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on the ACA
BY RICARDO MARTINEZ

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Behind the Scenes on Safe Harbors

*The ACEP Board of Directors
dives into a new issue*

by KEVIN KLAUER, DO, EJD, FACEP

The work of the ACEP Board of Directors is often messy, frequently goes unnoticed, and is always productive. The following is a recent email discussion between the ACEP Board Members, Council Officers, and ACEP executive leadership. The issue of safe harbor protections for following clinical guidelines was raised as a potential solution in response to regulatory pressure to reduce the cost of care delivery. ACEP started to feel the squeeze after an article published on February 23, 2014, in the lay press, "A Push for Less Testing in Emergency Rooms: Heavy Use of Imaging Scans May Drive Up Costs—and Risks," by Barbara Sadick of *The Wall Street Journal*.

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AS UKRAINE REACHES FOR FREEDOM, ITS PEOPLE WORRY AND PRAY

*The nation's struggle hits
home when your friends and
colleagues are in the crossfire*

by BRIAN R. McMURRAY, MD,
FACEP, FACP

Ukkraine is indeed a geopolitically diverse nation. There is much history and understandable thirst for true freedom and servant leadership. Ukrainians haven't had much of that kind of leadership. Consider the Holodomor in 1932–1933 when Stalin starved millions to death in Ukraine over a squabble with Ukraine's farmers; the many more millions who died in World War II, their own Holocaust, and the deaths caused by not only Hitler but by Stalin; and Stalin deporting the Crimean Tatars en masse to Central Asia after World War II and Russians put in Crimea in their place. The list goes on and on.

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SPOT CLEAR AND PRESENT DANGER

Some states require physicians to
report patients who pose a danger
to themselves and others.
What is your duty to report?

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Kevin Klauer, DO, EJD, FACEP
kklauer@acep.org

EDITOR

Dawn Antoline-Wang
dantolin@wiley.com

ART DIRECTOR

Paul Juestrich
pjuestri@wiley.com

MANAGER, DIGITAL MEDIA AND STRATEGY

Jason Carris
jcarris@wiley.com

ACEP STAFF

EXECUTIVE DIRECTOR

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dwilkerson@acep.org

DIRECTOR, MEMBER COMMUNICATIONS AND MARKETING

Nancy Calaway
ncalaway@acep.org

ASSOCIATE EXECUTIVE DIRECTOR, MEMBERSHIP AND EDUCATION DIVISION

Robert Heard, MBA, CAE
rheard@acep.org

COMMUNICATIONS MANAGER

Darrin Scheid
dscheid@acep.org

PUBLISHING STAFF

EXECUTIVE EDITOR/ PUBLISHER

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ldionne@wiley.com

ASSOCIATE DIRECTOR, ADVERTISING SALES

Steve Jezzard
sjezzard@wiley.com

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NEWS FROM THE COLLEGE



Section of Careers in Emergency Medicine Calls for Essays for Longevity and Tenure Awards

The ACEP Section of Careers in Emergency Medicine is recognizing longevity in the specialty and is asking for nominations for awards to be given in two categories:

- Longevity Award for the physician with the longest active career in emergency medicine
- Tenure Award for the physician with the longest active career in the same emergency department

Recognition also will be given to those physicians who are still actively practicing emergency medicine after 20, 25, 30, and 35 years. To be eligible, prospective recipients must have worked an average of 1,000 or more hours per year in emergency medicine practice or teaching. Hours for residency training and administration are not included. Nominees also must be current ACEP members.

Previous applicants may apply every year. However, they may not win the same award within a five-year period. Please submit a full historical sketch. For example, "Attending Emergency Physician, June 1974 to December 1979," is acceptable and must include details of the entire career along with a brief essay (300 words or fewer) about why the nominee made emergency medicine a career. Award recipients will be recognized during the section meeting at ACEP14 in Chicago this fall. Additional recognition will be given in the section newsletter.

To be considered for the awards, nominations must be received by July 18, 2014. Submit your application to:

Cathey Wise
Section of Careers in
Emergency Medicine, ACEP
PO Box 619911
Dallas, TX 75261-9911
Fax: 972-580-2816
Email: careers.section@acep.org

Apply Now to Serve on an ACEP Committee

ACEP President-Elect Michael J. Gerardi, MD, FACEP, has announced the beginning of the selection process for appointing members to serve on national ACEP committees during fiscal year 2014–15. Members interested in serving on a national ACEP committee are asked to contact Mary Ellen Fletcher, CPC, CEDC, at 800-798-1822, ext. 3145, or send an email to mfletcher@acep.org. The committee interest form is also available on ACEP's website at <http://webapps.acep.org/Membership/committeeinterest.aspx>.

Dr. Gerardi requests that, in addition to submitting a curriculum vitae with the com-

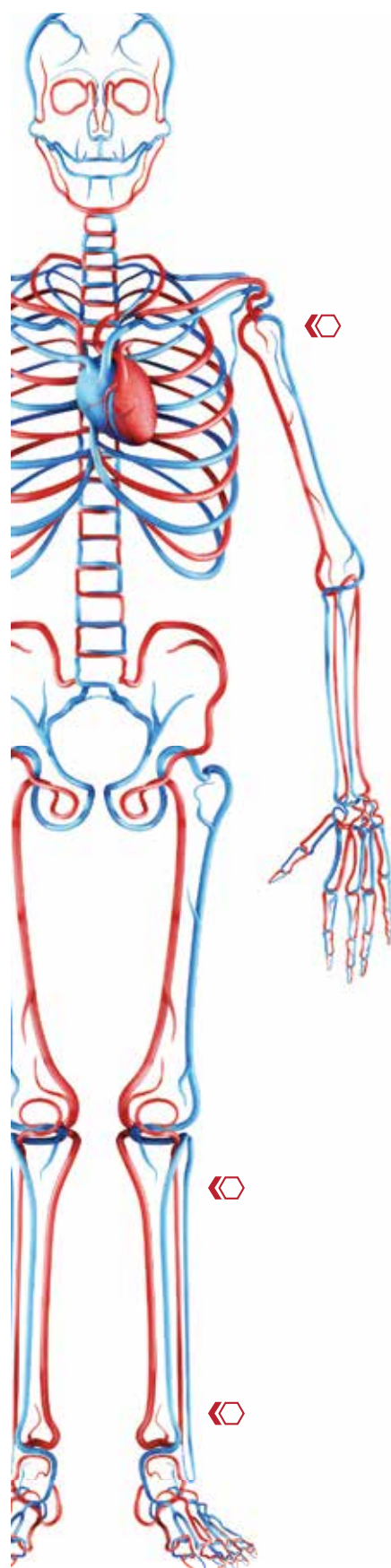
mittee interest form, members include specific information explaining qualifications and experiences relevant to a particular committee. Members are also encouraged to contact their chapter to obtain a letter of support for their appointment. Member interest and qualifications will be matched with College needs.

Lists of current national ACEP committees, members, objectives, and annual reports are located on ACEP's website.

Although most committee work will be accomplished through email and conference calls, committee members are expected to attend the organizational meetings at the annual meeting Oct. 27–30, 2014, in Chicago.

The deadline for submitting committee interest forms to Ms. Fletcher is May 19, 2014. Dr. Gerardi will finalize the committee appointments in June.

If you have any questions, please contact Ms. Fletcher at 800-798-1822, ext. 3145, or mfletcher@acep.org.



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References: 1. Rogers JJ, Fox M, Miller LJ, Philbeck TE. Safety of intraosseous vascular access in the 21st century [WoCoVA abstract O-079]. *J Vasc Access*. 2012;13(2): 1A-40A. 2. Paxton JH, Knuth TE, Klausner HA. Proximal humerus intraosseous infusion: a preferred emergency venous access. *J Trauma*. 2009;67(3):1-7. 3. Cooper BR, Mahoney PF, Hodgetts TJ, Mellor A. Intra-osseous access (EZ-IO®) for resuscitation: UK military combat experience. *J R Army Med Corps*. 2007; 153(4):314-316. 4. Dolister M, Miller S, Borron S, et al. Intraosseous vascular access is safe, effective and costs less than central venous catheters for patients in the hospital setting [published online ahead of print January 3, 2013]. *J Vasc Access*. doi:10.5301/jva.5000130.

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ACEP Now in Action

I wanted you to know that I have cited Paul Kivela's short piece on the two-midnight rule ("Counting on Emergency Medicine with the Two-Midnight Rule," February *ACEP Now*, p. 15) in an email to my partners. And from your piece ("Pregnancy and Clots: What's True and What's Not," February *ACEP Now*, p. 14), I didn't know that VTE disease was fairly evenly distributed throughout pregnancy. I thought, like many other physicians, that it was more a third-trimester/postpartum problem. Thank you for that bit of knowledge that, interestingly, I applied two nights ago with a pregnant patient.

—Bradford L. Walters, MD, FACEP
Royal Oak, Mich.

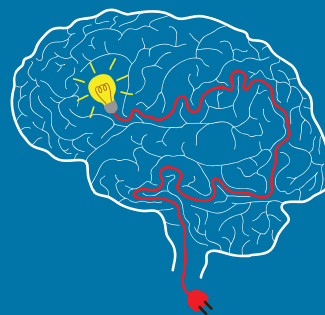
An Ounce of Prevention

This is in response to the pro-con debate on asset protection ("Afraid of Getting Sued and Losing Everything? Well, Just Hide Your Money! Or Not!" February *ACEP Now*, p. 20).

First of all, thanks to Drs. Frank and Segan for an interesting pro-con feature on a subject

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that is on almost every ED physician's mind to some degree.

I would like to respond to Dr. Frank's viewpoint. I have known a physician who lost his house and many of his assets due to an excess malpractice verdict. He was an obstetrician, and they historically have huge liability risks, but this did ruin him financially and emotionally, not to mention what this did to his family.

Second, I think Dr. Frank makes the case for good asset protection. He states (and I summarize) that most plaintiff attorneys will not be interested in going after the personal assets of a physician because (as in example 1, where

the verdict was \$5 million and the physician had \$1 million in coverage) "the chances of getting \$4 million (or anything close to that) from most physicians are slim to none." What I take from this is that the chances are truly "slim to none" of taking some or all of the physician's assets if the physician has engaged in an effective, reasonable asset-protection plan. I bet the plaintiff attorney would not be so merciful if, as with physician B in Dr. Segan's example, the physician had his assets in unprotected, easily confiscatable forms.

Third, one issue that is not addressed by Dr. Frank is the dread and anxiety one faces when

served with those awful papers. The amount of anxiety and stress that accompany a lawsuit is underappreciated and often makes physicians question the career they chose. Even with the fact that most physicians prevail, there is always the chance (even with excellent medical care) that you will be the unlucky one who has a jury who forgets the facts and sides with the perceived victim.

Having a good asset-protection plan, which may be expensive, is worth the money. Most things of value are, even if it is to protect you from the chance, albeit small, that you are the one who has "had [your] assets taken away by an excess verdict." The peace of mind that comes from protection against the sometimes illogical and unjust whims of the legal system is something that most physicians would find worth having.

Dr. Frank is correct; asset protection costs money and can be expensive, especially if done well. However, for most physicians, it is money well spent.

—Stephen F. Spontak, MD, ABEM
Homer Glen, Ill.

At ACEPNow.com, Alyssa Berns of Buckhannon, W.V., asked:

"In chronic-pain patients who have been properly screened for addiction risk using the Opioid Risk Tool (see Table 1), the risk of addiction for those who are scored at low risk is less than 0.2 percent"

That 0.2 percent is a great stat! Does anyone know where exactly it comes from?


In response to the great question from Alyssa Berns, here are my comments.

The data on risk have been accumulated in our nine community-based chronic non-cancer pain clinics over a period of three years. In our clinics, we average 60,000 visits per year, representing approximately 8,000 patients. All patients fill out the Opioid Risk Tool (ORT), along with many other validated assessment forms, at the time of entry into the clinics. Patients also sign an opioid agreement and are required to undergo random urine drug screening at a frequency determined by that initial risk stratification (anywhere from two per year to monthly).

Our patient retention is high, so we have fairly consistent evidence with respect to compliance and substance misuse. Others, however, have not reported such consistency in the value of any screening tool they have used. Witkin et al (*J Opioid Manag.* 2013;9:177-187) found that 38 percent of their low-risk patients had aberrant drug-related behavior (ADRB). It is important to note that ADRB is not the equivalent of addiction and represents acting-out behavior seen both with oligoanalgesia and addiction.

The Canadian Opioid Guideline (cited in the article) recommends the use of the ORT to establish baseline risk; it is the preferred screening tool at present. Another tool, the Drug Abuse Screening Test (DAST-20), specifically looks at presence of addiction risk at the point in time of seeing the patient rather than predicting risk in the future, as the ORT is meant

CONTINUED on page 8



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A NEW SPIN

Facing, and Embracing, the Facts

Obamacare isn't the root of all ills in health care today—bigger changes are cresting and spell opportunity

by RICARDO MARTINEZ, MD, FACEP



Most everything in the ACA are proposals or initiatives that were already underway, started by various constituents in politics, business, and health policy.

One of my favorite passion plays unfolds on CNBC from time to time. It usually involves a CEO of a company that has risen mainly because the market itself has done very well. He or she is revered and called a genius. A few months later, the stock begins to plummet, and the same CEO spends the next interview vigorously assigning blame for the stock decline. Routinely, the culprits are the government, the media, the short sellers, and the lawyers. Personally, I think it's the lawyers, but if the CEOs want to find the real culprit, someone should hand them a mirror. Even bad managers can do well in a good market, and these CEOs simply missed big trends that were obvious to their competitors. Poor insight does not lend itself to effective strategies for sustainability and growth.

In the same way, there are health care leaders who react to changes by hysterically screaming "Obamacare" at the top of their lungs rather than really understanding long-term trends that have been under way long before the Affordable Care Act (ACA). I can certainly understand politicians doing this because facts, although interesting, seem irrelevant to many of them. But educated health care leaders missing the big trends is a harder sell for me. Shouldn't they be leading?

Let's look at some those trends that have been occurring simply because we are at an inflection point for the health care system as a whole. The health care system wasn't always what it is today and has been constantly evolving, especially since the turn of the century. However, today's changes are happening faster than ever before. The transition to new financial and care models is largely built on large-scale changes in society that include increasing consumerism, greater price transparency, rapidly emerging technologies, hard financial realities, and changes in social demographics. Legislation has little to do with these trends.

The ACA rollout is clunky at best. It has to be changed and surely will be, but most major policy implementations are rocky. What the ACA attempted to do was reverse the effects of a market that allowed exclusion criteria that distorted risk pools so health insurance became either difficult to get or incredibly expensive. Most everything in the ACA are proposals or initiatives that were already underway, started by various constituents in politics, business, and health policy. The ACA has certainly increased the speed of that change, and we all know how much we love change in health care. So let's look at a few common claims about Obamacare and separate long-term trends that have been occurring and will occur no matter what happens to the ACA.

The law is causing a shortage of physicians!

The truth is that there has been a worldwide shortage of physicians for decades. In fact, this was a concern when I was a medical student (I'm a PGY 34), and we haven't meaningfully addressed the issue yet. There was a short time when we had additional medical school spots in the 1980s. However, the funding for that dried up. Graduate medical education slots have been decreasing since the 1990s, so we now have medical school graduates waiting for residency positions. Predictions of a physician shortage by 2020 have been a focus of major articles in the early 2000s, but what I learned from my time in Washington, D.C., is that policymakers often don't want to deal with difficult issues until there is a crisis. Congratulations, here's your crisis.

The law is causing business to cut health care benefits.

Oh, please. "Business" only got into health care benefits in the 1940s because wages were frozen and benefits were provided to get around the wage freeze and compete for employees. Since health care insurance costs started escalating rapidly, businesses have looked for ways to insulate themselves from those huge variations. We've seen businesses move from defined benefits, meaning that they would pay for certain benefits, to defined contributions, meaning that they would contribute a finite amount of dollars to employee benefits and employees could pick from a menu of benefits or pay the difference. This is driving the growth of private health-benefits exchanges. I know of no person, employer, or insurer who wants to pay a penny more for health care. Do you? For business, it is all about containing costs.

The law will cause a crisis in primary care.

In most countries, there are three generalists to each specialist. Therefore, access to primary care is much easier. In the U.S., that ratio is reversed, with three specialists per generalist, putting a squeeze on access to a generalist. That ratio has nothing to do with recent legislation but evolved over time and has become unsustainable. Simply put, specialty care pays well and allows growth in expertise in a narrow area, so physicians have chosen those career paths. We are just now recognizing, and rewarding, the value of those in primary care. Too little too late? In today's world, most generalists don't admit patients, preferring to have emergency physicians and hospitalists care for their patients. Let's take that opening and run with it.

The new law makes people pay more out-of-pocket.

Have you been sleeping? For decades, we've seen the rise of the patient as a payer class, but somehow, health care providers have ignored it. The rising copay for emergency department services was created to incentivize people to go elsewhere, despite the fact that they have nowhere else to go because regular physician practice office hours don't meet the needs of patients after hours and on weekends. Insurance companies have designed benefits with higher copays for emergency departments as "value based insurance," incenting the patient to go to less expensive care sources.

In 2003, President George W. Bush signed legislation that started health savings accounts (HSAs) and encouraged the growth of high-deductible health plans that had lower premiums and allowed consumers to keep the savings that were not spent in their HSA. The rapid rise of high-deductible health plans over the years has put the "first dollar" coverage on the consumer, essentially making the patient a payer source. This summer, the American Medical Association reported that 23–24 percent of physician payments came from the patients themselves. That trend is likely to continue, and increasingly, we will see patients change their patterns of access to care and their choices of care. Let's let them choose EM when it's the best option.

These changes were responses by payers to perceived overutilization of expensive and unnecessary care, creating a move to value-based care and driving growth of retail and urgent care clinics for acute care needs. Let's face it: the deductibles have gotten so high that patients simply won't pay large bills. It's a bit ironic that physicians and hospitals started health insurance back in the 1930s because patients couldn't afford to pay their bills. Now, we've come full circle.

But facing these facts provides opportunity to thrive. I predict that there will still be patients and they will need our care. The opportunity here is to design cheaper alternatives for care by emergency physicians and an "EM team," anywhere and anytime. If not, I can guarantee you that someone in Silicon Valley or Nashville is working on that solution right now—and at a profit. Now is a great time to lead these changes and redesign emergency care for all of our patients. ☺



DR. MARTINEZ is chief medical officer and vice president of North Highland Worldwide Consulting and assistant professor of emergency medicine at Emory University School of Medicine, both in Atlanta. He attends at Grady Memorial Hospital.



WHAT WILL HOSPITAL MERGER MANIA MEAN FOR EMERGENCY MED?

The big keep getting bigger when it comes to hospitals and health systems—and how that affects emergency physicians remains to be seen.

Earlier this year, Community Health Systems (CHS) of Franklin, Tenn., completed its \$3.9 billion acquisition of Health Management Associates (HMA), based in North Naples, Fla. CHS now owns, leases, or operates 206 hospitals in 29 states, making it the country's largest for-profit hospital operator ranked by number of hospitals.

The merger was blessed by the Federal Trade Commission (FTC), but only after CHS agreed to sell Riverview Regional Medical Center in Gadsden, Ala., and Carolina Pines Regional Medical Center in Hartsville, S.C., and related assets in both markets. The FTC said that, had those institutions been included in the merger, there would have been reduced competition in those areas.

That FTC decision to force that sale came around the same time a federal judge decided that St. Luke's Health System of Boise, Idaho, could not continue to own a multi-specialty medical group, Saltzer Medical Group of Nampa, Idaho. The FTC and others sued late last year to unwind St. Luke's 2012 acquisition, saying "the combination of St. Luke's and Saltzer would give it the market power to demand higher rates for health care services provided by primary care physicians in Nampa, Idaho, and surrounding areas, ultimately leading to higher costs for health care consumers."

The judge agreed, and the case was highlighted as one that may

change the future of health systems merging with local physician groups to integrate more services. It also, in effect, laid out the clear juxtaposition behind the current merger trend: health systems continue to look to add services and size as Medicare reimbursement payments slowly but surely move toward population health strategies and fiscal efficiencies driven by economies of scale.

But the frenetic pace of mergers—CHS alone has struck more than two dozen deals in the past seven years, according to the *New York Times*—means that smaller hospitals or medical groups may not be able to compete as a handful of regional or national firms dominate the landscape. It's a delicate balance aimed at providing the best care, but not from a position that eliminates consumer choice or gives one system the ability to negotiate higher reimbursement rates from health insurance plans that will ultimately be passed on to the consumer, the judge in the Idaho case wrote.

For emergency physicians at acquired hospitals or medical groups, immediate fears typically range from staff reductions to lessened hospital support from a less local owner. But in markets across the country where CHS has acquired HMA hospitals, executives are saying that's not the case.

"This transaction provides us with increased scale and broader geographic reach as we work to create strong health care networks across the nation," CHS chairman and chief executive officer Wayne Smith said in a news release when the merger consummated. "Our larger organization is well positioned to address the changing dynamics in our industry and dedicated to providing quality care for

millions of patients and all the communities we serve."

Still, the Idaho case—which St. Luke's has said it intends to appeal—highlights that the continued pace of growing hospital systems is likely to be the focus of attention.

The ruling "is a significant victory for the (Federal Trade Commission)," Jonathan Lewis, an antitrust attorney for Baker Hostetler in Washington, D.C., told the *Idaho Statesman* newspaper, "and should serve as a clear signal to hospitals looking to, and those that have already, acquired physician groups."

MEDICARE AUDITS CREATE MORE HEADACHES, DELAYS

Consultants and billing experts say emergency physicians and the hospitals they work in are increasingly frustrated with the growing length of the entire audit process—including getting paid back for denied claims that have successfully appealed.

James Blakeman, senior vice president of the billing company Emergency Groups' Office in Arcadia, Calif., said that delayed reimbursement can be damaging to hospitals, in particular, as those amounts are typically for hundreds of thousands of dollars. While individual payment denials to emergency physicians are "not usually material to a practice's financial viability," the implications of multiple held-up payments can be so significant physicians have no choice but to fight them, he said.

"Physicians cannot simply concede an audit if they know they are right because Medicare claims that these are all 'educational,'" Mr. Blakeman said, adding, "You are

made to feel like you have committed fraud and that someday they could say, 'We told you before that you were billing in error, now we are opening a large audit because you acknowledged (by not contesting before) that you were coding incorrectly.' That result could be disastrous. Injustice and fear of future audits are what haunt emergency physicians when they think about billing Medicare and Medicaid."

Practicing emergency physician John Stimler, DO, CPC, CHC, FACEP, a founder and managing member of health care consultant Bettinger, Stimler & Associates of Pinecrest, Fla., said he hears of too many groups that don't defend themselves. While he doesn't approve of that, he said it is understandable given the staffing and financial burden of mounting an aggressive defense.

"A lot of groups give up because they don't want to spend the money to do it," said Dr. Stimler, a member of ACEP's Reimbursement Committee. "It becomes a double-, or triple-, or quadruple-edged sword. You not only lose the money between the code choices, but you have to pay for the staff to defend yourself. All those steps are very expensive."

The process is also time consuming. If a hospital, physician group, or solo practitioner wants to appeal a Recovery Audit Contractor decision, it has 120 days to file what is known as a "redetermination," which is conducted by Medicare carriers or MACs. While the appeal deadline is 120 days, one can only avoid a Medicare recoupment action if the appeal is filed within 30 days. A second level of appeal is known as "reconsideration," and is conducted by Qualified Independent Contractors (QICs). Then a case can be appealed to an administrative law judge. Above that level, appeals

can be filed to the U.S. Department of Health and Human Services or a federal court.

"You're talking about issues that may drag out longer than a year," Dr. Stimler said.

Most cases stop at the administrative law judge level; however, the timeline to get there has grown dramatically. In a memo released earlier this year, Nancy Griswold, the chief judge of the Office of Medicare Hearings and Appeals, suspended scheduling new hearings. She wrote, "We do not expect general assignments to resume for at least 24 months." In a related hearing before Congress, Ms. Griswold presented data showing that that received appeals more than doubled, from 117,371 in fiscal year 2012 to 350,629 in fiscal year 2013. Decided appeals rose from 61,517, to 79,303 in the same period, a 29% increase that couldn't keep pace.

"Hence the big complaint that it's taking forever for appeals to get resolved because the OMHA is overwhelmed," said Mr. Blakeman.

"This is as bad as it's ever been," said Denise Wilson, assistant vice president of consulting firm Appeal-Masters of Lutherville, Md.

For Mr. Blakeman, the biggest impact on emergency physicians is "the injustice of it."

"The audit process is broken," he said. "Emergency physicians feel that you try to do the right thing for the patient but you can still lose your [Medicare] billing privileges if an auditor just has a bad day and picks you to unload all his or her mistakes on that day. It's just not right. And the defense costs are unnecessary. We pay the cost of the federal audit process being poorly run." ❖

RICHARD QUINN is a freelance writer in New Jersey.

THE BREAK ROOM | CONTINUED FROM PAGE 6

to do. In Gorchynski et al (*Cal J Emerg Med.* 2005;6:3-8), the DAST-20 identified 50 percent of the patients with addiction who would not have been identified by the clinician. This tool may be another one to consider.

A caveat: as per Brown et al (*J Opioid Manag.* 2011;7:467-483), the majority of patients seen in a family practice do not fall into the low-risk category; I would assume that would be equally true in the ED. Assessment of risk is to establish a level of comfort, along with the subjective (and biased) assessment of the caregiver; the latter has been shown to be fraught with error. Urine drug testing can also be of value: no one already testing positive for cocaine, for example, should be leaving any ED with a prescription for any controlled substance. The other important

We, as clinicians, cannot judge in a few minutes why the patient is manifesting ADRB...To help us better judge, validated tools and objective testing should be to what we turn.

objective resource is the state-based drug-monitoring programs that allow us to see who has received what prescriptions.

There is, thus, no perfect way to assess risk. Use of an objective tool plus or minus urine drug testing does shift the weight toward a more objective assessment. The best example I can provide is that roughly 40 percent of patients presenting with a vaso-occlusive crisis are found to have ADRB—not surprising given the poor pain management most

receive. In the *Annals of Internal Medicine* (2008;148:94), it was reported that 30 percent of patients with sickle cell disease experienced pain on at least 95 percent of days. When properly treated, however, only about 2 percent are found to have an addiction disorder, demonstrating that almost all ADRB seen is due to poor pain control in that population. One *BMJ* study found that only three of 1,900 patients with sickle cell disease were also suffering from addiction. Fishbain et al (*Pain*

Med. 2008;9:444-459) show that, in patients with no past or current addiction problems, the risk of addiction from long-term opioid use is 0.19 percent, whereas the rate of ADRB is 11 percent. This, again, demonstrates the need to recognize that for the large majority of patients ADRB is not associated with addiction but rather with poor pain control.

We, as clinicians, cannot judge in a few minutes why the patient is manifesting ADRB; unfortunately, most of us see ADRB and assume it is due to diversion or addiction when in the large majority of cases it is due instead to oligoanalgesia. To help us better judge, validated tools and objective testing should be to what we turn. ❖

—Jim Ducharme, MD, CM, FRCP
Hamilton, Ontario

AS UKRAINE REACHES FOR FREEDOM, ITS PEOPLE WORRY AND PRAY

CONTINUED FROM PAGE 1

It is a tribute to the human spirit and to Ukrainians that they stand strong to try to unify their country, whether Ukraine-centric or Russian-centric, in achieving true freedom. Allegiances can be mixed, but desire for freedom will triumph. Last November, their President, Viktor Yanukovich, was anticipated to sign an agreement to a path to joining the European Union. However, when he arrived in Vilnius, Lithuania for the meeting, it all changed when he declined to sign the EU membership agreement. That reversal and decision instead to accept a \$15 billion loan promise and 30 percent reduction in natural gas costs extended by Russian President Vladimir Putin is what set off the current mass protests at the Maidan (a rallying site in downtown Kyiv for protesters) and in other cities in central and western Ukraine. Many in Ukraine resist the notion of becoming a modern-day version of a Soviet republic.

The degree to which President Yanukovich and his son and their friends have plundered Ukraine's limited wealth and used it for themselves is astounding. Regardless of what else might happen, we should all hope and pray that Ukraine achieves true freedom and finds true servant leaders. It deserves nothing less.

A Complex and Dangerous Situation

As this is written, Putin is occupying Crimea with some 18,000 troops and many armaments. The average Ukrainian is very worried about Putin's ambition and aggressiveness, according to Sergei Bolyukh, MD, a friend and general surgeon in Vinnytsa, Ukraine. There is fear that Putin will move even further into Ukraine under the pretense of protecting Russian-centric Ukrainians from the temporary Ukrainian government appointed by the Rada (parliament) upon former President Yanukovich's departure from Kyiv to Russia. There is, per Sergei and the international media, no evidence that the Russian-centric Ukrainians are in any peril of any kind. In fact, with the call for a new presidential election to take place May 25, the hope of the majority of Ukrainians is to continue a path to true freedom and unity. Unity is stressed and is key to Sergei and to Ukraine. This is not to the exclusion of a peaceful relationship with neighboring Russia but specifically to include that relationship, but in a way that respects established internationally recognized borders.

It is understood that Putin is keen to maintain the Russian Black Sea fleet in Russia's only warm seaport, Sevastopol, which Russia has leased until 2042. Ukraine may need to extend that indefinitely as part of any accord moving forward. However, the blunt truth, per Sergei and others in Ukraine with whom I have spoken, is that they feel like Putin is being al-



Kyiv, Ukraine, January 20, 2014. The barricades on the street were built by Hrushevskoho defenders of democracy to stop advance of the special forces loyal to President Yanukovich.

lowed to "rape us." They feel the EU and the United States are being too slow and not harsh enough with sanctions and in isolating Putin. The Russian people in Russia have a long tradition of powerful leaders who they seldom stand up to, even if they are unsure of their leader's wisdom. At this moment, Ukrainians live in fear for their future as a free country.

It is one thing to watch the news on TV, to have numerous Facebook posts shared with you, to watch the Internet news and various TV reporting. Today everything is so "out there," so different from Sergei's and my younger years. But when Sergei and I spoke on Feb. 20, and he told me that his son, a neurosurgeon, had been manning a medical tent at the Maidan and that his son was in tears, I knew things had really worsened. Sergei himself had been manning such a medical tent for weeks before. His son told Sergei of the brutal snipers killing dozens of unarmed protesters and his painful witness to the death, helplessness, and agony, with hundreds of others injured. To hear Sergei ask for my prayers and those of my family ... well, I cried, too.

When Sergei and I spoke on Feb. 20, and he told me that his son, a neurosurgeon, had been manning a medical tent at the Maidan and that his son was in tears, I knew things had really worsened ... To hear Sergei ask for my prayers and those of my family ... well, I cried, too.

How Ukraine Became Important to Me

In April 1996, long before the ACEP International Section launched the Ambassador Program to facilitate international emergency medicine collaboration worldwide, I made my first trip to Ukraine. My wife, Catherine, and I had experienced a spiritual awakening, and our church was sending a family to live in Vinnytsa, Ukraine. The link was a family having moved from Vinnytsa to Franklin, Tenn., and sharing with their new church in America, where my wife and I are members, the needs of Ukraine as the nation was emerging from the Soviet era as a newly independent nation (as of 1991). I distinctly remember stepping off the airplane in Kyiv that first trip and feeling like I had landed in enemy territory, not because of the people—they were warm, although initially guarded—but because, after all, my sixth-grade class was repeatedly marched to the fallout shelter because of the Cuban Missile Crisis. So going to a part of the former Soviet Union was a mixture of anticipation, excitement, and some concern.

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AS UKRAINE REACHES FOR FREEDOM, ITS PEOPLE WORRY AND PRAY

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Medical collaboration over these 18 years has taken on many forms: the honor of speaking at Pirogov Medical University in 1996 on HIV emergencies; collaboration with that uni-

versity and with teams of other American or Canadian doctors on educational programs; sponsoring Ukrainians needing heart surgery as their nation's heart surgeons developed greater expertise; launching a program in 1998 for the use of high-dose ACE inhibitors for systolic heart failure; bringing Ukrainian doctors to Vanderbilt University School of Medicine, where they were welcomed by the dean and Department of Emergency Medicine; hosting Dr. Georgiy Roshchin of Ukraine's Disaster Medicine Program in Denver at ACEP 2012; working with churches that run drug and alcohol rehab centers; assisting doctors and nurses in providing care at desolate orphanages; and sending more than 20 containers full of medical supplies and equipment to Ukraine through Project C.U.R.E. of Denver and Nashville. Well, you get the idea—this has been my passion.

During the last several trips, it has been a treat to travel far and wide in Ukraine with a new friend, Vitaliy Krylyuk, MD, the chair of the Ukraine Resuscitation Society. Vitaliy ushered us from city to city across Ukraine as we presented "Highlights of ACLS, PALS, NALS, and ATLS." The last trip in September 2013 took us from Kyiv to Ternopil, Lviv, Vinnytsa, Mohyliv-Podilskyi, and finally to Sudak in Crimea. Joining me were Sergei; our translator, Ruslan Tkachuk (who, along with his wife, runs a foster home in Nemia, Ukraine, on the Moldovan border); and American doc-

Many in Ukraine resist the notion of becoming a modern-day version of a Soviet republic ... Regardless of what else might happen, we should all hope and pray that Ukraine achieves true freedom and finds true servant leaders.

tors Michelle Sergel, MD, of Cook County Chicago, Shannon Langston, MD, of Vanderbilt EM and a former international fellow there, and Mark McLean, MD, a fellow TeamHealth leader of Maury Regional EM in Columbia, Tenn (see photo). All of us have been in agony watching the recent events unfold, especially since we were so recently traveling through Crimea.

ACEP International

The roughly 10-year-old ACEP International Ambassador program is a wonderful opportunity to serve in international emergency medicine, whether it is in Ukraine or in numerous other countries around the world. The program was launched in 2004 as a means of organizing and further developing and coordinating many efforts already taking place among ACEP members in international emergency medicine. The field of international emergency medicine has since grown greatly in scope, with dozens of international emergency medicine fellowships now existing in the United States and abroad. ACEP's international Emergency Medicine Section provides all forms of networking and leadership to deepen the work of collaboration worldwide. In this coming year, we will see the development of the international liaison physician program within our ambassador program. This will facilitate ACEP membership by EM physician leaders from other countries served by the ACEP Ambassador program.

I encourage all ACEP members to become members of the International Section and to find their niche. Look at our blog at www.ukrainemedicalmission.com to gain more insight on outreach to Ukraine. We anticipate our next trip to occur in September 2014. You might want to participate.

A friend of mine once told me that, in going to Ukraine to help others, he had learned the difference between success and significance. I encourage you to find out that difference firsthand for yourself. ☺



DR. McMURRAY is medical director of the Wayne Medical Center Emergency Department in Waynesboro, Tenn., and medical director of First Stop Urgent Care in Columbia, Tenn. He is the ACEP International Ambassador to Ukraine. Since 1996, he and his wife, Catherine, and their three daughters all have been to Ukraine, initially on trips focused on helping orphanages.

But my concerns were replaced by warmth when I met Sergei and his family. Over the years, Sergei has met my family, too, and visited our home. He is a graduate of Pirogov Medical University in Vinnytsa, and was the first surgeon in Vinnytsa Oblast to agree to operate on known HIV-positive patients. Since we first met in 1996, he has developed a strong outreach to poor patients and HIV-positive patients and those recovering from alcohol and/or drug addiction.

We had both had a spiritual awakening not long before we first met. He was born in 1949 and I in 1952. We were "Cold War" kids. He had been a leader of the Communist Party medical wing in Vinnytsa Oblast. I was a kid who grew up in a GM family, moving often until I settled outside Detroit in the early 1960s. Then I went on to university and medical school and to a relatively wealthy existence compared to Sergei's. Could we have been more different? What were the odds that we would become best friends?

That was 32 trips ago. Having spent well over a year of my life in all areas of Ukraine, I can say that it is indeed my second home. Their emergency physicians ride on ambulances. They don't work in the hospital as we do. What a fascination it has been to ride in ambulances



Dr. McMurray and colleagues during their September 2013 trip to Ukraine. Pictured, from left to right, are Dr. Gudma, the host in Ternopil; Dr. Shannon Langston of Vanderbilt EM; Dr. McMurray; Dr. Vitaliy Krylyuk of Kyiv; Dr. Sergei Bolyukh of Vinnitsa; Dr. Michelle Sergel of Cook County, Chicago; and Dr. Mark McLean of Maury Regional EM and Team Health, Tenn.

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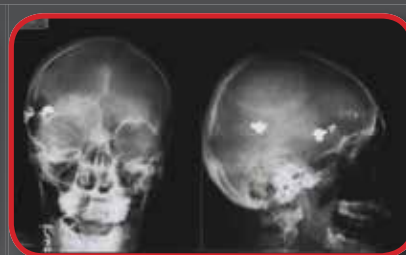
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Behind the Scenes on

DISCUSSION **PARTICIPANTS**



Mark L. Mackey, MD, MBA, FACEP,
ACEP Board Member



Rebecca B. Parker, MD, FACEP,
ACEP Board Member



Andrew E. Sama, MD, FACEP,
ACEP Chair of the Board and
Immediate Past President



This is all about risk benefit continuum or spectrum—in other words, how much certainty for how many dollars cost for the patient and how much risk for doing or not doing the test or procedure, which entails health risk for the patient and medical liability and career risk for the physician. Medical liability must be addressed.

—ACEP President Alexander M. Rosenau, DO, FACEP

Safe Harbors

CONTINUED FROM PAGE 1

This article was discovered by Michael Baldyga, ACEP public relations manager, and forwarded to Dean Wilkerson, ACEP Executive Director; Alexander Rosenau, ACEP President; and Michael Gerardi, ACEP President-Elect. The "think tank" erupted with a fury of interaction and communication over a 96-hour period.

It is important to recognize the raw nature of this work and see this for what it is: issue identification, rapid dissemination, and brainstorming. It is not a completed work and includes most, but not all, comments submitted. In the coming months, solutions will be investigated to support the interests and needs of emergency physicians and our patients.

KEVIN M. KLAUER, DO, EJD, FACEP, is director of the Center for Emergency Medical Education (CEME) and chief medical officer for Emergency Medicine Physicians, Ltd., Canton, Ohio; on the Board of Directors for Physicians Specialty Limited Risk Retention Group; assistant clinical professor at Michigan State University College of Osteopathic Medicine; and medical editor in chief of *ACEP Now*.

Dean,
Thanks for forwarding...unfortunate that medial liability reform/safe harbors got no mentions...the take home seems to be: "If only these ED docs could do a physical exam."

—Mark L. Mackey, MD, MBA, FACEP, ACEP Board Member

Yes, and we can't seem to shake the title "ER physician" instead of emergency physician. We haven't been holed up in a "room" for a long time.

—Rebecca B. Parker, MD, FACEP, ACEP Board Member

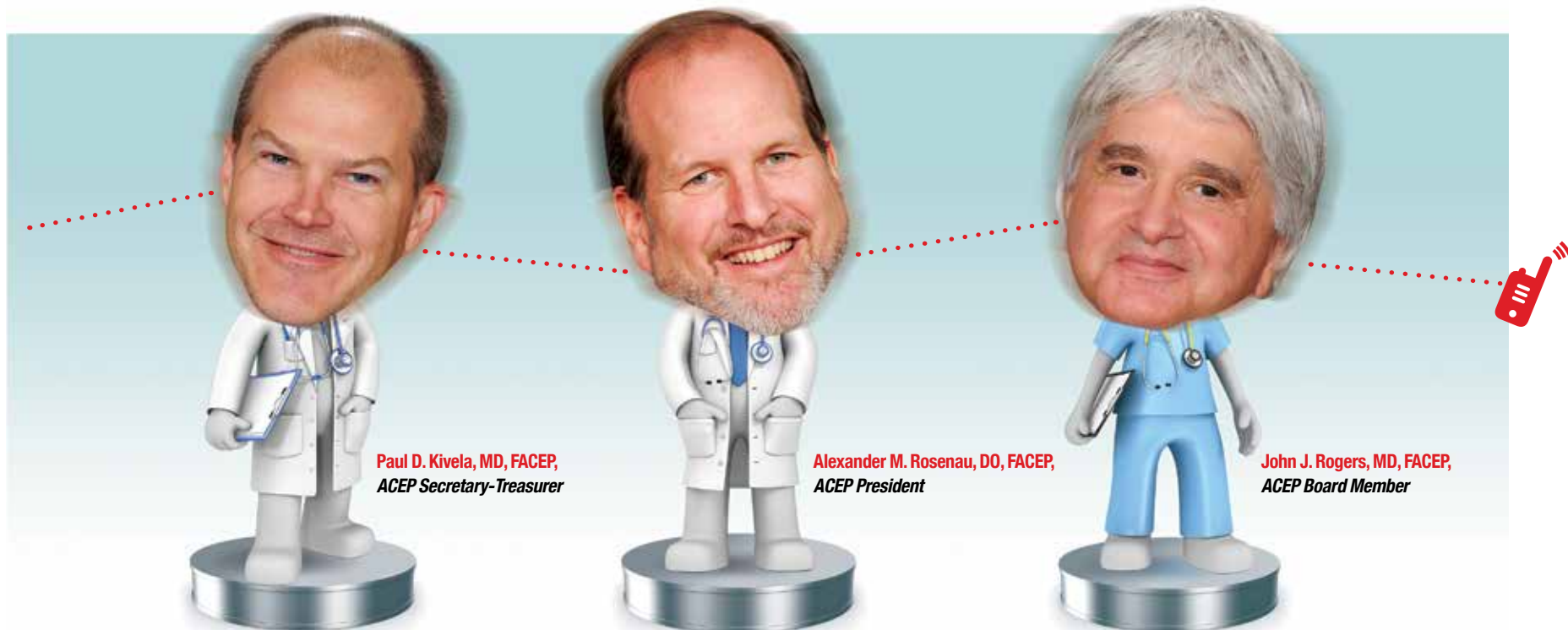
Unfortunately, no professional liability discussion. What is the acceptable miss rate? Where are the safe harbors, etc., etc.? We should draft a thoughtful editorial comment. We have been working hard on making progress on utilization issues.

—Andrew E. Sama, MD, FACEP, ACEP Chair of the Board and Immediate Past President

I think it would be interesting to pose this question to the trial attorneys whether the Choosing Wisely recommendations constitute safe harbors. Let's have somebody else debate this issue rather than us trying to make a statement that may appear to be self-serving. I wonder what the president of ATLA [the Association of Trial Lawyers of America] would say.

—Paul D. Kivela, MD, FACEP, ACEP Secretary-Treasurer

CONTINUED on page 14





Let's move forward and try something different. Let's establish safe harbors and advertise that this will save waste from the system ... Safe harbors to improve patient safety and decrease health care costs.

— ACEP Secretary-Treasurer Paul D. Kivela, MD, FACEP

As per my reply to Dean, this is all about risk benefit continuum or spectrum—in other words, how much certainty for how many dollars cost for the patient and how much risk for doing or not doing the test or procedure, which entails health risk for the patient and medical liability and career risk for the physician.

Medical liability must be addressed. Agree with Sama, a letter to the editor that clarifies that issue would be appropriate.

—Alexander M. Rosenau, DO, FACEP, ACEP President

My question is perhaps a philosophical one. It doesn't seem to matter if it's right or if it's wrong but how it is perceived. So why do we continue to self-advocate as it rarely seems to be effective in changing public opinion? I think we need to go and try something different from time to time. It seems like we are writing too many letters to editors to clarify misperceptions.

I would rather have articles written in our favor the first time around. What about pitching this to the *LA Times* if not *The Wall Street Journal* and having them ask the trial attorneys how they feel about safe harbors for Choosing Wisely measures. For balance, they can ask the insurance companies and the regulators.

—Paul D. Kivela, MD, FACEP, ACEP Secretary-Treasurer

Think Paul has struck a nerve.

Recently, an ACEP leader gave a talk about “What I learned in Washington.” It was illuminating. He says no one cares what we think. If we say it, then it is automatically seen as being self-serving and not to be trusted. [Politicians] want recommendations and data from impartial sources.

There were several other things he learned about how they think, how they view physicians, how they make decisions, etc. I've asked him to put his observations down as a report to the ACEP Board of Directors. Hope he does.

—John J. Rogers, MD, FACEP, ACEP Board Member

Great point, Paul, and good feedback, John.

Is there a way to change the conversation back to patient advocacy? Most patients want to see the system get better/improve (eg, heparin and Dennis Quaid's twins). Any studies out there that safe harbors allow for more error reporting, error reduction efforts, and open conversations when issues occur? It represents an agreement with physicians and patients that we commit to following evidence-based decision making whenever possible, understanding the risks.

—Rebecca B. Parker, MD, FACEP, ACEP Board Member

My understanding is there are safe harbors in just about any other field, from construction to accounting. Why don't we establish safe harbors and say that ACEP recommends the following safe harbors? Reality is that there's no such thing as a medical malpractice case, or any malpractice case, without an expert witness saying that something has deviated from the standard of care.

Let's move forward and try something different. Let's establish safe harbors and advertise that this will save waste from the system. I say we just establish that ACEP determines the standard of care consensus-wise for emergency medicine. We need to come up with the campaign slogan and go with it and see what happens. Doesn't mean you can't do more, but you will be protected if you do what

is the recommendation. I don't think it needs to be any more complex or complicated than this, and I don't think we have to ask for anybody's approval. Let's be bold.

Safe harbors to improve patient safety and decrease health care costs.

Safe harbors is smart and informed medicine.

—Paul D. Kivela, MD, FACEP, ACEP Secretary-Treasurer

I like the approach of creating safe harbors to give emergency physicians the confidence to practice evidence-based medicine without fear of litigation. This has to be patient-centered so that we are not viewed as self-serving when promoting safe harbors. As a practical matter, could we refer this to the medicolegal committee?

—Robert E. O'Connor, MD, FACEP, ACEP Vice President

I agree with moving forward with creation of safe harbors with appropriate efforts to approach it from a quality perspective with careful attention to not appear speaking from a self-serving perspective. The medicolegal committee might be a good place to start with this.

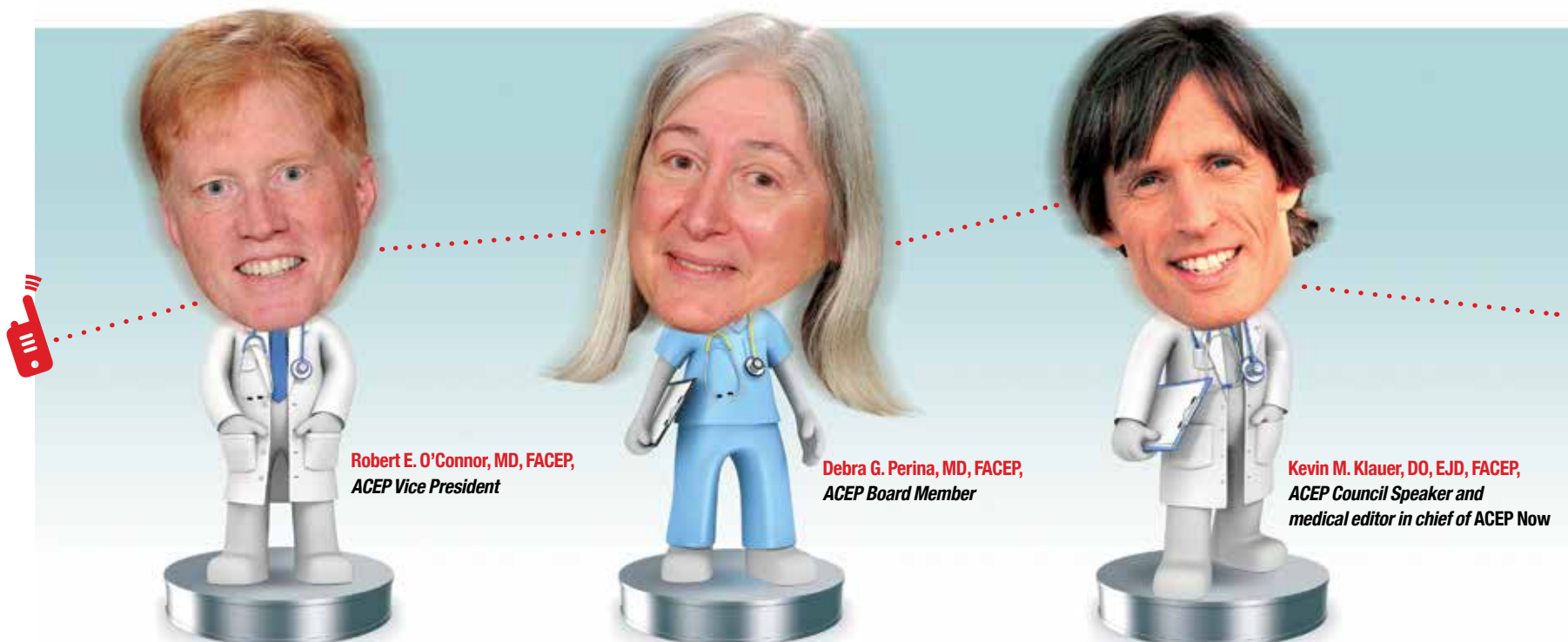
—Debra G. Perina, MD, FACEP, ACEP Board Member

How do we ensure it does not appear to only be about protecting physicians?

Who would need to recognize the safe harbor? The courts? In every state?

Feds have seemed very uninterested in addressing liability concerns. Then again, if it was a matter of saving them money, they may take more interest.

—John J. Rogers, MD, FACEP, ACEP Board Member





Defensive medicine is an expensive and unnecessary part of medical practice that does not benefit patients. But doctors have to do it because of the unreasonable and out-of-control liability environment.

— ACEP Executive Director Dean Wilkerson, JD, MBA, CAE

I'd like to see the first five EM safe harbors introduced this fall at ACEP14. In being good partners in the house of medicine, I'd like to invite the other specialties to similarly submit safe harbors that improve patient safety and decrease health care costs. *Consumer Reports* partnered with Internal Medicine. I wonder if *The Wall Street Journal*, *USA Today*, or someone else representing consumers, even [the Pacific Business Group on Health] or the Institute of Medicine, might want to jump in and partner with us. It might be nice to ask [former Secretary of State] Hillary Clinton and [NJ Governor] Chris Christie to be honorary board members. Now that would be interesting to see what they say to being on a panel that has the serious potential to decrease health care costs.

I think we should push forward the "Safe Harbors Are Smart Medicine" campaign or whatever it ends up being called.

I think if we find the right partner(s), we can accomplish this to everyone's benefit, other than the trial attorneys. Government wins with less costs, employers win with less costs, health care plans win with less costs, patients win with low-yield tests not being done, and physicians win by decreased anxiety, decreased time doing tests, being able to treat more patients, and improved access.

Having ACEP establish safe harbors may be an actual solution rather than just PR. ACEP has been pushing the envelope since before our inception. Let's be bold.

—Paul D. Kivela, MD, FACEP, ACEP Secretary-Treasurer

Dean, et al.

Perhaps the article has served us well by driving our attention to this issue.

With respect to safe harbors, the Choosing Wisely recommendations are a good start, as you must have an

evidence-based recommendation to create the safe harbor of professional liability protection around. In addition, safe harbors must be drafted by intent and not implied via common sense. For instance, it makes perfect sense to avoid unnecessary head CTs per our recommendation. However, the Choosing Wisely recommendation would provide an excellent platform for defense but is a far cry from a safe harbor, which should be crafted to avoid all liability if followed. The plaintiff's burden would then be to prove that the safe harbor does not apply or is not applicable to the facts in question. The policy would need a safe harbor provision, and that policy would have to become law, from my perspective. The tort of negligence is handled at the state level. However, I do believe that preemption is possible if this were tied to a federal program such as the ACA [Affordable Care Act] (ie, value-based payment modifier).

I agree with everyone that firing back in our own defense is most likely to be perceived as self-preservation. However, I would like for such an article to spark an ACEP-led debate on shared decision making. Serving our patients is always the best road to travel. In addition, shared decision making, in my opinion, functions as a bedside safe harbor. I avoid the provision of more unnecessary tests in this way and serve my patients better while also reducing my liability by informed discussions and documenting patient preferences.

I included this concept in a chapter in the new edition of Jim Adam's management text, *Emergency Medicine: Clinical Essentials, 2nd ed.*

I have considered addressing this concept in *ACEP Now*. Following this article, I'm certain that I will.

Thank you.

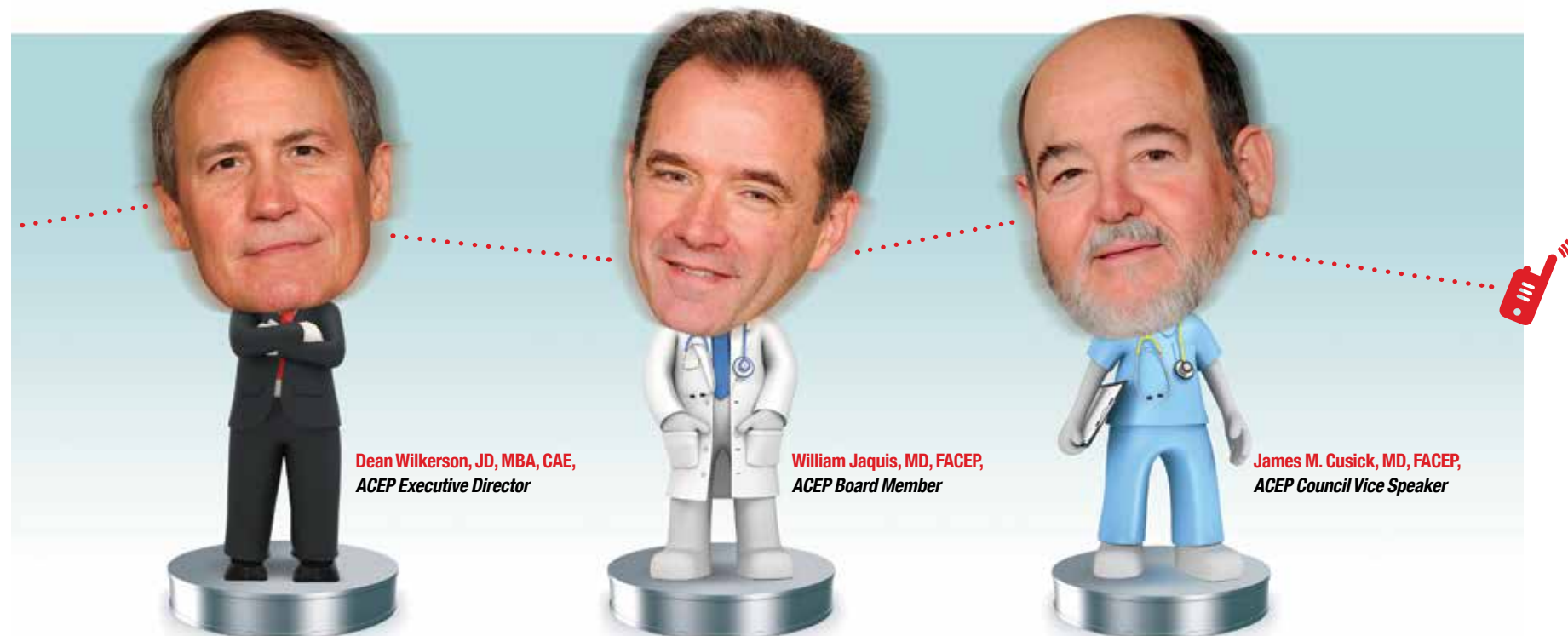
—Kevin M. Klauer, DO, EJD, FACEP, ACEP Council Speaker

Alex, I like [ACEP public relations director Laura Gore's] opinion. Editorial boards will want to know what we intend to discuss that is new. At root, this remains an argument we have been making for years. Defensive medicine is an expensive and unnecessary part of medical practice that does not benefit patients. But doctors have to do it because of the unreasonable and out-of-control liability environment. Advocating for safe harbors for practicing evidence-based medicine (which is cheaper for society and better for patients), and thereby allowing doctors to be exempt from medical liability if there is the unexpected bad outcome, is not a new concept. Insurers and hospitals will support it along with doctors, but trial lawyers, some consumer groups, and many Democrats will fight it to the death. We can try to get meetings and be more proactive and raise our voice on this, but I think Kevin Klauer's analysis is correct. Unless there is legislation, or perhaps some hardwired regulation, establishing the safe harbor, it will not be a true safe harbor insulating from liability. Without the legislative or regulatory underpinning, ACEP can say what is the standard of care, but it will then be litigated in each case. I think we might want to get some legal advice from [former CMS administrator and ACA regulatory law expert] Tom Scully's firm or [association and health care law expert] Rob Portman on any angle there may be for us to truly establish safe harbors either through legislation or regulation under the ACA.

—Dean Wilkerson, JD, MBA, CAE, ACEP Executive Director

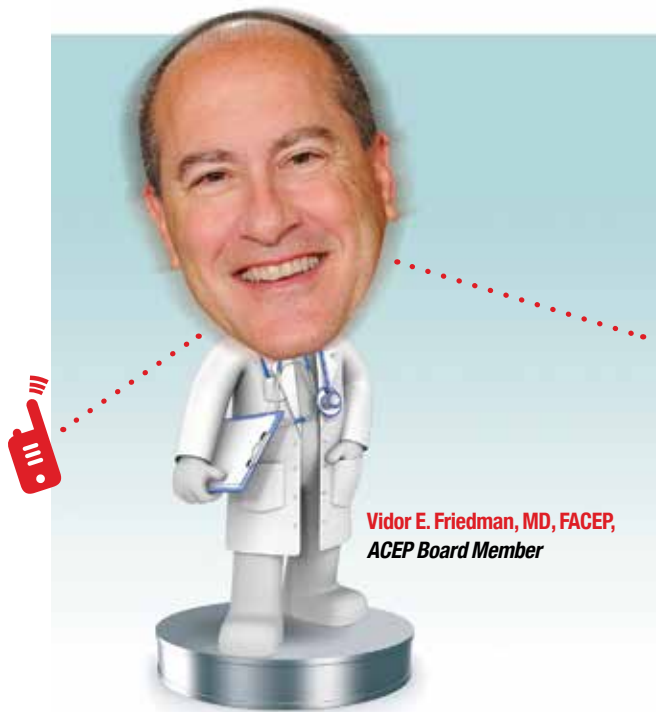
After thinking about this, and I do appreciate Kevin's insight as well as Laura's and the rest of the staff's, what about the simple strategy of stating that ACEP has developed five proposed safe harbors and then submitting those

CONTINUED on page 16



Behind the Scenes on Safe Harbors

CONTINUED FROM PAGE 15



Vidor E. Friedman, MD, FACEP,
ACEP Board Member

Society does not fathom the actual cost of not having safe harbors ... They do not realize that the cost of medical tort to society is at least \$300 billion a year (8 percent of what we spend on health care, between direct and indirect costs).

—Vidor E. Friedman, MD, FACEP



Gordon Wheeler,
ACEP Associate Executive
Director for Public Affairs

to the media? We would certainly need Laura to craft a great message about how safe harbors are the right thing to do, and we let the other people shoot them down. The worst thing that could happen is that ACEP was proposing cost-saving measures that benefit patients and eliminate unnecessary tests. I think it might be hard politically for ATLA and even consumer groups to say that safe harbor should not exist, particularly if we pick something very simple and straightforward. Emergency physicians determine the standard of care, and there's no reason why we should not be able to determine what safe harbors should exist in our field. If we can determine what is unethical and egregious testimony, certainly we should be able to agree on some straightforward, simple safe harbors. Jay [Kaplan's] list and some of our Choosing Wisely submissions might be a good start, but I'd like to do something with chest pain and POLST [Physician Orders for Life-Sustaining Treatment]. I don't think we do need to make this too complicated. Legislation will take forever and get bogged down, and if it gets close, they may even filibuster it.

—Paul D. Kivela, MD, FACEP, ACEP Secretary-Treasurer

Maybe not safe harbors, but could we have more transparency around what following the guidelines means in terms of risk? For instance, following PECARN [the Pediatric Applied Research Network Head Injury/Trauma Algorithm], 1 in 2,000 kids will have clinically significant traumatic brain injury that will not have been CT'd initially. The "cost" of trying to be perfect is the cost of 1,999 CTs and the subsequent radiation exposure versus the cost of defense/settlement/verdict for the one "miss."

—William Jaquis, MD, FACEP, ACEP Board Member

Bill,
Excellent points. I think an important educational point for the layperson is that reducing utilization and cost is the right thing to do, but there are two sides of the equation. Albeit a small percentage, some patients who are exempted by the guideline will have a bad outcome due

to missed or delayed diagnoses from not ordering the test. When looking at population data, most, if not all, agree that this is the right thing to do. However, applying this to the individual patient encounter is a very different application of the concept. In other words, most laypersons agree this is the right thing to do. However, their opinions may change when they personally will not receive the test and particularly if they ultimately suffer a bad outcome.

We can reduce cost with a simple pen stroke (oversimplification), but why should the medical legal burden created by following a guideline fit squarely on the shoulders of the providers just trying to follow it?

I think this is an important question that could be posed in the lay press and to legislators.

—Kevin M. Klauer, DO, EJD, FACEP, ACEP Council Speaker

Hence the need for fair compensation with shared risk and shared payout by all of society, not just the provider.

—Alexander M. Rosenau, DO, FACEP, ACEP President

Could this be a case where we seek a cap for non-economic damages?

—Rebecca B. Parker, MD, FACEP, ACEP Board Member

Cogent points, absolutely agree! This conversation needs to be aired. It's time for an honest debate about what is appropriate and needed, what is not, and how clinical providers can be free to strike that balance for the overall good of society. Answer: Choosing Wisely and Safe Harbors!

—James M. Cusick, MD, FACEP, ACEP Council Vice Speaker

Becky,
It could. However, the medical legal community's acceptance of such caps is lukewarm, and their effectiveness is debatable. In addition, economic damages (special damages) come from hospital bills, lost future earnings, etc., and they can be huge. So I would not limit our protection

to non-economic damages (ie, severe pain, disfigurement, loss of consortium, etc.). I think we really are entitled to true indemnification when we follow such clinical policies correctly and a bad outcome occurs.

—Kevin M. Klauer, DO, EJD, FACEP, ACEP Council Speaker

I think the problem is even more basic than this.

Society does not fathom the actual cost of not having safe harbors; most people just think it is doctors whining and wanting a better deal for ourselves.

They do not realize that the cost of medical tort to society is at least \$300 billion a year (8 percent of what we spend on health care, between direct and indirect costs).

There is an economic argument that needs to be made since every one of those dollars is paid by consumers of health care.

This is true cost savings, not just making it easier for physicians to practice.

—Vidor E. Friedman, MD, FACEP, ACEP Board Member

Apropos to this week's discussion about safe harbors, I wanted to let you know that two members of the U.S. House of Representatives, Rep. Ami Bera (D-CA) and Rep. Andy Barr (R-KY), have introduced legislation in the House that would establish safe harbors for physicians "who can demonstrate they followed the recommended best practices...." Those recommended best practices will be developed by the physician community based on the best available scientific evidence. The bill, HR 4106, was introduced yesterday and has been referred to the House Energy & Commerce Committee and the House Judiciary Committee.

We will be discussing this bipartisan bill on next week's Federal Government Affairs Committee monthly conference call and will presumably recommend that Dr. Rosenau send a letter of support. There will be other opportunities to work with the bill's sponsors in the coming weeks and months. ☺

—Gordon B. Wheeler, ACEP Associate Executive Director for Public Affairs

SPOT CLEAR AND PRESENT DANGER

Some states require physicians to report patients who pose a danger to themselves and others. What is your duty to report?

BY CRAIG PRICE, CAE

Q. Craig, Illinois just passed the Firearm Concealed Carry Act (PA 98-063), which requires Illinois clinicians to report those they believe pose a “clear and present danger” to themselves or others through the Illinois Firearm Owner’s Identification Mental Health Reporting System. What are your thoughts on the clear and present danger law?

— **Rebecca B. Parker, MD, FACEP**, executive vice president for EmCare’s North Division and attending emergency physician at Presence Covenant Medical Center in Urbana, Ill. She is a member of the ACEP Board of Directors.

A. After doing some quick research, I found that the “clear and present danger” language in Illinois appears to be somewhat unique, although “duty to report” requirements exist for physicians in other states. Most of those requirements are limited to mental health providers, but some mandates have been extended to physicians. New York and Illinois both enacted mandates last year. New York focused on mental health professionals, while Illinois extended the requirement to physicians and other providers.

According to an extensive Law Center to Prevent Gun Violence review of state mental health reporting laws (<http://smartgunlaws.org/mental-health-reporting-policy-summary/>): “New York adopted a law in 2013 that requires a mental health professional to report any person receiving treatment who is likely to engage in conduct that would result in serious harm to self or others; this information may be used to determine firearms eligibility and must be destroyed after five years. Illinois enacted

A DUTY TO WARN ARISES IF THE PATIENT HAS COMMUNICATED TO THE PRACTITIONER A THREAT OF IMMINENT, SERIOUS PHYSICAL VIOLENCE AGAINST A READILY IDENTIFIABLE INDIVIDUAL OR AGAINST HIMSELF.

a law in 2013 requiring reporting by any physician, clinical psychologist, qualified examiner, law enforcement official, or the primary administrator for any school who determines that a person presents a ‘clear and present danger’ to self or others, including any person determined to demonstrate threatening physical or verbal behavior.”

Many states have mandatory duty-to-warn laws in cases where direct threats of violence to others or to self are expressed, and some of these apply to all physicians (including in Colorado, Georgia, Illinois, and New Jersey), according to the National Conference of State Legislatures report of state laws on duty to warn (<http://www.ncsl.org/research/health/mental-health-professionals-duty-to-warn.aspx>). For example, it cites New Jersey Statute 2A:62A-16, which applies to physicians and nurses as well as other mental health providers and provides immunity except when there is a duty to warn: “A duty to warn arises if the patient has communicated to the practitioner a threat of imminent, serious physical violence against a readily identifiable individual or against himself and the circumstances are such that a reasonable professional in the practitioner’s area of expertise would believe the patient intended to carry out the threat; or the circumstances are such that a reasonable professional in the practitioner’s area of expertise would believe the patient intended to carry out an act of imminent, serious physical violence against a readily identifiable individual or against himself. The duty is discharged by arranging hospitalization, involuntary commitment, advising law enforcement of the identity of the intended victim, warning the victim or their parent or guardian of the patient if the threat is of self inflicted violence.” (Mississippi and South Carolina have permissive, not mandatory, duty-to-warn laws for physicians.)

The National Conference of State Legislatures also has a report on state laws related to possession of firearms by people with mental illness (<http://www.ncsl.org/research/civil-and-criminal-justice/possession-of-a-firearm-by-the-mentally-ill.aspx>). This information is a year old and does not include the new Illinois law. It notes that some states (including Maryland and Massachusetts) prohibit people who were hospitalized for a mental illness to own a gun unless a physician formally attests that they are not a danger. Texas prohibits concealed handgun permits for any persons who have been diagnosed by a physician with a serious mental condition (including schizophrenia and bipolar disorder) that might impair mood or judgment, with a condition that left them incompetent to handle their own affairs, or with a dependency on alcohol or drugs in the previous five years. However, this information does not indicate a requirement that physicians report patients with those conditions.

For further discussion of the controversy surrounding the issue of reporting and the ability of those treated for mental illness to carry guns, see this story from Kaiser Health News that came out after New York passed its duty-to-report law last year: <http://www.kaiserhealthnews.org/stories/2013/march/21/stateline-states-mental-illness-gun-ownership.aspx>. ☐

CRAIG PRICE is senior policy director at ACEP.

Better Outcomes and Patient Satisfaction Go Hand in Hand

Beyond surveys and payments, the bottom line is that communication and trust lead to better care

BY JAY A. KAPLAN, MD, FACEP

The words “patient satisfaction” elicit a wide variety of emotions in emergency physicians. Some immediately become angry and feel like the entire concept has been foisted upon them by hospital administrators only interested in market share and the bottom line. Some feel victimized by the move on the part of the federal government and third-party payers to tie payment to quality and patients’ perceptions of their experience. Others feel that the push for patient satisfaction leads to physicians acquiescing to patients and giving them whatever they ask for, including opiate medication prescriptions or advanced imaging studies such as CTs or MRIs, when those prescriptions and diagnostic studies are truly not in patients’ best interests. For some, it is not the concept of patient satisfaction but rather how it is measured and then used as a quality

metric to judge physicians that creates concern. However, others believe that patient satisfaction and clinical quality are intimately interdependent and so patient satisfaction is part and parcel of being an outstanding physician.

All of the above feelings have merit and should be addressed by our specialty as we continue to promote excellence in what we do. I have heard my colleagues say the following:

“Clinical quality is the real deal; this customer service stuff is the fluff stuff.”

“I am an excellent physician, highly trained and skilled at procedures; I can move patients; and my RVUs are among the highest in my group—why do I have to pay attention to this?”

“These patient-satisfaction surveys are poorly devised, do not measure quality, and are not statistically valid.”

“My patients are different. We are a different kind of hospital (inner city with angry patients/suburban hospital with patients with high expectations/trauma center with a lot of homeless and drug-seeking patients) and should not be measured as others are.”

What does the literature say about the connection between patients’ perceptions of care and clinical outcomes? In a study published in the *Archives of Internal Medicine* in 2012 titled “The Cost of Satisfaction,” the authors concluded, “In a nationally representative sample, higher patient satisfaction was associated with less emergency department use but with greater inpatient use, higher overall health-care and prescription drug expenditures, and increased mortality.”

This article has been used by naysayers of patient satisfaction to suggest that the entire concept is misguided, and some quote a *Forbes* article based on that study published online in January 2013, “Why Rating Your Doctor Is Bad for Your Health.”² The conclusion is that physicians are paying more attention to satisfying their patients than to treating them in an evidence-based manner and consequently their care costs more and they die more. This study, however, has serious methodological flaws: 1) They studied patient satisfaction only in the year 2000 (year 0) and never in the years when they studied cost and outcomes. 2) Prescription drug expenditures and hospital visits and admissions (cost) were studied only in 2001 (year 1) and never again, and mortality was studied in years 2001–2006 (years 1–6), during which years they never studied patient satisfaction or cost. Their conclusions have no legitimacy.

On the other hand, there are multiple articles in the literature that come to far different conclusions. In a review published in 2009, it was found that physician communication correlates strongly with patient adherence rates to treatment recommendations in acute and chronic disease.³ The authors noted that there were, at that time, more than 100 observational and 20-plus experimental studies published demonstrating the correlation of communication (patient satisfaction) with compliance. Compliance with treatment regimens has significant influence on quality measures in chronic disease and outcomes.³ In a review of the medical literature published in the *British Medical Journal* in 2013, patient experience was positively associated with clinical effectiveness and patient safety in 77.8 percent of studies, no association was found in 22 percent of studies, and a negative association was found in only one study (0.2 percent).⁴ *Academic Medicine* published a



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study titled “Physicians’ Empathy and Clinical Outcomes for Diabetic Patients,” which was based on the experience in the Department of Family & Community Medicine at Thomas Jefferson University. It found that, after removing all confounders, patients who rated their doctor’s empathy high had better clinical outcome markers, lower HgbA1C and LDL levels, than those who rated their physician’s empathy lower. The authors concluded, “Empathic engagement in patient care can contribute to

is common sense: If physicians practice evidence-based medicine and communicate better with patients, and consequently patients have more trust in their physicians and better understand what they should do, patients will follow those evidence-based recommendations more often and will have better clinical outcomes. There are unfortunately no specific studies in this area in emergency medicine, and studying clinical outcomes in and of itself in emergency medicine is fraught with difficulty.

achieving great patient satisfaction is not rocket science. There are simple tactics that emergency physicians can implement, most of which take no more time than we currently spend, and that lead to an improved perception of care. Those tactics include: 1) introducing ourselves and our roles and acknowledging everyone in the room; 2) sitting down at the bedside; 3) using key words to communicate our caring; 4) always estimating for patients how long the ED visit will

Let us not bristle at the thought of the words, “patient satisfaction.” Most of us became physicians because we want to help people and we want to have purpose in our lives and do worthwhile work. If improved communication with patients leads to improved adherence to our recommendations for treatment, and therefore to improved clinical outcomes, we should be all for it. ☺



DR. KAPLAN is director of service and operational excellence at CEP America Emergency Physician Partners and medical director of the Studer Group. He is a member of the ACEP Board of Directors.

In a review of the medical literature ... patient experience was positively associated with clinical effectiveness and patient safety in 77.8 percent of studies, no association was found in 22 percent of studies, and a negative association was found in only one study.

patient satisfaction, trust, and compliance, which lead to more desirable clinical outcomes.”⁵ In another paper titled “Communication and Medication Refill Adherence,” published in *Archives of Internal Medicine* in 2012, after adjusting for potential confounders, the prevalence of poor refill adherence increased by 0.9 percent (95 percent CI, 0.2–1.7 percent, $P=.01$) for each 10-point decrease in CAHPS (patient satisfaction) scores.⁶

All of these studies support what, to me,

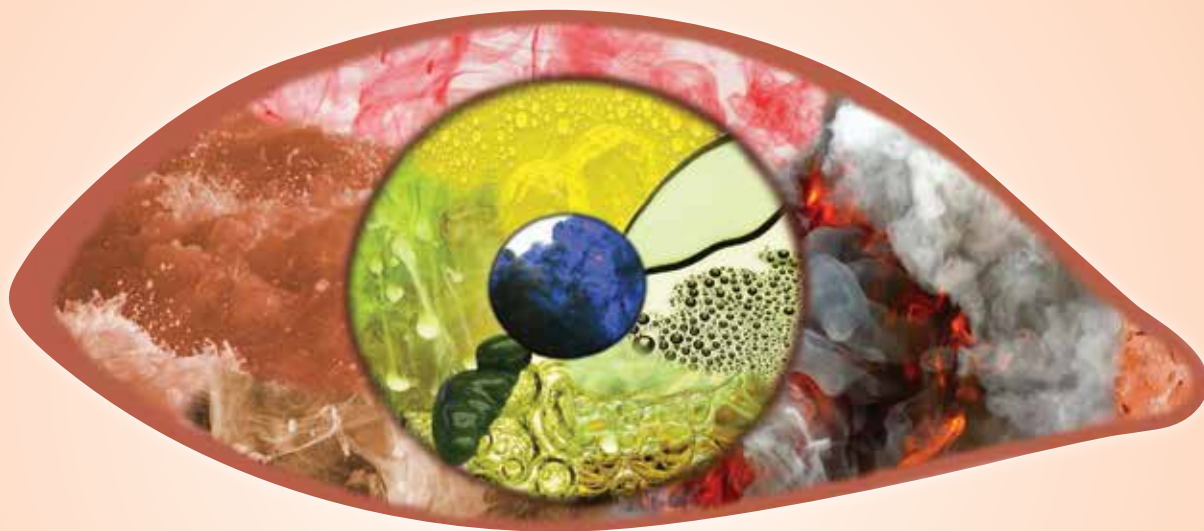
The entire issue of how the patient satisfaction surveys are then used is an entirely different matter. We do need to understand that our hospital administrators, the Centers for Medicare & Medicaid Services, and private insurers will continue to use the patient experience as a metric to measure quality, and they will then tie that value to payment, rewarding physicians and hospitals that do well and penalizing those that do not.

In the interim, let’s also be clear that

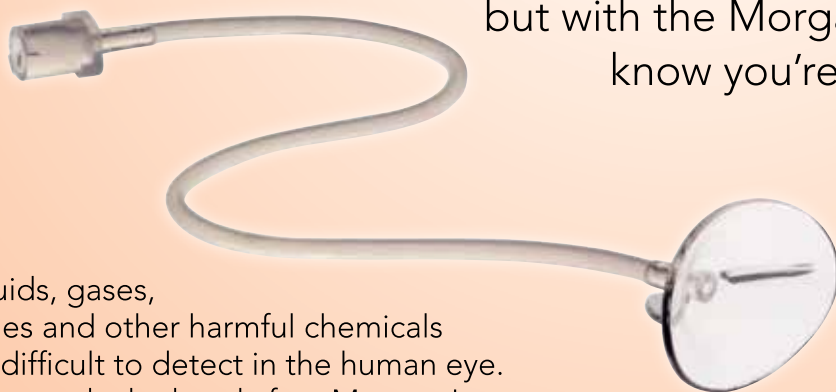
take and saying it will take longer than we believe it will take (we create expectations that we can then exceed); 5) ending the patient interaction with, “What questions do you have for me? Is there anything you would like for me to go over again?”; and 6) calling back patients who are discharged home within 48 hours to see how they are doing clinically and to ensure that they understood their home-care instructions and are following your recommendations.

References

1. Fenton JJ, Jerant AF, Bertakis KD, et al. The cost of satisfaction: a national study of patient satisfaction, health care utilization, expenditures, and mortality. *Arch Intern Med*. 2012;172:405-411.
2. Falkenberg K. Why rating your doctor is bad for your health. *Forbes*. January 21, 2013.
3. Zolnierok KB, Dimatteo MR. Physician communication and patient adherence to treatment: a meta-analysis. *Med Care*. 2009;47:826-834.
4. Doyle C, Lennox L, Bell D. A systematic review of evidence on the links between patient experience and clinical safety and effectiveness. *BMJ Open*. 2013;3:e001570.
5. Hojat M, Louis DZ, Markham FW, et al. Physicians’ empathy and clinical outcomes for diabetic patients. *Acad Med*. 2011;86:359-364.
6. Ratanawongsa N, Karter AJ, Parker MM, et al. Communication and medication refill adherence: the Diabetes Study of Northern California. *JAMA Intern Med*. 2013;173:210-218.



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CMS and Maryland Enter into **ACCOUNTABLE CARE** AGREEMENT

Maryland's system, exempted from the Inpatient and Outpatient Prospective Payment Systems, shifts from fee-for-service to pay-for-performance model

BY WILLIAM JAQUIS, MD, FACEP

In 2014, Maryland made a dramatic move toward a population-based payment model. The change to a more globally based payment system is an attempt to move forward on the triple aim of improved health at a lower cost and with a better patient experience. Maryland's unique all-payer system has recently been under increased scrutiny by the Centers for Medicare & Medicaid Services (CMS). This move may also help to preserve the system.



The all-payer system for hospital payments began in the early 1970s. The impetuses for its development were concerns not unique to Maryland: rapidly increasing Medicare and Medicaid costs and the disproportionate burden placed on hospitals in areas with a large number of patients without health insurance. The Maryland legislature took a different approach than other states with respect to its goals of controlling the growth in hospital costs, maintaining the viability of all hospitals that committed to quality care, and ensuring the fairness of reimbursement to hospitals. Out of this act, the Health Services Cost Review Commission (HSCRC) began in 1974. The HSCRC was given the authority to set hospital rates for all payers. Initially, this did not include Medicare and Medicaid, as federal law pre-empted state law. However, by 1977, Maryland was able to negotiate a waiver to include Medicare and Medicaid in its all-payer system. Hospitals may negotiate rates with the HSCRC to some degree, and the rates at a given hos-

pital may vary from other hospitals based on factors such as the rate of self-pay patients. Once the HSCRC determines rates for hospitals for a given year, the reimbursement from the payers is the same across all payers, from Medicaid to third-party payers.

The model has served Maryland, and presumptively CMS, well over the past 30-plus years. When the all-payer system started, the cost per admission for Medicare was 25 percent greater than the national average. In 2005, the cost per admission was 5 percent below the national average, continuing into 2007. Since then, however, the cost per admission has been increasing relative to the national average, and the waiver that allows Maryland to include Medicare and Medicaid in the all-payer system has been in jeopardy. Rather than lose the waiver, Maryland began negotiating with CMS. The negotiations led to the proposal and approval of a new payment system for hospitals. For the next five years, this model will be in place, and if Maryland is

not successful in implementing this plan, it will transition to the national Medicare hospital-payment system.

As of January 2014, the payment model in Maryland began migrating from a traditional fee-for-service model to expenditures per capita for all payers. For the next five years, cost growth is capped at 3.58 percent for inpatient and outpatient care. For Medicare, Maryland will limit the growth to 0.5 percent less than the national growth rate per year. This is estimated to save Medicare \$330 million in that five-year period. The base rate for individual hospitals is their total revenue from 2013, with a growth-rate ceiling of 3.58 percent. Hospitals can choose from two models of transition. The first is to transition to a global budget model from the beginning. The second involves a variable cost factor that reduces the incentive for hospitals to make money by increasing volume. If volume goes up, hospitals keep a fraction of the increase, but they also retain some of the lost revenue if volume goes down.

For Medicare, Maryland will limit the growth to 0.5 percent less than the national growth rate per year. This is estimated to save Medicare \$330 million in that five-year period.

The goal of the change, besides the obvious cost savings, is to encourage hospitals to move to a population-based approach of providing care. Hospitals will move away from rewards for inpatient volume to a system that emphasizes prevention, quality, and more care coordination. Keeping patients out of the hospital and working with medical homes and community resources could lead to better outcomes and a healthier population. If successful, this could lead to control of the total cost of health care for Maryland. ☐



DR. JAQUIS is system chief of emergency medicine at LifeBridge Health and chief of emergency medicine and attending physician at Sinai Hospital, both in Baltimore. He is a member of the ACEP Board of Directors.



DR. LEVITAN is an adjunct professor of emergency medicine at Dartmouth's Geisel School of Medicine in Hanover, N.H., and a visiting professor of emergency medicine at the University of Maryland in Baltimore. He works clinically at a critical care access hospital in rural New Hampshire and teaches cadaveric and fiber-optic airway courses.

Cric 2.0 Part Deux

Making the incision and inserting the tube

The importance of verifying the cricothyroid membrane cannot be overstated. At this location, the incision has protected boundaries created by what I call the "cartilaginous cage."

Article and Photography by RICHARD M. LEVITAN, MD, FACEP

Part two of a two-part series.

Part one of this article (February *ACEP Now*, p. 24) addressed the "laryngeal handshake," a means of reliably finding the external landmarks for performing a cricothyrotomy. We left off with the nondominant hand stabilizing the larynx, and the dominant hand resting on the sternum. "Sternal stabilization" is fundamental for good control of the scalpel. By firmly pushing your dominant hand against the patient's sternum, your hand is not hovering in space over the neck. It also helps tremendously when your elevated heart rate would otherwise impede fine motor control. The blade needs to be controlled two ways: first, for the midline vertical incision through the skin and, second, rotating the blade for the horizontal incision through the cricothyroid membrane.

Breaking down the sequential steps:

- 1) Laryngeal handshake, nondominant hand on larynx (see Figure 1)
- 2) Sternal stabilization (dominant hand on sternum)
- 3) Vertical skin incision
- 4) Palpation of the cricothyroid membrane with the nondominant index finger
- 5) Horizontal incision through the membrane
- 6) Flip the blade (extending the incision) in the other direction

Although single stab incisions through the skin and membrane are feasible in thin individuals, a vertical skin incision is best. A skin incision permits direct palpation of the cartilages and cricothyroid membrane, confirming the correct location before making the horizontal incision into the airway (see Figure 2). In the super obese, larger vertical incisions are required to enable the horizontal incision.

The importance of verifying the cricothyroid membrane cannot be overstated. At this location, the incision has protected boundaries created by what I call the "cartilaginous cage" (see Figures 3 and 4). This is a "safe space" delineated by cartilage: above is the inferior aspect of the thyroid lamina; below is the anterior cricoid ring; laterally

are the inferior cornu of the thyroid (on either side); and, perhaps most important, there is a firm backstop, the high back wall of the cricoid cartilage (see Figure 5). If the incision is made too high (between the hyoid and thyroid), it will be above the vocal cords. If made too low (below the cricoid) you enter the trachea. At the trachea, there is nothing

stopping the blade from going too far laterally (i.e., cutting great vessels) and also nothing to prevent puncturing the posterior membranous trachea (entering the esophagus and mediastinum).

A tracheal hook has a sharp point to puncture the membrane and lift up on the inferior thyroid, stabilizing the trachea while the incision is

performed. Whether or not a hook is used, when using a #11 blade, it's necessary to widen the incision by extending the cut in the other direction after the blade enters the trachea. A #10 blade, because it has a larger width, may not require this. If a hook is not used to control the trachea, something should go imme-

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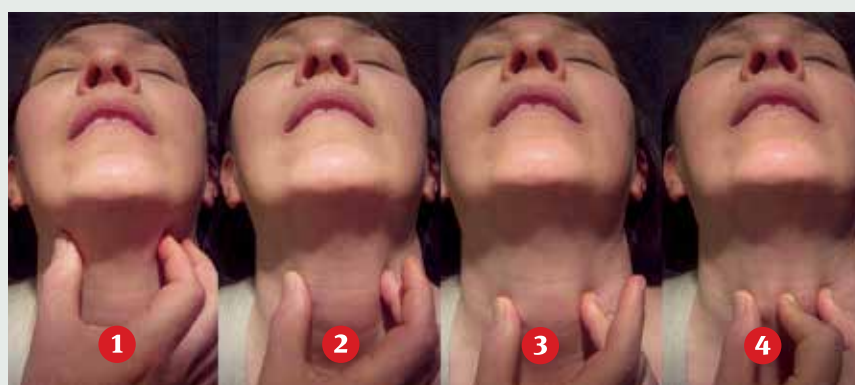


Figure 1. The "laryngeal handshake," from left to right: 1) hyoid, 2) thyroid, 3) cricoid, and 4) palpation of cricothyroid membrane.



Figure 2. Making the initial vertical skin incision.



Figure 3. Palpating the cricothyroid membrane.



JAMES M. DAHLE, MD, FACEP, is the author of *The White Coat Investor: A Doctor's Guide to Personal Finance and Investing* and blogs at <http://whitecoatinvestor.com>. He is not a licensed financial adviser, accountant, or attorney and recommends you consult with your own advisers prior to acting on any information you read here.

Student Loans: Get Them Forgiven or Pay Them Off?

by JAMES M. DAHLE, MD, FACEP

Question: *I have heard that there are debt-consolidation and loan-forgiveness programs that might be useful to me. How should I manage my student loans?*

Answer: Many established attending emergency physicians are unaware of the incredible size of the student loan burden faced by more recent graduates. According to the Association of American Medical Colleges, in 2012, the average student loan debt among indebted medical school graduates was about \$167,000 for MD students. Debt levels are even higher for DO students. These numbers, of course, are mere averages. Twenty-five percent of 2012 graduates owe more than \$200,000, and 5 percent owe more than \$300,000. I'm confident these sums have not gone down since 2012. Student loan interest rates for those in residency now are no lower than 6.8 percent and sometimes as high as 11 to 15 percent for private loans. At an average interest rate of 8 percent, a student with \$300,000 of debt at medical school graduation may owe as much as \$378,000 upon completion of residency. Required payments on

this debt may be more than \$3,600 per month, much more than the typical American, and many a physician, spends on a mortgage. Many of these young physicians also have substantial consumer debt from automobile loans or credit cards. Emergency physicians, however, should count their blessings. Some attending physicians practicing in lower-paying specialties after attending expensive medical schools are now being turned down for student loan refinancing due to their income-to-debt ratio being too high! No wonder young doctors are looking for some relief from this financial pressure.

The Income-Based Repayment (IBR) Plan

Without IBR, most residents would be either bankrupt or forced into forbearance or hardship deferrals. IBR bases student loan payments on income rather than total debt or interest rate. As a result, residents

making IBR payments on unsubsidized loans are often paying much less than even the interest on their loans. The IBR plan was recently changed; it is technically a modification of an older loan program called Income-Contingent Repayment, or ICR-A, and is also called "Pay as You Earn." It caps student loan payments at 10 percent of "discretionary income" instead of the previous 15 percent under IBR. Discretionary income is defined as the difference between adjusted gross income (line 38 on IRS Form 1040) and 150 percent of the federal poverty level, about \$18,000 for a single physician and about \$36,000 for a family of four. So if you're a resident making \$50,000, your payments are capped at \$267 per month if you are single and \$117 per month if you are married with two kids. Since the interest alone on a \$300,000 8 percent loan is \$2,000 per month, you can see that the IBR/ICR-A payments are just a drop in the bucket, and the debt will continue to grow while in the program. When a resident graduates and begins earning a higher income, IBR/ICR-A payments will revert to a higher amount, calculated using the original debt on a 10-year repayment basis. If payments are made every month for 20 years, the remainder of the debt will then be forgiven. However, the typical emergency physician making even the minimum payments will have the debt paid off by then, so IBR forgiveness is really not a factor for most doctors.

The Public Service Loan Forgiveness (PSLF) Program

PSLF is a type of loan forgiveness that can be beneficial for doctors. If a doctor works for a qualifying 501(c)3 employer, such as the military, Department of Veterans Affairs, a university hospital, or a non-profit hospital, the remainder of the loan forgiveness can be received after 10 years of qualifying payments instead of 20. This is a particularly beneficial program for specialists with long training programs, such as medical, pediatric, and surgical subspecialists. However, even emergency physicians, with their relatively short residency, can gain substantial benefits from PSLF. Ba-

Even emergency physicians, with their relatively short residency, can gain substantial benefits from Public Service Loan Forgiveness.

sically, you are forgiven the amount by which you underpaid your loans in residency, plus the interest that accumulated because of those underpayments.

Consider again the physician with \$300,000 of debt at 8 percent. On a straightforward 10-year repayment plan, the payments would be \$3,616 per month. Since three of those seven years were spent on an IBR plan paying \$117 per month, then the underpayment is $(\$3,616 - \$117) \times 36$, or nearly \$126,000. However, due to accumulated interest, the amount forgiven after 10 years will be even more, about \$252,000. The physician who owed \$300,000 upon medical school graduation will end up paying about \$308,000 and receiving another \$252,000 in loan forgiveness. The more years spent in training and the higher the interest rate, the higher the debt burden and the more that stands to be forgiven. Forgiveness obtained through PSLF, unlike IBR forgiveness, is tax-free.

A few caveats: First, notice how the emergency physician in the example still ended up paying more than the original debt. It does not make any sense to run up extra debt thinking it will all be forgiven. You will end up paying a large portion of it, especially after a short residency. Second, many emergency physicians who work in 501(c)3 hospitals are not actually employed by the hospital. They may be an employee or a partner of a small democratic group or a large contract-management group that contracts with the



Sarah Hoper, MD, recently joined the staff at Vanderbilt University. She is interested in health policy and is EMRA's Legislative Advisor. EMRA President Jordan Celeste, MD, is a fourth year resident at Brown University in Providence, R.I., and will be heading to Florida this summer to begin practice.



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hospital. These doctors are not eligible for PSLF. Third, I would not be surprised to see the benefits of this program disappear or become means-tested once the press finds out that “rich doctors are having hundreds of thousands of dollars forgiven at the taxpayers’ expense.”

Decision Time

Nearly every resident will need to make IBR/ICR-A payments in residency. They simply cannot afford the regular payments. However, at residency graduation, physicians need to make a decision. If they will be working for a 501(c)3, they should probably go for PSLF, continuing to make minimum payments for another seven years. If they will be working for a private employer, then it is time to get busy paying off those loans just as fast as they can. Continuing a lifestyle similar to the one they had as a resident is the key to freeing themselves from this substantial financial burden within two to five years.

Loan Consolidation Versus Loan Refinancing

The federal government has offered loan-consolidation programs for years. However, they were nearly useless because they simply turned all a borrower’s loans into a single

loan at the average interest rate of the consolidated loans. While convenient, this did not actually save the physician borrower any money. A better option for doctors not going for PSLF is loan refinancing with a private bank or other lender, although they do have to qualify based on their income-to-debt ratio and credit score. Refinancing can currently be done at rates as low as 5 percent fixed and 3 percent variable, but there are very few lenders currently offering these refinancing loans. Refinanced loans are not eligible for PSLF, may be assessed against the estate should the borrower die before paying them off, and, like other student loans, are generally not forgivable in bankruptcy. Doctors with some home equity have an even better option: converting student loans into mortgage loans by using a home-equity loan or other refinancing technique. Student loans are inferior to mortgage loans in many ways. They are generally nondeductible, usually nonforgivable, and are often high interest, at least for loans taken out in the last eight to 10 years. A physician with fully deductible mortgage interest might be able to turn an 8 percent student loan into an after-tax 2 percent loan.

Student Loans Versus Investing

Another dilemma attending physicians face is deciding when to use extra money to invest, particularly in tax-advantaged retirement accounts, and when to use that money to pay down student loan debt. The following guidelines published in chapter six of *The White Coat Investor: A Doctor’s Guide to Personal Finance and Investing* may be helpful:

1. Get the match. Employer-provided retirement plan matching funds are really part of your salary. Don’t leave the match on the table by not contributing.
2. Pay off any high-interest debt (greater than 8 percent), such as credit cards, car loans, expensive private student loans, etc. This is a fantastic guaranteed investment return.
3. Maximize your tax-deferred retirement plan contributions, including 401(k)s, profit-sharing plans, 403(b)s, 457s, and defined benefit/cash balance plans.
4. Fund a Health Savings Account (HSA) if eligible (see my January 2014 *ACEP Now* column for details).

The following four items can be reordered, according to your financial priorities.

Many established attending emergency physicians are unaware of the incredible size of the student loan burden faced by more recent graduates.

5. Fund a personal and spousal Backdoor Roth IRA (see <http://whitecoatinvestor.com/backdoor-roth-ira-tutorial/> for more on this technique to be covered in a future column).
6. Fund a college savings plan (529) for each child up to the amount that your state subsidizes with tax breaks.
7. Pay off moderate-interest debt (4 to 8 percent), such as student

- loans (unless you anticipate forgiveness).
 8. Save for a house down payment (if not using a physician loan).
- The next four items can be reordered, according to your financial priorities and comfort level with debt.
9. If you used a physician mortgage, pay it down to enable refinancing into a lower-rate conventional mortgage.
 10. Add additional funding if desired to college savings (529) accounts.
 11. Invest in a taxable account in risky investments (stock index funds, real estate, etc.).
 12. Pay off low-interest (1 to 3 percent) student loan debt (unless you anticipate forgiveness).
- The final three items can also be reordered according to your priorities.
13. Make extra payments on your mortgage.
 14. Invest in a taxable account in low-risk investments (municipal bond funds, etc.).
 15. Spend your money on what makes you happy.
- Managing your student loans wisely will set you up for financial success during your career and retirement. ☺

AIRWAY | CONTINUED FROM PAGE 21



Figure 4. The “cartilaginous cage” (arrow) on a papier-mâché model of the laryngeal cartilages. Produced by Dr. Louis Auzoux, Paris, France, circa 1850. Collection of Richard M. Levitan, MD.



Figure 5. Auzoux laryngeal model showing, top to bottom, the hyoid, thyroid, and cricoid separated. The cricoid incision is aimed at the high back wall of the cricoid cartilage (arrow).

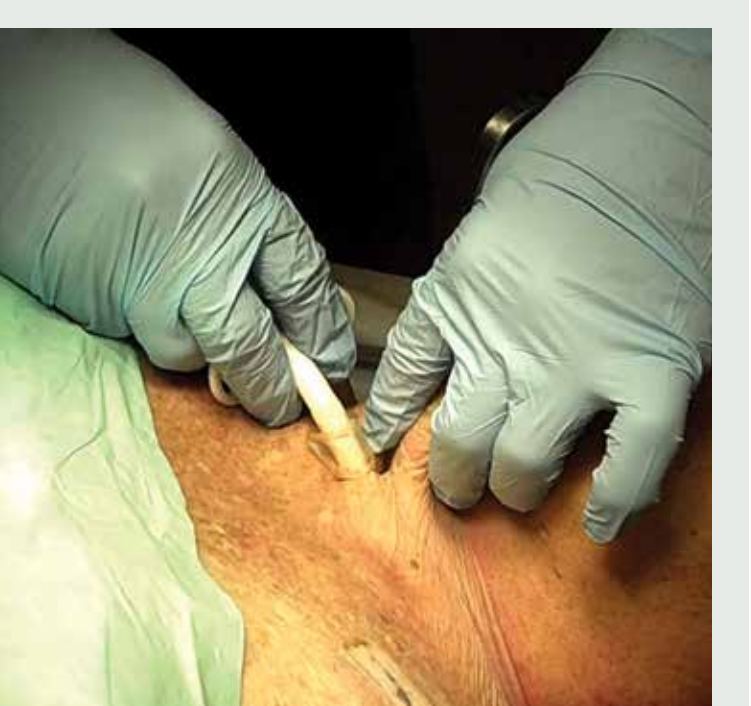


Figure 6. Inserting a Shiley. Initial tip insertion is made 90 degrees to the tracheal axis, and then after the tip has passed, the device is rotated in the direction of the tracheal axis on full insertion.

diately into the hole. A finger, the back end of the scalpel, or a bougie all have been recommended for this task. A tracheal hook can also be used at this stage, after the hole has been made, to control and lift up the trachea.

Bougie advocates claim it can confirm placement by depth of in-

sertion (e.g., if in the trachea, it will advance considerably). A tube can then be railroaded over it once you know the bougie is in the correct place.

It is far easier to insert a standard tube (6-0 ID, OD 8.2 mm) than a Shiley into the cricothyroid membrane. Its flexibility and smaller size

allow for easy insertion, but one has to watch the depth of placement. It is only 11 mm from the cords to the carina. Most pilot balloons on a tracheal tube are at about 14 mm from the tip. Overinsertion will lead to right main-stem intubation. A 6-0 Shiley has an OD of 10.8 mm, while the cricothyroid membrane has a

height ranging from 8–11 mm (females to males). Shileys are also mechanically harder to insert because they must be rotated into position. Initially, they should be 90 degrees to the tracheal axis, and after the tip is placed into the hole, the back end is swung around to be in line with the tracheal axis as it is fully

inserted (see Figure 6).

The surgical airway is one of the most intimidating procedures for emergency physicians. The “laryngeal handshake,” “sternal stabilization,” and appreciating the “cartilaginous cage” can make you perform like a hero in the crisis moment when your patient needs a cric. ☺



DR. RADECKI is assistant professor of emergency medicine at The University of Texas Medical School at Houston. He blogs at Emergency Medicine Literature of Note (emlitofnote.com) and can be found on Twitter @emlitofnote.

Predicting TIMI's Mortality

It is time for this risk score to leave the ED

by RYAN PATRICK RADECKI, MD, MS



Can you recite the elements of the TIMI Score—the Thrombolysis in Myocardial Infarction Risk Score for Unstable Angina/Non-ST Elevation Myocardial Infarction—from memory? If you still can, it's not surprising. Over the last decade, this score has been drilled, dogmatically, into many specialties, including emergency medicine. Numerous studies have utilized it, attempting to define a low-risk cohort from unselected chest pain patients presenting to the emergency department. Fortunately for EM, but unfortunately for the brain cells sacrificially dedicated to its memory, the next wave of decision instruments promises to eliminate it from use.

The original TIMI Score is not derived from an emergency department cohort. These were patients admitted and anticoagulated for con-

cerning chest pain in the setting of ECG changes, known coronary artery disease, or positive biomarkers. The original predictive value of the TIMI Score was intended to prognosticate 14-day mortality or new cardiac ischemia for cardiac inpatients, not emergency department presentations. The generalizability of this cohort to our setting is simply lacking, and the logistic regression identifies elements—aspirin use within seven days—that may add specificity for poor outcomes in an intermediate- to high-risk cohort but fails in providing utility for describing a minimal-risk cohort. As expected, the largest meta-analysis of prospective studies using TIMI in the emergency department demonstrated even requiring a TIMI of 0 for discharge is only 97.2 percent (95 percent CI, 96.4–97.8) sensitive for cardiac events.² This strategy would result in 78 percent of patients being admitted for cardiac evaluation and still result in adverse outcomes for one in 50 discharged patients. Pursuing this strategy is clearly foolish.

Fortunately, science marches on. From the Netherlands, the HEART (History, ECG, Age, Risk Factors, Troponin) Score was derived and designed for use in the emergency department.³ Reflecting several elements common to clinician gestalt, HEART demonstrates substantially improved performance over TIMI. When used as recommended by the authors, a HEART Score of 0 to 3 reflects a six-week event-free prognosis with a miss rate ranging between 0.6 percent and 1.8 percent in validation studies.^{4,5} At the same time, the number of patients classified as low risk increases to up to a third of the presenting cohort—an improvement that, by itself, ought to retire TIMI to its intended place on the inpatient side.

The next step in ED-centric decision-instrument development may come from New Zealand and Australia, with the Emergency Department Assessment of Chest Pain Score (EDACS).⁶ This score incorporates many of the same elements seen in the HEART Score but at a more detailed and granular level. Rather than each of the five elements being awarded up to two points, the EDACS breaks age, coronary disease, and signs and symptoms into myriad additive and subtractive elements. The advantage of this is greater specificity. In the original derivation and validation cohort, it was used in conjunction with zero-hour and two-hour troponin measurements to classify nearly 50 percent of the cohort as low risk, with a sensitivity greater than 99 percent. The downside: get out your calculator. While not nearly as bad as the GRACE (Global Registry of Acute Coronary Events) Score, this decision-instrument approaches the complexity limit for clinical acceptability. Increasing availability of computerized decision support potentially decreases the resultant cognitive strain, but this

The development of these ED-centric decision instruments and disposition pathways indicate EM has moved beyond the hand-me-downs from cardiology.

remains a limitation. Prospective validation of the EDACS-Accelerated Diagnostic Protocol is under way in Europe and North America.

Most important, however, the development of these ED-centric decision instruments and disposition pathways, along with the North American Chest Pain Rule, indicate emergency medicine has moved beyond the hand-me-downs from our cardiology brethren. Not only is it time for TIMI to be retired, it's likely time to reconsider the relevance of the other American Heart Association recommendations for the evaluation of acute nonspecific chest pain in the emergency department. Universal recommendations for early provocative or anatomic testing are discordant with the reality of our resource-limited settings, and a recognition of the harms of false positives further informs the need for practice evolution. ACEP should support emergency physicians utilizing these prospectively derived risk-stratification tools for early disposition of patients from the emergency department, specifically to address the medical legal fallout from moving to a rational, but not “zero miss,” strategy. We've gone too far down the rabbit hole, but there may yet be light at the end of the tunnel. ☺

References

1. Antman EM, Cohen M, Bernink RJ, et al. The TIMI risk score for unstable angina/non-ST elevation MI: A method for prognostication and therapeutic decision making. *JAMA*. 2000;284:835-842.
2. Hess EP, Agarwal D, Chandra S, et al. Diagnostic accuracy of the TIMI risk score in patients with chest pain in the emergency department: a meta-analysis. *CMAJ*. 2010;182:1039-1044.
3. Six AJ, Backus BE, Kelder JC. Chest pain in the emergency room: value of the HEART score. *Neth Heart J*. 2008;16:191-196.
4. Six AJ, Cullen L, Backus BE, et al. The HEART score for the assessment of patients with chest pain in the emergency department: a multinational validation study. *Crit Pathw Cardiol*. 2013;12:121-126.
5. Backus BE, Six AJ, Kelder JC, et al. A prospective validation of the HEART score for chest pain patients at the emergency department. *Int J Cardiol*. 2013;168:2153-2158.
6. Than M, Flaws D, Sanders S, et al. Development and validation of the Emergency Department Assessment of Chest pain Score and 2h accelerated diagnostic protocol. *Emerg Med Australas*. 2014;26:34-44.

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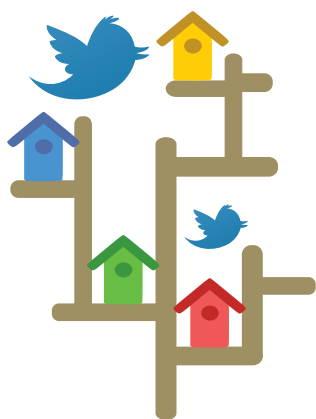
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DR. FAUST is an emergency-medicine resident at Mount Sinai Hospital in New York and Elmhurst Hospital Center in Queens. He tweets about #FOAMed and classical music @jeremyfaust.

Twitter Newcomers, Toxicology Tips, Game-Changing Research, and ARDS Advice



by JEREMY SAMUEL FAUST, MD, MS, MA

Not addicted to Twitter yet? Not a problem. Here are five recent tweets that'll give you a sense of what is going on in the emergency medicine Twitterverse.

1 The emergency medicine Twitterverse has an egalitarian feel, and people from all levels of training and experience frequently make valuable contributions and interact as a community. When a big name joins the conversation, it brews real excitement. So, when Indiana University pulmonary embolism guru **Jeffrey Kline, MD**, began tweeting in February, his presence was immediately noticed and appreciated. Dr. Kline has only tweeted a few dozen times, but each tweet has packed a punch. "Causes of a false negative #D-dimer: symptoms greater than 72h, distal clots, lipemia with turbidimetric assays and blocking proteins" and "Clinician gestalt is as good as a validated computerized method for estimating PE probability; not so for ACS. Ann Emerg Med 2014 63:275-80" are just two representative tweets from this evidence-based medicine luminary. Welcome to Twitter, Dr. Kline (@KlineLab).

2 **Leon Gussow, MD** (@poisonreview), a professor at the University of Illinois, frequently tweets links to his blog, which zeroes in on relevant and topical toxicology cases that have appeared in peer-reviewed journals. He reviews these papers with expertise that few can rival. His recent post, "Central pontine myelinolysis associated with ethylene glycol intoxication <http://ow.ly/2EpoL6>," is a review of an article from the *Journal of Emergency Medicine* (2014;46:369-374). One great pearl from Dr. Gussow's review: osmotic demyelination syndrome (the new proposed name for central pontine myelinolysis) resulting from hyperosmolar insults such as ethylene glycol and other toxic alcohols has similar neurological sequelae as some of the other more "classic" causes. However, in some of the toxin-related cases, there are reports of possible associations with better outcomes, which may be helpful in keeping some hope alive for favorable prognoses in such challenging cases.

3 A relatively new FOAM resource is REBEL EM by **Salim Rezaie, MD, FACEP** (@srrezaie), assistant program director and clinical assistant professor of emergency medicine and internal medicine at the University of Texas Health Science Center at San Antonio. Dr. Rezaie's site is a growing resource for EM board review and other general EM topics. Sal also wins the award for best new acronym with his eponymous Rezaie's Evidence Based Evalu-

article on Dr. Rezaie's site cowritten by some bright minds in EM, each of whom suggested articles that were "Game Changers in EM" (<http://zite.to/1mQyBOX>). The article contains four short but remarkably in-depth and thoughtful reviews of four major articles of the past decade: the ADAPT trial on discharging patients with low-risk chest pain; Perry et al. on the sensitivity of CT for subarachnoid hemorrhage within six hours of headache onset; the 2012 Cochrane review on antiemetics for pediatric acute gastroenteritis; and the recent and landmark addition to therapeutic hypothermia literature, Nielson's study comparing 33°C

the most comprehensive free stats tutorial/review I have found! <http://bit.ly/1ohGBUC> #FOAMed #EBMed" is a real find. Whether you need a review on the difference between populations and samples or you want to know just what exactly the t-test, chi squared, or an exact probability test is, you'll find the explanations and simplified equations in this one free resource. On a side note, admissions directors shouldn't need a personal statement from Mr. Sifford: just read his Twitter feed!

5 Finally, "Epitaph for nitric oxide for ARDS (Crit Care Med) <http://goo.gl/fb/ao-QHc> - vive la #FOAMed" is a post from the anonymous account **@EgertonYDavisIV** (although this homage account to the fictitious alter ego of the legendary Dr. William Osler seems to be associated with the Life in the Fastlane blog, the standard bearer for EM blogs Down Under and the world over). The tweet links to a great article in the PulmCCM.org blog, created by **Matthew Hoffman, MD**. The author analyzes a new review in the journal *Critical Care Medicine* (2014;42:404-412), "Inhaled nitric oxide does not reduce mortality in patients with acute respiratory distress syndrome regardless of severity: systematic review and meta-analysis." The meta-analysis aggregates data from 1,142 patients with acute respiratory distress syndrome (ARDS) and comes to some harrowing conclusions. Just as devastating as the authors' conclusion that nitric oxide has no mortality benefit for patients with ARDS regardless of how poorly the patients' lungs were performing at the time of administration is the association between nitric oxide and the development of renal impairment. Taken together with the cost and hassle of nitric oxide administration, this article (and its recirculation in the FOAM world) may finally put this well-intentioned, but apparently futile, modality to rest. ☹



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ation of Literature in Emergency Medicine (REBEL EM); well played, sir. His Twitter feed has quickly become a staple and is part of the reason Dr. Rezaie will be appearing on an upcoming episode of Mel Herbert's EM:RAP. This tweet actually comes from fellow EBM junkie and FOAMite, **Ken Milne, MD** (@theSGEM), and it links to a splendid

versus 36°C as target temperatures for post-cardiac arrest care. It's always nice to have a slew of great papers discussed at such a high level in one easy-to-read article.

4 Flight paramedic (and premed!) **Derek Sifford's** (@flightmed1) post "BMJ: Statistics at square 1. So far,

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

TWEET AT ME @JEREMYFAUST OR EMAIL TO JSFAUST@GMAIL.COM.



DR. MELL is clinical assistant professor in the Department of Surgery at the University of Illinois at Urbana. He is the EMS Medical Director for EmCare's North Division, EMS Assurance, the Newark (OH) Division of Fire, and Ohio Ambulance.

Trick or Treat?

Why choose when you can have both?

by HOWARD "HOWIE" MELL, MD, MPH, CPE, FACEP

My 8-year-old daughter recently had a tonsillectomy at Rainbow Babies & Children's Hospital in Cleveland. The perioperative nurse came to her before she was wheeled back to the operating room and asked, "What flavor do you like? Cherry, blueberry, or watermelon?" When my daughter picked cherry, the nurse pulled a tube of lip balm from her pocket, and together, they coated the inside of a pediatric non-rebreather mask and anesthesia bag mask with it. The nurse explained that this way it would "smell good while (she) went to sleep." My daughter loved it.

There is a body of research that suggests sweet or pleasant odors may improve pain tolerance.^{1,2} Perhaps as a result, some pediatric anesthesia teams use flavored lip balms (e.g., cherry ChapStick) to coat the inside of masks that are used to provide anesthesia or to provide oxygen in support of procedural sedation. This seems to improve patient tolerance and reduce anxiety. Offering patients their pick of flavors may also increase their comfort by allowing them a small item of choice during a time when they feel events are beyond their control.

Given the increasing use of the intranasal route of medication administration in emergency medicine (e.g., intranasal fentanyl 1–2 mg/kg for pain control or intranasal midazolam 0.4 mg/kg for procedural sedation) and the increasing use of emergency department procedural sedation in children often via ketamine (1 mg/kg IV, 4–5 mg/kg IM), whose dissociative effects may be aided by inclusion of pleasant sensations such as sweet smells, emergency physicians should include flavored lip balm in their practice. Consider offering lip balm to any patients who will receive intranasal medications or undergo procedural sedation (especially if using ketamine) or as a distraction and calming technique for children. Ideally, have more than one flavor to offer, as children are easier to calm if they are offered choices that make them participants in their care. Take the lip balm and liberally spread it over the inside surface of a non-rebreather mask. School children can be guid-



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Some pediatric anesthesia teams use flavored lip balms to coat the inside of masks used to provide anesthesia or oxygen in support of procedural sedation.

ed to do this themselves (and they often enjoy decorating the outside of the mask with stickers if you have any available). Allow patients to inhale from the coated mask prior to and immediately following the use

of intranasal medications or during initiation and recovery from procedural sedation. Anecdotally, patients and their families are very appreciative of this small comfort we can provide.

If you choose to use this technique, be aware that several health care organizations have erroneously interpreted the National Fire Protection Association's (NFPA) 1996 edition of the Standard for Health Care Facilities to mean that any petroleum-based product presents a fire hazard in the presence of oxygen.³ Fortunately, the Federal Aviation Administration (FAA) did laboratory testing on this very question in the 1960s. Its report, published by the Civil Aeromedicine Research Institute, found that "a large margin of safety exists in using hydrocarbon face, lip, and hair preparations in the presence of 100 percent oxygen at or below one atmosphere (760 mm Hg)."⁴ The report went on to list the physical properties of

commonly used products, including ChapStick, in the presence of 100 percent oxygen. It found that the combustibility of these types of products was comparable to normal skin oils at pressures at or near one atmosphere. The FAA allows pilots using oxygen in flight to wear cosmetics or use lip balm.⁵ It is reasonable to assume that it is safe for our patients as well. ☺

References

1. Prescott J, Wilkie J. Pain tolerance selectively increased by a sweet-smelling odor. *Psychol Sci*. 2007;18:308–11.
2. Bartolo M, Serrao M, Gamgebeli Z, et al. Modulation of the human nociceptive flexion reflex by pleasant and unpleasant odors. *Pain*. 2013;154:2054–2059.
3. Winslow E, Jacobson A. Dispelling the petroleum jelly myth. *Am J Nurs*. 1998;98:16RR.
4. Dille JR, Crane CR. The flammability of lip, face and hair preparations in the presence of 100 percent oxygen. *Rep 62-27. Rep Civ Aeromed Res Inst US*. 1963;Nov:1–5.
5. Oxygen equipment use in general aviation operations. Federal Aviation Administration Web site. Available at: www.faa.gov/pilots/safety/pilotsafetybrochures/media/Oxygen_Equipment.pdf. Accessed February 7, 2014.



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The UCSF Department of Emergency Medicine provides comprehensive emergency services to a large local and referral population with approximately 93,000 visits a year at UCSF Medical Center and San Francisco General Hospital. The new UCSF Benioff Children's Hospital Emergency Department will open in February 2015. SFGH, a level-1 trauma center, paramedic base station and training center, is opening a new hospital in 2015, with a 60-bed emergency department, including a new 8-bed pediatric ED. The Chief will have the opportunity to work with outstanding EM and pediatric residents at all sites. The Department of Emergency Medicine has a fully-accredited 4-year Emergency Medicine Residency Program with 48 residents and directs several fellowship programs. The pediatric training program has 87 residents and 15 fellowships. Research is a major priority, with over 50 ongoing studies and 100 peer-reviewed publications in the Department of Emergency Medicine last year. There are opportunities for leadership and growth within the Department and UCSF School of Medicine.

Applicants for this position must have a minimum of 5 years leadership experience in an academic emergency department and must be Board Certified in Pediatric Emergency Medicine.

The University of California, San Francisco, is one of the nation's top five medical schools and demonstrates excellence in basic science and clinical research, global health sciences, policy, advocacy, and medical education scholarship. The San Francisco Bay Area is well-known for its great food, mild climate, beautiful scenery, vibrant cultural environment, and its outdoor recreational activities.

Send cover letter and curriculum vitae to:

Ellen Weber, MD, Vice Chair
c/o Natalya Khait

UCSF Department of Emergency Medicine
533 Parnassus Avenue, Suite U575
San Francisco, CA 94143-0749
Natalya.khait@emergency.ucsf.edu

UCSF seeks candidates whose experience, teaching, research, or community service has prepared them to contribute to our commitment to diversity and excellence. UCSF is an Equal Opportunity/Affirmative Action Employer. The University undertakes affirmative action to assure equal employment opportunity for underutilized minorities and women, for persons with disabilities, and for covered veterans. All qualified applicants are encouraged to apply, including minorities and women. For additional information, please visit our website at <http://emergency.ucsf.edu>



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DEPARTMENT OF EMERGENCY MEDICINE RESIDENCY PROGRAM DIRECTOR

University of California, San Francisco

The Department of Emergency Medicine at the University of California, San Francisco (UCSF), seeks outstanding candidates for the position of Residency Program Director. The residency program is a fully-accredited four-year program with 48 residents and plans to expand in the near future. Residents are exposed to a diverse patient population with a combined total of approximately 93,000 patient visits a year at their primary sites. Residents rotate at UCSF Medical Center, San Francisco General Hospital and Trauma Center, San Francisco VA Medical Center, Children's Hospital & Research Center Oakland, and Kaiser Permanente San Francisco Hospital. In 2015, the new UCSF Benioff Children's Hospital will open in Mission Bay, and a new hospital will open at San Francisco General Hospital, each with a dedicated pediatric ED.

The Department of Emergency Medicine serves as the primary teaching site for the residency program, providing comprehensive emergency services to a large local and referral population at both UCSF Medical Center and San Francisco General Hospital. The UCSF Medical Center is ranked among the nation's 10 best hospitals by U.S. News & World Report. SFGH is a level-1 trauma center, paramedic base station and training center. Research is a major priority of the department, with over 50 ongoing studies and 100 peer-reviewed publications in the past year. There are opportunities for leadership and growth within the Department and UCSF School of Medicine.

Applicants for this position must have a minimum of five years educational leadership experience, three years experience as a core faculty member at an ACGME-approved Emergency Medicine Residency Program, and be board certified by the American Board of Emergency Medicine. Candidates must have strong interpersonal skills and be able to work cooperatively and congenially with a diverse academic and clinical environment. Candidates with leadership skills and a vision for enhancing the educational and academic missions of the department are especially encouraged to apply. Appointment level and rank will be commensurate with experience and qualifications. Opportunities exist for an expanded leadership role in the department for qualified candidates.

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EMERGENCY MEDICINE FACULTY

University of California
San Francisco

The University of California San Francisco, Department of Emergency Medicine is recruiting for faculty beginning with the 2014-15 academic year. We have a particular interest in 1) individuals fellowship-trained in pediatric emergency medicine and 2) individuals who have a track record of successful research activities, as demonstrated by peer-review publications and funding. Rank and series will be commensurate with qualifications.

The Department of Emergency Medicine provides comprehensive emergency services to a large local and referral population with approximately 93,000 visits a year at UCSF Medical Center and San Francisco General Hospital. The new UCSF Benioff Children's Hospital Emergency Department will open in February 2015. SFGH, a level 1 trauma center, paramedic base station and training center, is opening a new hospital in 2015, with a 60-bed emergency department, including an 8-bed pediatric ED. The Department of Emergency Medicine serves as the primary teaching site for a fully accredited 4-year Emergency Medicine residency program which currently has 48 residents and directs several fellowships. Research is a major priority, with over 68 ongoing studies and 102 peer-review publications in the past year. There are opportunities for leadership and growth within the Department and UCSF School of Medicine.

We are looking for outstanding pediatric emergency physicians with board certification in Emergency Medicine or Pediatric Emergency Medicine. For the research position, board certification in emergency medicine is required and the successful candidate will demonstrate outstanding and original research, a track record of funding, and a collaborative spirit. We will also consider emergency medicine faculty with outstanding and original contributions in education and training, and/or noteworthy innovation in clinical practice.

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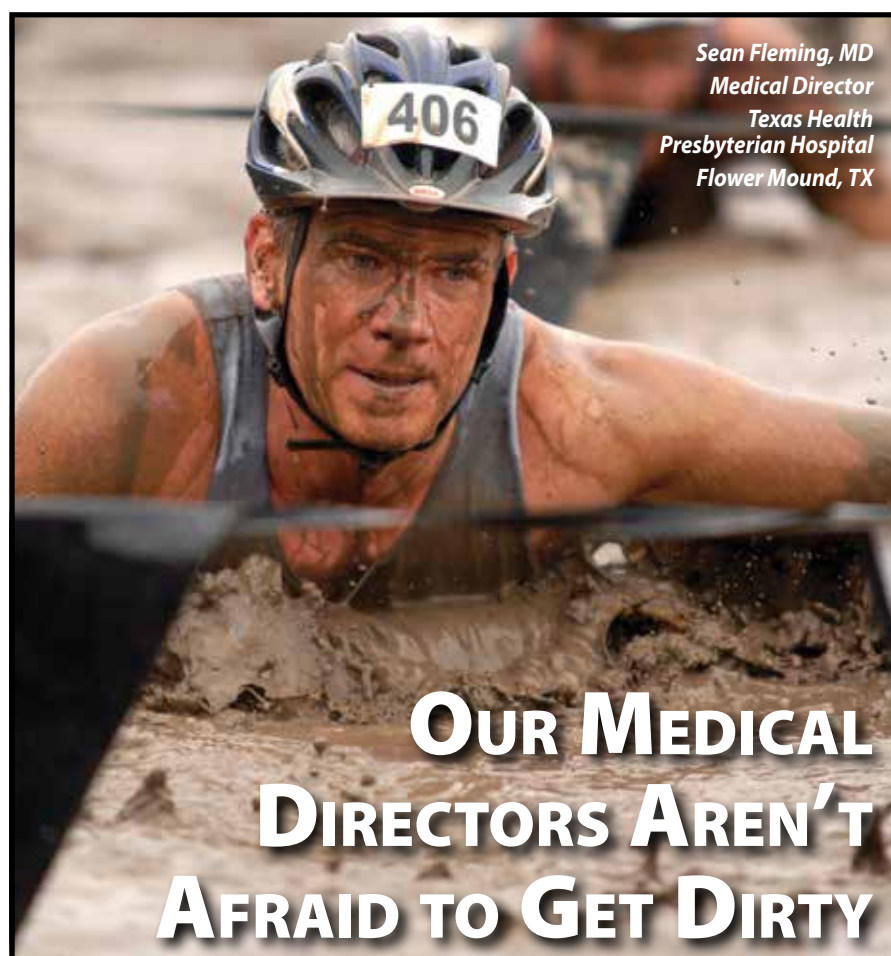
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19K annual visits
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Aventura Hospital and Med Ctr

Aventura, FL
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NEW! Residency Program Director

Lawnwood Regional

Fort Pierce, FL
60K annual visits, Level II Trauma

Lehigh Regional

Ft. Myers, FL
36K annual visits

Lake City Medical Center

Lake City, FL
25K annual visits
Medical Director

Osceola Regional

Orlando, FL
84K annual visits
Medical Director
Affiliated Freestanding ED -
NEW! Hunter's Creek ER
Opening Spring 2014!

Poinciana Hospital

Orlando, FL
35K annual visits

West Florida Hospital

Pensacola, FL
51K annual visits

Doctor's Hospital

Sarasota, FL
23K annual visits
Medical Director

FL Hospital Heartland System

Sebring, FL
3 Hospital System
11-25K annual visits

Northside Hospital

St. Petersburg, FL
31K annual visits
Medical Director

Capital Regional

Tallahassee, FL; 65K annual visits
Affiliated Freestanding ED -
Gadsden Memorial Campus
Quincy, FL; 15K annual visits

Bayfront Health

Tampa Bay, FL
2 campus system
26K-30K annual visits

Bayonet Point

Tampa Bay, FL
36K annual visits, Level II Trauma

Brandon Regional

Tampa Bay, FL
106K annual visits
Second campus in Plant City -
Estimated 15K visits in year one

Medical Center of Trinity

Tampa Bay, FL
50K annual visits

Cartersville Med Ctr

Cartersville, GA
48K annual visits

Fairview Park

Dublin, GA
36K annual visits

Mayo Clinic Health System

Waycross, GA
50K annual visits

Hutchinson Reg Med Ctr

Hutchinson, KS
23K annual visits
Medical Director

Wesley Medical Center

Wichita, KS
65K annual visits, Level I Trauma
Affiliated Freestanding ED -
Wesley West ER
18K annual visits

Frankfort Regional

Frankfort, KY
34K annual visits

Greenview Regional

Bowling Green, KY
32K annual visits

NEW! Christus St. Patrick

Lake Charles, LA
25K annual visits

NEW! New Orleans East

New Orleans, LA; Brand new facility
currently under construction.
Estimated 15K visits in year one
Medical Director

Golden Valley

Clinton, MO
13K annual visits

Albemarle Hospital

Elizabeth City, NC
47K annual visits

McLeod Dillon/Loris/Seacoast

Dillon and Myrtle Beach area, SC
23-30K annual visits
Medical Director (Loris)

Centennial Medical Center

Nashville, TN
32K annual visits
Second campus in Ashland City -
10K annual visits

TriStar ER Portland

Nashville, TN
Freestanding ED affiliated with
TriStar Hendersonville.
Brand new! Opened Jan. 2014.

University Med Ctr

Nashville, TN
30K annual visits

NEW! Christus St. Elizabeth

Beaumont, TX
50K annual visits
Medical Director

Valley Regional

Brownsville, TX
33K annual visits
Medical Director

Bayshore Med Ctr

Houston, TX
46K annual visits
Affiliated Freestanding ED -
NEW! HealthOne Fairmont
19K visits/yr.
Medical Director

NEW! Christus Jasper

Jasper, TX
23K annual visits

NEW! Christus St. Mary

Port Arthur, TX
27K annual visits

NEW! Metro. Methodist

San Antonio, TX
47K annual visits
Second campus -
Methodist Texsan
7K annual visits
Medical Director

LewisGale Health System

Roanoke/Blacksburg area, VA
13-41K annual visits
Medical Director (Montgomery & Alleghany)

Spotsylvania Reg Med Ctr

Fredericksburg, VA
37K annual visits

Henrico Doctors' Hospital

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Ohio - Columbus

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OHIO - Dayton

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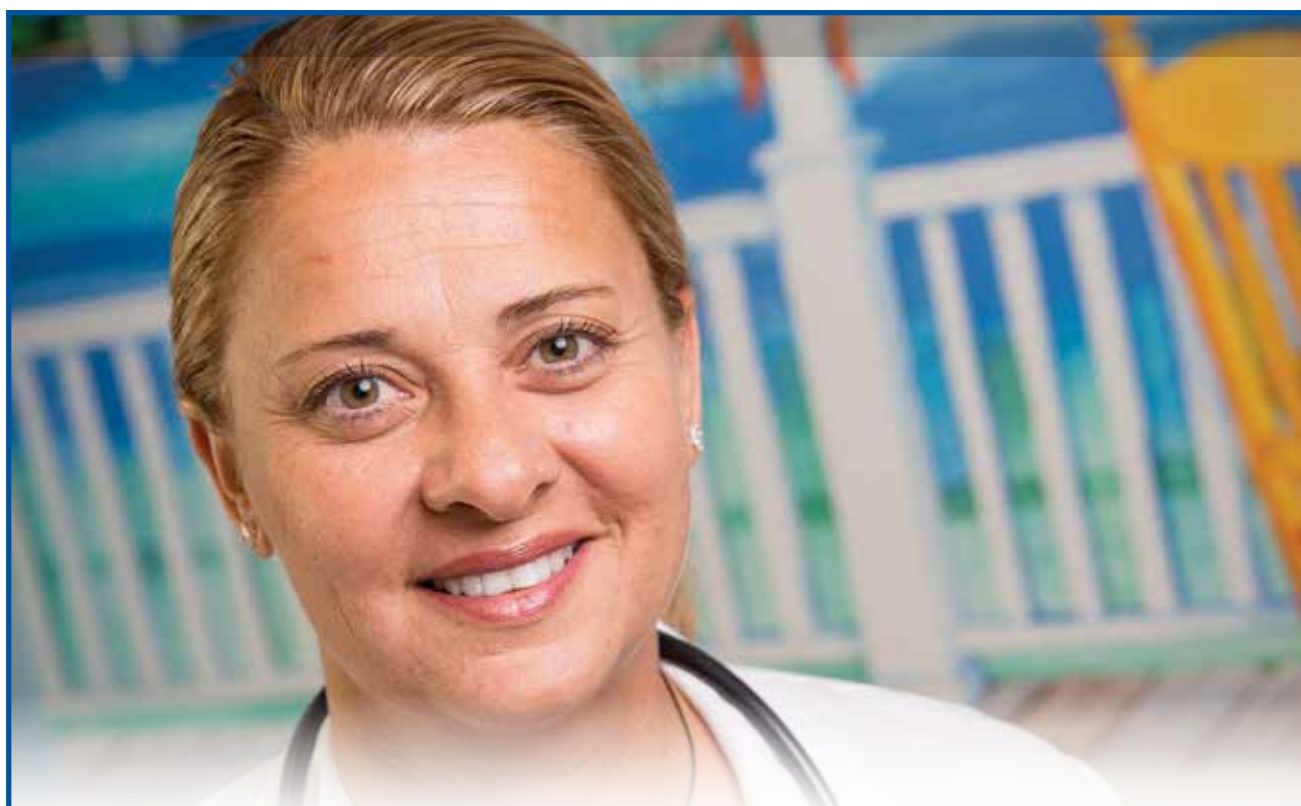
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