurting. It is up to us to advocate for our patients with the administrators and policymakers.

ZDoggMD at LAC

ZDoggMD, an internal medicine physician who is known for music videos, parodies, and comedy sketches about medical issues and working as a physician, is coming to the ACEP Leadership & Advocacy Conference, March 12–15, 2017, in Washington, D.C. He is the only non-emergency physician on EM Docs, voted in by the membership because of his advocacy efforts for the practice of medicine. Now he has a better understanding of emergency medicine challenges and he will be meeting us in D.C. to help us advocate for real solutions to the opioid crisis and to discuss social media, resiliency, and how to be a leader in Health 3.0 that we are building together.

Subgroups

Since we have a no-advertising and a no-recruiting policy, with only emergency physicians on EM Docs, we have a few free subgroups:

- Doc to Doc Rental and Homes for Sale: (multispecialty) for vacation rentals or when one of our colleagues is relocating.
- Doc to Doc Job Connect: (multispecialty) for non-recruiters are allowed on this page, but we allow physicians to connect with one another when there is a need to fill a position or when someone is considering a career change.
- EMDOCS Mentoring Medical Students Interested in EM: when they match, they can stay on as mentors and also join the main EM Docs group.
- Physician Entrepreneur: a place where we can support our colleagues who have created a useful tool or service.
- EM Docs Education: where conferences, board review courses, books, and educational opportunities can be announced and discussed.

EMPOWER Events

EM Docs are getting together outdoors through EM Physician Outdoor Wellness for Resiliency (EMPOWER). Have your local event! Just make it happen and take photos to encourage others to do the same.

EM Docs Meet-ups/EMPOWR events

At ACEP16, we met at 6 a.m. for group runs, and we had the outdoor terrace area designated for EM Docs at the Opening Party in Las Vegas. Plans for face-to-face meet-ups (EMPOWER events) so far in 2017 include:

- March 12–15, 2017: ACEP Leadership & Advocacy Conference meet-ups include a wellness room for 6 a.m. yoga and ballet and group outdoor runs/walks before lectures.
- May 16–18, 2017: At Essentials of EM, we will have daily outdoor events specifically for members of EM Docs as well as EM Docs designated VIP rooms.
- Summer 2017 (date TBD): Meet-up in New Mexico for hiking in the Pecos Wilderness.
- Nov. 3–5, 2017: Meet-up in Arkansas for a free cattle drive and barbecue at my family ranch.

If you want to be included in the conversation, ask a colleague to add you to the Facebook group—chances are, someone in your department is on EM Docs. Send a private Facebook message to the admin page for EM Docs with proof that you are an emergency physician, for example, a photo of your ID badge or diploma, etc. 📸

ZDoggMD will be speaking at this year’s Leadership & Advocacy Conference.
Important Safety Information

Rapivab® (peramivir injection) is indicated for the treatment of acute uncomplicated influenza in patients 18 years and older who have been symptomatic for no more than 2 days.

• Efficacy of Rapivab was based on clinical trials in which the predominant influenza virus type was influenza A; a limited number of subjects infected with influenza B virus were enrolled.

• Influenza viruses change over time. Emergence of resistance substitutions could decrease drug effectiveness. Other factors (for example, changes in viral virulence) might also diminish clinical benefit of antiviral drugs. Prescribers should consider available information on influenza drug susceptibility patterns and treatment effects when deciding whether to use Rapivab.

• Efficacy could not be established in patients with serious influenza requiring hospitalization.

Contraindications

Rapivab is contraindicated in patients with known serious hypersensitivity or anaphylaxis to peramivir or any component of the product. Severe allergic reactions have included anaphylaxis, erythema multiforme, and Stevens-Johnson syndrome.

Warnings and Precautions

• Rare cases of serious skin reactions, including erythema multiforme, have been reported with Rapivab in clinical studies and in postmarketing experience. Cases of anaphylaxis and Stevens-Johnson syndrome have been reported in postmarketing experience with Rapivab. Discontinue Rapivab and institute appropriate treatment if anaphylaxis or a serious skin reaction occurs or is suspected. The use of Rapivab is contraindicated in patients with known serious hypersensitivity or anaphylaxis to Rapivab.

• Patients with influenza may be at an increased risk of hallucinations, delirium, and abnormal behavior early in their illness. There have been postmarketing reports (from Japan) of delirium and abnormal behavior leading to injury in patients with influenza who were receiving neuraminidase inhibitors, including Rapivab. Because these events were reported voluntarily during clinical practice, estimates of frequency cannot be made, but they appear to be uncommon. These events were reported primarily among pediatric patients. The contribution of Rapivab to these events has not been established. Patients with influenza should be closely monitored for signs of abnormal behavior.

Concurrent use with Live Attenuated Influenza Vaccine

Antiviral drugs may inhibit viral replication of a live attenuated influenza vaccine (LAIV).

Concurrent use of Rapivab with LAIV intranasal has not been evaluated. Because of the potential for interference between these two products, avoid use of Rapivab within 2 weeks after or 48 hours before administration of LAIV unless medically indicated.

You are encouraged to report negative side effects of prescription drugs to the FDA. Visit www.fda.gov/medwatch or call 1-800-FDA-1088.


Rapivab® is a registered trademark of BioCryst Pharmaceuticals, Inc. All other trademarks herein are the property of their respective owners.

For flu patients in the emergency department who may not be appropriate for oral treatment • Only one 15- to 30-minute IV infusion required • Treats acute uncomplicated influenza in patients 18+ who have been symptomatic for no more than 2 days • Appropriate for many patients, including those who cannot tolerate or may be noncompliant with oral flu treatment and those requiring IV hydration • Can be used with OTC supportive therapies