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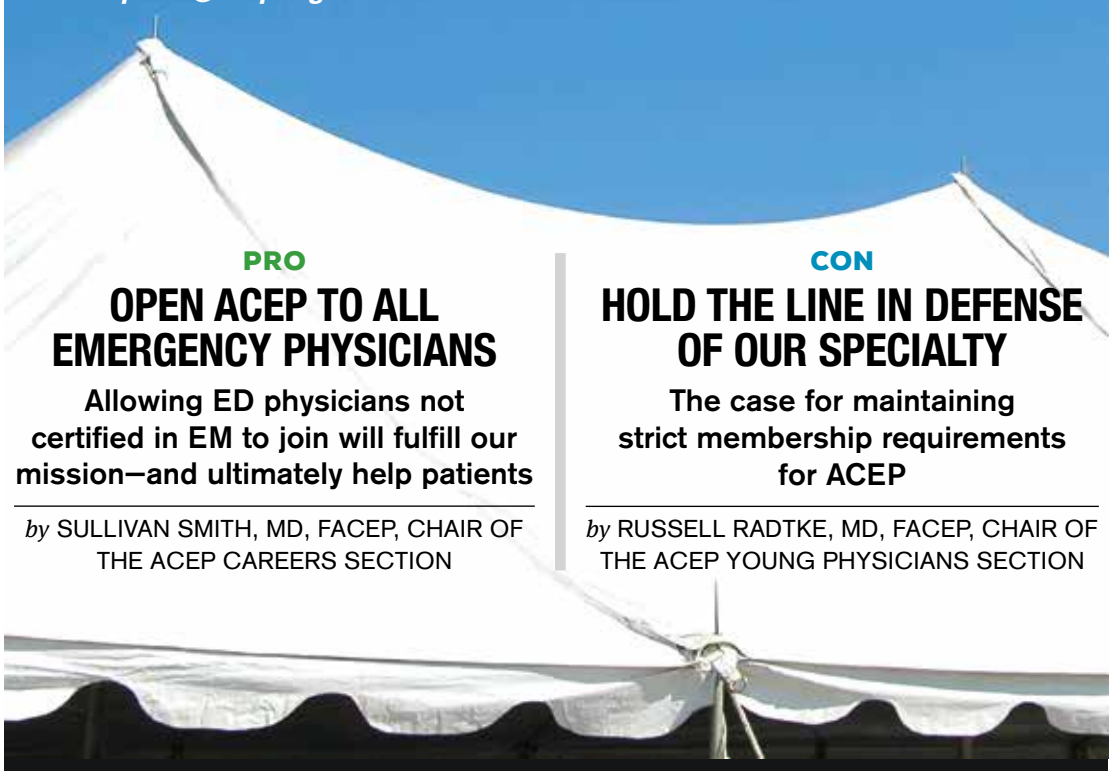
The Big Tent *of* Emergency Medicine

ACEP is facing a choice in how we will define ourselves and who we will count as members in the future. Should we open the tent of emergency medicine to those physicians who work by our side in the ED but are not EM certified? Or should we save our tent for those who have dedicated time and effort to EM certification and maintain the current membership policies? Two ACEP members share their opinions on the issue. What do you think? ***Send your comments to acepnow@acep.org.***



PRO

OPEN ACEP TO ALL EMERGENCY PHYSICIANS

Allowing ED physicians not certified in EM to join will fulfill our mission—and ultimately help patients

by SULLIVAN SMITH, MD, FACEP, CHAIR OF THE ACEP CAREERS SECTION

CON

HOLD THE LINE IN DEFENSE OF OUR SPECIALTY

The case for maintaining strict membership requirements for ACEP

by RUSSELL RADTKE, MD, FACEP, CHAIR OF THE ACEP YOUNG PHYSICIANS SECTION

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A TICK AWAY FROM DEATH

CDC partners with ACEP to disseminate info about disseminated Lyme: critical update on Lyme carditis

by JOSEPH D. FORRESTER, MD, MSC

Disclaimer: *The findings and conclusions in this report are those of the author and do not necessarily represent the official position of the Centers for Disease Control and Prevention. Case-patient details have been changed to protect confidentiality.*

The Case

On a late-summer afternoon, an otherwise healthy 32-year-old woman presented to an urgent care facility in New York complaining of episodic shortness of breath for the past week. She became quite anxious when these episodes occurred but couldn't identify any precipitating activities or events. The patient reported vacationing in the Northeast during the previous two weeks and had frequented woody areas where she was exposed to ticks. She denied

CONTINUED *on page 12*

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PERIODICAL

Welcome to the Hot Seat

BODY LANGUAGE TIPS FOR THE EMERGENCY PHYSICIAN ABOUT TO TESTIFY

by PATTI WOOD MA, CSP, AND DOUGLAS SEGAN MD, JD, FACEP

SEE PAGE 19

SIEMENS

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THE BREAK ROOM

Don't Underestimate the Physician Exam

I am writing in response to the article "The Death of the Physical Exam" by Shari Welch, MD, FACEP (Feb. 2014). I note, with dismay, the continued justification for the present-day lowering of the standard of care expected of physicians. The physical exam is required to assist in diagnosis and not because it is needed for full reimbursement. I will not defend the yearly physical exam as an effective screening test. In the emergency department, the focused physical exam is necessary for the experienced practitioner to use this skill and the patient's history to render unnecessary many laboratory tests.

The suggestion that the vaginal exam in someone with first-trimester bleeding lacks value is a good example of the disturbing trend to no longer emphasize physical diagnosis in some medical schools. The vaginal exam may show an abortion in progress, a bleeding endocervical polyp, a septic abortion, or an incompetent cervix. A normal exam (with the history of vaginal bleeding) might suggest a bloody cystitis or unsuspected bleeding from the rectum. Those who "could make it through their shift without a stethoscope" have not been trained properly, and Laennec and Auenbrugger would roll over in the graves, as would Osler.

Physicians without stethoscopes will not hear the rales of heart failure or the gallop rhythm, or feel the palpable thyroid and hear the irregular rhythm in the patient complaining of weakness. The contention that the urinalysis is superior to the physical exam is poor thinking: the history, physical exam, and urinalysis are complementary. When there is no fever and no costovertebral angle tenderness, pyelonephritis is less likely, and it points to the lower urinary tract. However, when abdominal tenderness is found, one may be looking at a gynecological infection soiling the urine or an inflamed appendix resting on the bladder causing white cells to be present in the urine. The Advanced Trauma Life Support course has eliminated the digital rectal exam from the pelvic protocol because the floating prostate or the prostatic hematoma will rarely be the main clue to a pelvic fracture or a transected urethra. The yield was almost zero!

The focused physical exam gives assurance to both the physician and patient. It is critical and should justify the laboratory test that is ordered. It has not, indeed, gone the way of the dinosaur.

—Orzie Henderson, MD, FACEP
Saline, Michigan

NEWS FROM THE COLLEGE

Section of Medical Humanities Writing and Visual Arts Awards Deadline Sept. 1

The Section of Medical Humanities is soliciting submissions for its eighth annual Writing Award. Eligible pieces are creative works published in print or online between November 2013 and August 2014. Blog entries are only eligible if reconfigured and submitted as an independently publishable piece of creative writing. Self-nominations or nominations of someone else's writing are both welcome. Limit two pieces per person.

The Section of Medical Humanities is also soliciting submissions for its second annual Visual Arts Award. This is an opportunity for artists to show off their paintings, photography, etc. Submit a digital image or file of the visual art (photograph, sculpture, textile, pottery, painting, etc.). Limit two pieces per person.

Submissions for both awards are accepted

from any member of ACEP. Submissions will be voted on by the members of the Section of Medical Humanities.

Nominations should be e-mailed to Tracy Napper (tnapper@acep.org) before September 1, 2014. Submissions will be blinded before being sent to the judging panel.

The winning pieces will be announced at ACEP14 in Chicago.

New Jersey Doctor Named Distinguished ED Director

For his work at Capital Health in New Jersey, William Dalsey, MD, FACEP, was named 2014 Distinguished Emergency Department Director. Blue Jay Consulting, the Emergency Medicine Foundation, and ACEP give the award each year to an outstanding emergency department director who demonstrates collaborative efforts to improve health care.

Dr. Dalsey helped make drastic improvements to the emergency departments at Capital Health's three sites, which include an urban emergency room with a Level II trauma center, psychiatric evaluation service, and neurological emergency room.

Dr. Dalsey also has been a strong advocate for improving throughput. He has set the expectations for patient care and throughput at every aspect of the patient encounter.

One of the team's first tasks was to reduce the left-without-treatment and left-without-being-seen rates at the urban hospital, which were hovering at 9 percent. Working with the nursing staff, they trialed a split-flow triage process for two weeks with some success. After further discussion and reviewing other options, a decision was made to implement a "pull to full" strategy.

In the last quarter of 2013, the combined rate was down to 3.8 percent. In December 2013 and January 2014, the combined rate was 2.5 percent.

Dr. Dalsey also has been a strong advocate for improving throughput. He has set the expectations for patient care and throughput at every aspect of the patient encounter, including door-to-provider time and outpatient turnaround times. Prior to his arrival, door-to-provider had a median time of 48 minutes at the urban hospital and 27 minutes at the suburban hospital. As a result of setting expectations and focused strategies, fourth-quarter times were 24 minutes at the urban hospital and 15 minutes at the suburban location. In their nomination letters, colleagues remarked that all of these accomplishments came within six months of Dr. Dalsey's arrival in July 2013.

Dr. Dalsey attended the Medical College of Pennsylvania in Philadelphia and completed his residency in emergency medicine at the University of Cincinnati in 1984.

HOT OFF THE PRESSES

MNACEP Helps Preserve Reimbursement for Auto Accident Health Care Providers

by SHARI AUGUSTIN

Minnesota is a "no-fault" auto insurance state, providing that auto insurance policies include first-dollar medical coverage, up to $20,000, for an individual injured in a motor vehicle accident. No-fault auto coverage serves as critical reimbursement for auto-related EMS response and trauma care services. Alerted by billers of a new trend in which law firms were interfering in the reimbursement of medical claims, Minnesota Chapter ACEP (MNACEP) worked to pass an amendment in the final hours of the legislative session to fix the emerging issue. A growing number of law firms, encouraged by seminars advising on the practice, had begun to issue liens and notices of representation to auto insurance carriers in order to intercept the medical claim reimbursement to the provider for treatment provided to an accident victim. This was done prior to any legitimate arbitration decision or denial.

Most often, EMS and trauma providers would learn of the interception of the payment upon receipt of an explanation of benefits (EOB) from the insurance company showing the claim as paid. However, rather than reimburse the provider for services rendered, the insurer redirected payment to the lawyer due to a notice to the insurer of a lien or certificate of representation. The law firm might make reduced payments to providers out of the $20,000 benefit or, in some cases, suggest providers treat the bill as charity care or bill the claim to the injured patient's health insurance, despite an EOB clearly showing payment of the medical claim.

Approached about the issue, the trial attorneys' association, Minnesota Association for Justice, and insurance industry representatives denounced the practice and joined MNACEP in the pursuit of a legislative solution. The bill, signed by Governor Dayton on May 21, 2014, clearly states that firms are prohibited from placing liens on no-fault awards to providers if an insurer had not denied the no fault claim. This represents preserving millions of dollars in first-dollar coverage for the health care provider and EMS community.

—Ms. Augustin is the Minnesota ACEP executive director.

BRIEF SUMMARY

ADASUVE® (loxapine) inhalation powder, for oral inhalation use

The following is a brief summary only; see full prescribing information, included Boxed Warnings for complete product information.

WARNING: BRONCHOSPASM and INCREASED MORTALITY IN ELDERLY PATIENTS WITH DEMENTIA-RELATED PSYCHOSIS

Bronchospasm

ADASUVE can cause bronchospasm that has the potential to lead to respiratory distress and respiratory arrest. Administer ADASUVE only in an enrolled healthcare facility that has immediate access on-site to equipment and personnel trained to manage acute bronchospasm, including advanced airway management (intubation and mechanical ventilation) *[see Warnings and Precautions (5.1, 5.2)]*. Prior to administering ADASUVE, screen patients regarding a current diagnosis, history, or symptoms of asthma, COPD and other lung diseases, and examine (including chest auscultation) patients for respiratory signs. Monitor for signs and symptoms of bronchospasm following treatment with ADASUVE *[see Dosage and Administration (2.2, 2.4) and Contraindications (4)]*.

Because of the risk of bronchospasm, ADASUVE is available only through a restricted program under a Risk Evaluation and Mitigation Strategy (REMS) called the ADASUVE REMS *[see Warnings and Precautions (5.2)]*.

Increased Mortality in Elderly Patients with Dementia-Related Psychosis

Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death. ADASUVE is not approved for the treatment of patients with dementia-related psychosis *[see Warnings and Precautions (5.3)]*.

1 INDICATIONS AND USAGE

ADASUVE is a typical antipsychotic indicated for the acute treatment of agitation associated with schizophrenia or bipolar I disorder in adults.

"Psychomotor agitation" is defined in DSM-IV as "excessive motor activity associated with a feeling of inner tension." Patients experiencing agitation often manifest behaviors that interfere with their care (e.g., threatening behaviors, escalating or urgently distressing behavior, self-exhausting behavior), leading clinicians to the use of rapidly absorbed antipsychotic medications to achieve immediate control of the agitation *[see Clinical Studies (14)]*. The efficacy of ADASUVE was established in one study of acute agitation in patients with schizophrenia and one study of acute agitation in patients with bipolar I disorder *[see Clinical Studies (14)]*.

Limitations of Use:

As part of the ADASUVE REMS Program to mitigate the risk of bronchospasm, ADASUVE must be administered only in an enrolled healthcare facility *[see Warnings and Precautions (5.2)]*.

4 CONTRAINDICATIONS

ADASUVE is contraindicated in patients with the following:

- Current diagnosis or history of asthma, COPD, or other lung disease associated with bronchospasm *[see Warnings and Precautions (5.1)]*
- Acute respiratory symptoms or signs (e.g., wheezing) *[see Warnings and Precautions (5.1)]*
- Current use of medications to treat airways disease, such as asthma or COPD *[see Warnings and Precautions (5.1)]*
- History of bronchospasm following ADASUVE treatment *[see Warnings and Precautions (5.1)]*
- Known hypersensitivity to loxapine or amoxapine. Serious skin reactions have occurred with oral loxapine and amoxapine.

5 WARNINGS AND PRECAUTIONS

5.1 Bronchospasm

ADASUVE can cause bronchospasm that has the potential to lead to respiratory distress and respiratory arrest *[see Adverse Reactions (6.1)]*. Administer ADASUVE only in an enrolled healthcare facility that has immediate access on-site to equipment and personnel trained to manage acute bronchospasm, including advanced airway management (intubation and mechanical ventilation) *[see Boxed Warning and Warnings and Precautions (5.2)]*.

Prior to administering ADASUVE, screen patients regarding a current diagnosis or history of asthma, COPD, and other lung disease associated with bronchospasm, acute respiratory symptoms or signs, current use of medications to treat airways disease, such as asthma or COPD; and examine patients (including chest auscultation) for respiratory abnormalities (e.g., wheezing) *[See Dosage and Administration (2.2) and Contraindications (4)]*. Monitor patients for symptoms and signs of bronchospasm (i.e., vital signs and chest auscultation) at least every 15 minutes for a minimum of one hour following treatment with ADASUVE *[see Dosage and Administration (2.4)]*. ADASUVE can cause sedation, which can mask the symptoms of bronchospasm.

Because clinical trials in patients with asthma or COPD demonstrated that the degree of bronchospasm, as indicated by changes in forced expiratory volume in 1 second (FEV1), was greater following a second dose of ADASUVE, limit ADASUVE use to a single dose within a 24 hour period.

Advise all patients of the risk of bronchospasm. Advise them to inform the healthcare professional if they develop any breathing problems such as wheezing, shortness of breath, chest tightness, or cough following treatment with ADASUVE.

5.2 ADASUVE REMS to Mitigate Bronchospasm

Because of the risk of bronchospasm, ADASUVE is available only through a restricted program under a REMS called the ADASUVE REMS. *[see Boxed Warning and Warnings and Precautions (5.1)]* Required components of the ADASUVE REMS are:

- Healthcare facilities that dispense and administer ADASUVE must be enrolled and comply with the REMS requirements. Certified healthcare facilities must have on-site access to equipment and personnel trained to provide advance airway management, including intubation and mechanical ventilation.
- Wholesalers and distributors that distribute ADASUVE must enroll in the program and distribute only to enrolled healthcare facilities.

Further information is available at www.adasuverems.com or 1-855-755-0492.

5.3 Increased Mortality in Elderly Patients with Dementia-Related Psychosis

Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at increased risk of death. Analyses of 17 placebo-controlled trials (modal duration of 10 weeks), largely in patients taking atypical antipsychotic drugs, revealed a risk of death in drug-treated patients of 1.6 to 1.7 times the risk of death in placebo-treated patients. Over the course of a typical 10-week controlled trial, the rate of death in drug-treated patients was about 4.5%, compared to a rate of about 2.6% in the placebo group. Although the cases of death were varied, most of the deaths appeared to be either cardiovascular (e.g., heart failure, sudden death) or infectious (e.g., pneumonia) in nature. Observational studies suggest that, similar to atypical antipsychotic drugs, treatment with conventional antipsychotic drugs may increase mortality. The extent to which the findings of increased mortality in observational studies can be attributed to the antipsychotic drug as opposed to some characteristic(s) of the patients is not clear. ADASUVE is not approved for the treatment of elderly patients with dementia-related psychosis *[see Boxed Warning]*.

5.4 Neuroleptic Malignant Syndrome

Antipsychotic drugs can cause a potentially fatal symptom complex termed Neuroleptic Malignant Syndrome (NMS). Clinical manifestations of NMS include hyperpyrexia, muscle rigidity, altered mental status, and autonomic instability (irregular pulse or blood pressure, tachycardia, diaphoresis, and cardiac dysrhythmia). Associated features can include elevated serum creatine phosphokinase (CPK) concentration, rhabdomyolysis, elevated serum and urine myoglobin concentration, and renal failure. NMS did not occur in the ADASUVE clinical program.

The diagnostic evaluation of patients with this syndrome is complicated. It is important to consider the presence of other serious medical conditions (e.g., pneumonia, systemic infection, heat stroke, primary CNS pathology, central anticholinergic toxicity, extrapyramidal symptoms, or drug fever).

The management of NMS should include: 1) immediate discontinuation of antipsychotic drugs and other drugs that may contribute to the underlying disorder, 2) intensive symptomatic treatment and medical monitoring, and 3) treatment of any concomitant serious medical problems. There is no general agreement about specific pharmacological treatment regimens for NMS.

If a patient requires antipsychotic drug treatment after recovery from NMS, the potential reintroduction of drug therapy should be carefully considered. The patient should be carefully monitored, since recurrences of NMS have been reported.

5.5 Hypotension and Syncope

ADASUVE can cause hypotension, orthostatic hypotension, and syncope. Use ADASUVE with caution in patients with known cardiovascular disease (history of myocardial infarction or ischemic heart disease, heart failure or conduction abnormalities), cerebrovascular disease, or conditions that would predispose patients to hypotension (dehydration, hypovolemia, or treatment with antihypertensive medications or other drugs that affect blood pressure or reduce heart rate).

In the presence of severe hypotension requiring vasopressor therapy, the preferred drugs may be norepinephrine or phenylephrine. Epinephrine should not be used, because beta stimulation may worsen hypotension in the setting of ADASUVE-induced partial alpha blockade.

In short-term (24-hour) placebo-controlled trials of patients with agitation associated with schizophrenia or bipolar I disorder, hypotension occurred in 0.4% and 0.8% in the ADASUVE 10 mg and placebo groups, respectively. There were no cases of orthostatic hypotension, postural symptoms,

OPINIONS FROM EMERGENCY MEDICINE

A NEW SPIN

Enthusiasm for Patient Satisfaction Scores Is Unjustified

by JOSHUA J. FENTON, MD, MPH, AND ANDREW N. FENTON, MD, FACEP

Jay Kaplan MD, FACEP, recently argued in *ACEP Now* (April 2014) that emergency physicians should embrace patient experience metrics because patient satisfaction has been linked to patient adherence to evidence-based recommendations and improved clinical outcomes. However, Dr. Kaplan was selective in his review of the literature and, at times, erroneous. We believe that emergency physicians have legitimate concerns about the potential misuse of patient experience metrics and that Dr. Kaplan's enthusiasm is unjustified.

Dr. Kaplan concluded that the literature overwhelmingly supports a causal connection between patient satisfaction and clinical care quality, citing a 2013 *BMJ Open* review.[1] However, this review included studies utilizing sophisticated patient communication measures bearing little resemblance to widely used patient experience metrics. Key negative studies were excluded from the review, including a Dartmouth Atlas analysis that found no consistent relationship between satisfaction and clinical care quality.[2]

Indeed, the Dartmouth Atlas study is consistent with other studies of the relationship between patient satisfaction and technical health care quality.[3] While some literature supports an association between patient satisfaction and adherence, patient satisfaction

CONTINUED *on page 8*

presyncope or syncope. A systolic blood pressure ≤ 90 mm Hg with a decrease of ≥ 20 mm Hg occurred in 1.5% and 0.8% of the ADASUVE 10 mg and placebo groups, respectively. A diastolic blood pressure ≤ 50 mm Hg with a decrease of ≥15 mm Hg occurred in 0.8% and 0.4% of the ADASUVE 10 mg and placebo groups, respectively.
In 5 Phase 1 studies in normal volunteers, the incidence of hypotension was 3% and 0% in ADASUVE 10 mg and the placebo groups, respectively. The incidence of syncope or presyncope in normal volunteers was 2.3% and 0% in the ADASUVE and placebo groups, respectively. In normal volunteers, a systolic blood pressure ≤ 90 mm Hg with a decrease of ≥ 20 mm Hg occurred in 5.3% and 1.1% in the ADASUVE and placebo groups, respectively. A diastolic blood pressure ≤ 50 mm Hg with a decrease of ≥ 15 mm Hg occurred in 7.5% and 3.3% in the ADASUVE and placebo groups, respectively.

5.6 Seizures

ADASUVE lowers the seizure threshold. Seizures have occurred in patients treated with oral loxapine. Seizures can occur in epileptic patients even during antiepileptic drug maintenance therapy. In short term (24 hour), placebo-controlled trials of ADASUVE, there were no reports of seizures.

5.7 Potential for Cognitive and Motor Impairment

ADASUVE can impair judgment, thinking, and motor skills. In short-term, placebo-controlled trials, sedation and/or somnolence were reported in 12% and 10% in the ADASUVE and placebo groups, respectively. No patients discontinued treatment because of sedation or somnolence.
The potential for cognitive and motor impairment is increased when ADASUVE is administered concurrently with other CNS depressants *[see Drug Interactions (7.1)]*. Caution patients about operating hazardous machinery, including automobiles, until they are reasonably certain that therapy with ADASUVE does not affect them adversely.

5.8 Cerebrovascular Reactions, Including Stroke, in Elderly Patients with Dementia-Related Psychosis

In placebo-controlled trials with atypical antipsychotics in elderly patients with dementia-related psychosis, there was a higher incidence of cerebrovascular adverse reactions (stroke and transient ischemic attacks), including fatalities, compared to placebo-treated patients. ADASUVE is not approved for the treatment of patients with dementia-related psychosis *[see Boxed Warning and Warnings and Precautions (5.3)]*.

5.9 Anticholinergic Reactions Including Exacerbation of Glaucoma and Urinary Retention

ADASUVE has anticholinergic activity, and it has the potential to cause anticholinergic adverse reactions including exacerbation of glaucoma or urinary retention. The concomitant use of other anticholinergic drugs (e.g., antiparkinson drugs) with ADASUVE could have additive effects.

6 ADVERSE REACTIONS

The following adverse reactions are discussed in more detail in other sections of the labeling:

- Hypersensitivity (serious skin reactions) *[see Contraindications (4)]*
- Bronchospasm *[see Warnings and Precautions (5.1)]*
- Increased Mortality in Elderly Patients with Dementia-Related Psychosis *[see Warnings and Precautions (5.3)]*
- Neuroleptic Malignant Syndrome *[see Warnings and Precautions (5.4)]*
- Hypotension and syncope *[see Warnings and Precautions (5.5)]*
- Seizure *[see Warnings and Precautions (5.6)]*
- Potential for Cognitive and Motor Impairment *[see Warnings and Precautions (5.7)]*
- Cerebrovascular Reactions, Including Stroke, in Elderly Patients with Dementia-Related Psychosis *[see Warnings and Precautions (5.8)]*
- Anticholinergic Reactions Including Exacerbation of Glaucoma and Urinary Retention *[see Warnings and Precautions (5.9)]*

6.1 Clinical Trials Experience

Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in the clinical trials of a drug cannot be directly compared to rates in the clinical trials of another drug and may not reflect the rates observed in clinical practice.
The following findings are based on pooled data from three short-term (24-hour), randomized, double-blind, placebo-controlled clinical trials (Studies 1, 2, and 3) of ADASUVE 10 mg in the treatment of patients with acute agitation associated with schizophrenia or bipolar I disorder. In the 3 trials, 259 patients received ADASUVE 10 mg, and 263 received placebo *[see Clinical Studies (14)]*.
Commonly Observed Adverse Reactions: In the 3 trials in acute agitation, the most common adverse reactions were dysgeusia, sedation, and throat irritation. These reactions occurred at a rate of at least 2% of the ADASUVE group and at a rate greater than in the placebo group. (Refer to Table 1).

Table 1. Adverse Reactions in 3 Pooled Short-Term, Placebo-Controlled Trials (Studies 1, 2, and 3) in Patients with Schizophrenia or Bipolar Disorder

Adverse Reaction	Placebo (n = 263)	ADASUVE (n = 259)
Dysgeusia	5%	14%
Sedation	10%	12%
Throat Irritation	0%	3%

Airway Adverse Reactions in the 3 Trials in Acute Agitation
Agitated patients with Schizophrenia or Bipolar Disorder: In the 3 short-term (24-hour), placebo-controlled trials in patients with agitation associated with schizophrenia or bipolar disorder (Studies 1, 2, and 3), bronchospasm (which includes reports of wheezing, shortness of breath and cough) occurred more frequently in the ADASUVE group, compared to the placebo group: 0% (0/263) in the placebo group and 0.8% (2/259) in the ADASUVE 10 mg group. One patient with schizophrenia, without a history of pulmonary disease, had significant bronchospasm requiring rescue treatment with a bronchodilator and oxygen.
Bronchospasm and Airway Adverse Reactions in Pulmonary Safety Trials
Clinical pulmonary safety trials demonstrated that ADASUVE can cause bronchospasm as measured by FEV1, and as indicated by respiratory signs and symptoms in the trials. In addition, the trials demonstrated that patients with asthma or other pulmonary diseases, such as COPD are at increased risk of bronchospasm. The effect of ADASUVE on pulmonary function was evaluated in 3 randomized, double-blind, placebo-controlled clinical pulmonary safety trials in healthy volunteers, patients with asthma, and patients with COPD. Pulmonary function was assessed by serial FEV1 tests, and respiratory signs and symptoms were assessed. In the asthma and COPD trials, patients with respiratory symptoms or FEV1 decrease of ≥ 20% were administered rescue treatment with albuterol (metered dose inhaler or nebulizer) as required. These patients were not eligible for a second dose; however, they had continued FEV1 monitoring in the trial.
Healthy Volunteers: In the healthy volunteer crossover trial, 30 subjects received 2 doses of either ADASUVE or placebo 8 hours apart, and 2 doses of the alternate treatment at least 4 days later. The results for maximum decrease in FEV1 are presented in Table 2. No subjects in this trial developed airway related adverse reactions (cough, wheezing, chest tightness, or dyspnea).
Asthma Patients: In the asthma trial, 52 patients with mild-moderate persistent asthma (with FEV1 ≥ 60% of predicted) were randomized to treatment with 2 doses of ADASUVE 10 mg or placebo. The second dose was to be administered 10 hours after the first dose. Approximately 67% of these patients had a baseline FEV1 ≥ 80% of predicted. The remaining patients had an FEV1 60-80% of predicted. Nine patients (17%) were former smokers. As shown in Table 2 and Figure 7, there was a marked decrease in FEV1 immediately following the first dose (maximum mean decreases in FEV1 and % predicted FEV1 were 303 mL and 9.1%, respectively). Furthermore, the effect on FEV1 was greater following the second dose (maximum mean decreases in FEV1 and % predicted FEV1 were 537 mL and 14.7 %, respectively). Respiratory-related adverse reactions (bronchospasm, chest discomfort, cough, dyspnea, throat tightness, and wheezing) occurred in 54% of ADASUVE-treated patients and 12% of placebo-treated patients. There were no serious adverse events. Nine of 26 (35%) patients in the ADASUVE group, compared to one of 26 (4%) in the placebo group, did not receive a second dose of study medication, because they had a ≥ 20% decrease in FEV1 or they developed respiratory symptoms after the first dose. Rescue medication (albuterol via metered dose inhaler or nebulizer) was administered to 54% of patients in the ADASUVE group [7 patients (27%) after the first dose and 7 of the remaining 17 patients (41%) after the second dose] and 12% in the placebo group (1 patient after the first dose and 2 patients after the second dose).
COPD Patients: In the COPD trial, 53 patients with mild to severe COPD (with FEV1 ≥ 40% of predicted) were randomized to treatment with 2 doses of ADASUVE 10 mg or placebo. The second dose was to be administered 10 hours after the first dose. Approximately 57% of these patients had moderate COPD [Global Initiative for Chronic Obstructive Lung Disease (GOLD) Stage II]; 32% had severe disease (GOLD Stage III); and 11% had mild disease (GOLD Stage I). As illustrated in Table 2 there was a decrease in FEV1 soon after the first dose (maximum mean decreases in FEV1 and % predicted FEV1 were 96 mL and 3.5%, respectively), and the effect on FEV1 was greater following the second dose (maximum mean decreases in FEV1 and % predicted FEV1 were 125 mL and 4.5%, respectively). Respiratory adverse reactions occurred more frequently in the ADASUVE group (19%) than in the placebo group (11%). There were no serious adverse events. Seven of 25 (28%) patients in the ADASUVE group and 1of 27 (4%) in the placebo group did not receive a second dose of study medication because of a ≥ 20% decrease in FEV1 or the development of respiratory symptoms after the first dose. Rescue medication (albuterol via MDI or

is affected by factors frequently unmeasured in satisfaction studies. In a nationally representative sample, unadjusted positive associations between patient satisfaction and preventive care adherence were eliminated, or even reversed, with sequential adjustment for patient sociodemographics, physical and mental health status, and attitudes toward health care.[4]

Meanwhile, Dr. Kaplan criticized a study one of us published.[5] Within a nationally representative sample, the study found that patients in the highest patient satisfaction quartile (versus the lowest) had 8.8 percent greater total health expenditures, 9.1 percent greater prescription drug expenditures, and significantly higher mortality over a mean follow-up of 3.9 years. The study adjusted for patient-level covariates often not included in prior investigations, including physical and mental health status, chronic illness, and prior health care utilization. The results highlighted the need to better understand the potential link between patient satisfaction and health care utilization, including the use of health care that may, on balance, be harmful.

Dr. Kaplan stated that the study "has no legitimacy" due to three "serious methodological flaws": 1) that satisfaction was only measured in 2000 and not in later years, 2) that drug and total expenditures were only measured in 2001, and 3) that mortality was assessed in 2001–2006 and never in years when satisfaction or cost were measured. Each statement is false. Regarding the first two, relationships between patient satisfaction and utilization were studied all years from 2000 to 2008. Regarding the third, satisfaction in 2000–2005 and mortality outcomes through 2006 were assessed for the subsample initially enrolled in 2000–2005.

In our view, the evidence supports a conceptualization of satisfaction as a quality metric unrelated to technical health care quality. Technical care quality is often invisible to patients. Consider the delivery of antibiotics within six hours in patients diagnosed with pneumonia in the emergency department. Patients will likely be oblivious to this care process but will be sensitive to wait times or any noise or odors near them. They will also care about how their physicians communicate with them, and for this reason, physicians shouldn't be nihilistic about patient experience metrics.

Physicians have a responsibility to understand and address patient expectations during medical encounters, and unmet expectations are a key driver of patient satisfaction. Emergency physicians should strive to identify what patients want from their encounter and to address those expectations with empathy, tact, and respect—but there are crucial caveats. Physicians are obligated to steer patients away from tests or treatments that are either low-value or inappropriate, even if patients request them. Physicians are also obligated to deliver unwelcome news and to counsel patients about risky or self-destructive behaviors. We believe all physician duties can be carried out in a humanistic, patient-centered manner, but the primary goal of many emergency encounters is more nuanced than achieving an "excellent" patient satisfaction rating.

With the impending launch of the emergency department version of the Centers for Medicare & Medicaid Services' Consumer Assessment of Healthcare Providers and Systems survey (ED-CAHPS), we argue for a cautious approach to incentives to boost satisfaction. These metrics may be helpful in identifying physicians with communication problems. However, incentives should not dissuade physicians from professional obligations to steward resources wisely and to engage in conversations that may challenge patients at the risk of making some dissatisfied.

Incentives also should not discourage physicians from caring for subgroups that may be more difficult to satisfy (eg, Medicaid patients, patients with mental illness or chronic pain). Lack of health care access may lead to fragmented care for these subgroups and an increased reliance on emergency departments. Questions remain regarding what drives these metrics and how they relate to personal and population health, calling for a measured approach to interpreting and rewarding patient satisfaction.

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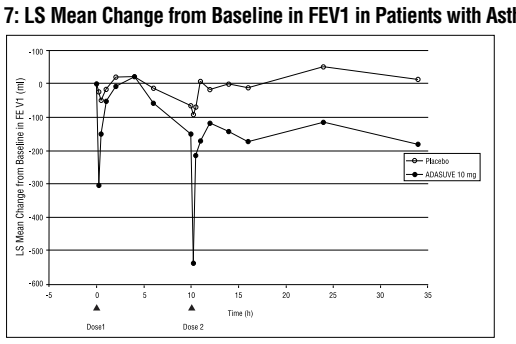
nebulizer) was administered to 23% of patients in the ADASUVE group: 8% of patients after the first dose and 21% of patients after the second dose, and to 15% of patients in the placebo group.

Table 2: Maximum Decrease in FEV1 from Baseline in the Healthy Volunteer, Asthma, and COPD Trials

		Healthy Volunteer		Asthma		COPD	
	Maximum % FEV ↓	Placebo n (%)	ADASUVE 10 mg n (%)	Placebo n (%)	ADASUVE 10 mg n (%)	Placebo n (%)	ADASUVE 10 mg n (%)
After any Dose		N=26	N=26	N=26	N=26	N=27	N=25
	≥10	7 (27)	7 (27)	3 (12)	22 (85)	18 (67)	20 (80)
	≥15	1 (4)	5 (19)	1 (4)	16 (62)	9 (33)	14 (56)
	≥20	0	1 (4)	1 (4)	11 (42)	3 (11)	10 (40)
After Dose 1		N=26	N=26	N=26	N=26	N=27	N=25
	≥10	4 (15)	5 (19)	2 (8)	16 (62)	8 (30)	16 (64)
	≥15	1 (4)	2 (8)	1 (4)	8 (31)	4 (15)	10 (40)
	≥20	0	0	1 (4)	6 (23)	2 (7)	9 (36)
After Dose 2		N=26	N=25	N=25	N=17	N=26	N=19
	≥10	5 (19)	6 (24)	3 (12)	12 (71)	15 (58)	12 (63)
	≥15	0	5 (20)	1 (4)	9 (53)	6 (23)	10 (53)
	≥20	0	1 (4)	1 (4)	5 (30)	1 (4)	5 (26)

FEV1 categories are cumulative; i.e. a subject with a maximum decrease of 21% is included in all 3 categories. Patients with a ≥ 20% decrease in FEV1 did not receive a second dose of study drug.

Figure 7: LS Mean Change from Baseline in FEV1 in Patients with Asthma



Patients with a ≥ 20% decrease in FEV1 did not receive a second dose of study drug and are not included in the curves beyond hour 10.

Extrapyramidal Symptoms (EPS): Extrapyramidal reactions have occurred during the administration of oral loxapine. In most patients, these reactions involved parkinsonian symptoms such as tremor, rigidity, and masked facies. Akathisia (motor restlessness) has also occurred.

In the 3 short-term (24-hour), placebo-controlled trials of ADASUVE in 259 patients with agitation associated with schizophrenia or bipolar disorder, extrapyramidal reactions occurred. One patient (0.4%) treated with ADASUVE developed neck dystonia and oculogyration. The incidence of akathisia was 0% and 0.4% in the placebo and ADASUVE groups, respectively.

Dystonia (Antipsychotic Class Effect): Symptoms of dystonia, prolonged abnormal contractions of muscle groups, may occur in susceptible individuals during treatment with ADASUVE. Dystonic symptoms include spasm of the neck muscles, sometimes progressing to tightness of the throat, difficulty swallowing or breathing, and/or protrusion of the tongue. Acute dystonia tends to be dose-related, but can occur at low doses, and occurs more frequently with first generation antipsychotic drugs such as ADASUVE. The risk is greater in males and younger age groups.

Cardiovascular Reactions: Tachycardia, hypotension, hypertension, orthostatic hypotension, lightheadedness, and syncope have been reported with oral administration of loxapine.

7 DRUG INTERACTIONS

7.1 CNS Depressants

ADASUVE is a central nervous system (CNS) depressant. The concurrent use of ADASUVE with other CNS depressants (e.g., alcohol, opioid analgesics, benzodiazepines, tricyclic antidepressants, general anesthetics, phenothiazines, sedative/hypnotics, muscle relaxants, and/or illicit CNS depressants) can increase the risk of respiratory depression, hypotension, profound sedation, and syncope. Therefore, consider reducing the dose of CNS depressants if used concomitantly with ADASUVE.

7.2 Anticholinergic Drugs

ADASUVE has anticholinergic activity. The concomitant use of ADASUVE and other anticholinergic drugs can increase the risk of anticholinergic adverse reactions including exacerbation of glaucoma and urinary retention.

8 USE IN SPECIFIC POPULATIONS

In general, no dose adjustment for ADASUVE is required on the basis of a patient's age, gender, race, smoking status, hepatic function, or renal function.

8.1 Pregnancy

Pregnancy Category C

Risk Summary

There are no adequate and well-controlled studies of ADASUVE use in pregnant women. Neonates exposed to antipsychotic drugs during the third trimester of pregnancy are at risk for extrapyramidal and/or withdrawal symptoms following delivery. Loxapine, the active ingredient in ADASUVE, has demonstrated increased embryofetal toxicity and death in rat fetuses and offspring exposed to doses approximately 0.5-fold the maximum recommended human dose (MRHD) on a mg/m^2 basis. ADASUVE should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Human Data

Neonates exposed to antipsychotic drugs during the third trimester of pregnancy are at risk for extrapyramidal and/or withdrawal symptoms following delivery. There have been reports of agitation, hypertonia, hypotonia, tremor, somnolence, respiratory distress, and feeding disorders in these neonates. These complications have varied in severity; in some cases symptoms have been self-limited, but in other cases neonates have required intensive care unit support and prolonged hospitalization.

Animal Data

In rats, embryofetal toxicity (increased fetal resorptions, reduced weights, and hydronephrosis with hydroureter) was observed following oral administration of loxapine during the period of organogenesis at a dose of 1 mg/kg/day. This dose is equivalent to the MRHD of 10 mg/day on a mg/m^2 basis. In addition, fetal toxicity (increased prenatal death, decreased postnatal survival, reduced fetal weights, delayed ossification, and/or distended renal pelvis with reduced or absent papillae) was observed following oral administration of loxapine from mid-pregnancy through weaning at doses of 0.6 mg/kg and higher. This dose is approximately half the MRHD of 10 mg/day on a mg/m^2 basis.

No teratogenicity was observed following oral administration of loxapine during the period of organogenesis in the rat, rabbit, or dog at doses up to 12, 60, and 10 mg/kg, respectively. These doses are approximately 12-, 120-, and 32-fold the MRHD of 10 mg/day on a mg/m^2 basis, respectively.

8.3 Nursing Mothers

It is not known whether ADASUVE is present in human milk. Loxapine and its metabolites are present in the milk of lactating dogs. Because many drugs are excreted in human milk and because of the potential for serious adverse reactions in nursing infants from ADASUVE, a decision should be made whether to discontinue nursing or discontinue ADASUVE, taking into account the importance of the drug to the mother.

8.4 Pediatric Use

The safety and effectiveness of ADASUVE in pediatric patients have not been established.

8.5 Geriatric Use

Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death *[see Boxed Warning and Warnings and Precautions (5.3)]*. ADASUVE is not approved for the treatment of dementia-related psychosis. Placebo-controlled studies of ADASUVE in patients with agitation associated with schizophrenia or bipolar disorder did not include patients over 65 years of age.

10 OVERDOSAGE

Signs and Symptoms of Overdosage

As would be expected from the pharmacologic actions of loxapine, the clinical findings may include CNS depression, unconsciousness, profound hypotension, respiratory depression, extrapyramidal symptoms, and seizure.

Management of Overdosage

For the most up to date information on the management of ADASUVE overdosage, contact a certified poison control center (1-800-222-1222 or www.poison.org). Provide supportive care including close medical supervision and monitoring. Treatment should consist of general measures employed in the management of overdosage with any drug. Consider the possibility of multiple drug overdosage. Ensure an adequate airway, oxygenation, and ventilation. Monitor cardiac rhythm and vital signs. Use supportive and symptomatic measures.

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Interview Policy for Candidates for ACEP Offices

ACEP Member Questions Campaign Policy

by LIAM YORE, MD, FACEP

ACEP is a large and diverse group of emergency care providers united around the core mission of providing the best possible care to the patients we serve. While we all share the same goals, there has rarely been unanimity in regard to the best way to accomplish them. Indeed, the spirit of emergency medicine has seemed to select the individualists and contrarians in the house of medicine. In a way, this makes sense: emergency physicians are the crazy ones who were told that there was no such thing as emergency medicine but founded the specialty anyway. We accomplish the impossible every day in the nation's resource-starved emergency departments using nothing more than duct tape and baling wire. We are members of a specialty composed of doers and visionaries; the best way to get emergency physicians to do something is to tell them it cannot be done.

Getting 30,000 fractious and energetic emergency physicians to agree on anything has always been a challenge, and it has led to some "lively" debates throughout the history of the College. Some very vivid and larger-than-life personalities have emerged as leaders of the Council over the years. Whatever the issue, there was one thing you could be sure of: emergency physicians would not shrink from the debate.

That is why it is so discordant that the ACEP Council Steering Committee has approved a policy restricting the free speech rights of candidates for leadership in the College. In this novel and unusual step, the College has prohibited any candidate for Council office—including the Board of Directors and president of the College—from granting interviews with any media other than *ACEP Now*.

The Steering Committee, in setting this rule, was presumably well-intentioned in its stated goal of creating the environment for a fair election. Regardless of the intention, the effect is exactly opposite of what the leadership should strive for: the appearance of transparency and avoidance of perceived bias.

First and foremost, this is an unconscionable prior restraint on the free speech rights of the candidates. Under this policy, candidates who wish to explain their policy opinions and vision for the future direction of the College to an independent outlet may not do so. While the College is a private organization that may make its own rules, the principle of the First Amendment demands that any restrictions on freedom of expression be narrowly crafted to serve a compelling interest. The Committee has, to date, offered only a vague and unsupported assurance that this restriction will make the election more fair.

I would argue the contrary: that the more exposure our candidates get and the more viewpoints they address and the more questions they answer, the better off the College is. We are not afraid of a robust debate—it strengthens us and better informs the Council electorate.

The perception created by this policy, however, is that the College is afraid of partaking in debate in a venue it does not control, that its candidates are unprepared to answer questions relating to College policy, and that disagreement about policy is best handled by stifling rather than engaging dissent. While nothing could be further from the truth, ACEP is ill served by promulgating a rule that fosters this impression.

Additionally, ACEP's core mission is to further the interests of all emergency care providers and our patients. Not all emergency physicians are ACEP members, and not all of them read *ACEP Now*. Restricting the ability of our future leaders to speak to independent publications reduces their ability to reach these audiences. The broader the campaigns can be, the more inclusive of all emergency physicians they are, and the more the College can further its mission and reach potential new members.

The College, in its defense of this policy, intimated that independent publications might be biased in their coverage. I have seen no evidence of this actually being the case, and none is offered by the College. If it were so, however, it is selling Councillors short by implying that they are unable to discern bias when it exists and unable to weigh and evaluate the information as presented. To the contrary, the Council may be better served by its candidates speaking to publications that have an independent editorial voice and a willingness to ask direct questions. For that matter, direct access to candidates likely will reduce any potential for bias in allowing the candidates to speak for themselves rather than requiring outside news organizations to infer candidates' positions and qualifications. The leaders of ACEP will need to take on members of Congress, FOX News, and MSNBC after they have been elected; surely as candidates they can be trusted to handle the far-friendlier confines of industry journals and newspapers.

> To the degree that there exists valid disagreement and criticisms of the manner in which ACEP is governed and in its policy decisions, the College is best served when it meets these directly and defends its positions in open debate.

To the degree that there exists valid disagreement and criticisms of the manner in which ACEP is governed and in its policy decisions, the College is best served when it meets these directly and defends its positions in open debate. This gag rule creates separation between the College and its members, creates a chilling effect on the debate, and does not move the College forward in a positive direction. I call on the ACEP Council Steering Committee to work with the Council to create a set of rules that will allow for fair elections while assuring open speech rights for the candidates. I encourage ACEP members reading this to express their opinion to the designated inbox for concerns at communications@acep.org.

DR. YORE is an emergency physician at Providence Regional Medical Center in Everett, Washington.

The Council Responds: Clarification on Campaign Rules

by KEVIN M. KLAUER, DO, EJD, FACEP

The ACEP Council Steering Committee's decision not to allow candidate interviews by emergency medicine publications outside of ACEP for the 2014 campaign demands clarification. First, and most important, I must say that the intent of the Steering Committee was altruistic and meant to ensure fairness in the campaign process for all candidates, maintaining the internal campaign process that has been in place for decades. There is not any motivation to control messaging or to inhibit members from learning more about the candidates as some have suggested. The Steering Committee is open to modifying these procedures. However, given time constraints, the Steering Committee was not prepared to endorse an outside campaign process without fully considering the implications, potential benefits, and unintended consequences. The Steering Committee addresses Council matters while the Council is not in session. However, it should not act unilaterally on matters that require broader consideration by the Council (367 Councillors representing approximately 33,000 members). The Steering Committee comprises 15 Councillors appointed by the speaker and the vice speaker. Steering the ship away from icebergs is appropriate, but setting sail for uncharted waters is not. I know we are slow to change, but that's part of the democratic process. Although being nimble and quick to action is important in some circumstances, careful consideration before action is important in others.

Perhaps visiting the history of this process will shed some necessary light on why any changes are made cautiously. The Council campaign and elections process is deeply rooted in tradition and ceremony that has been consistently conducted with little change for decades. The rules have been very restrictive, including the submission of standardized written materials, a data sheet, disclosure statement, responses to written questions, and a single campaign handout. Campaign materials, such as campaign buttons, may not be distributed at the Council meeting. Even the number of official endorsements is limited to one endorsement from a component body (chapter, section, or other voting Council entity) or a single joint endorsement from two component bodies. Interview-style questions have historically been limited to the Council Candidate Forum, which is held prior to the elections at the annual Council meeting. The rationale for these restrictions has always been to avoid pressuring College leaders and candidates into spending valuable time and financial resources to gain an edge over others with more effective campaigning.

> **Historically, no outside organizations or publications have participated in the campaign and elections process by conducting interviews or any other activities, and no such requests have ever been received.**

Historically, no outside organizations or publications have participated in the campaign and elections process by conducting interviews or any other activities, and no such

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The Big Tent *of* Emergency Medicine

PRO

OPEN ACEP TO ALL EMERGENCY PHYSICIANS

Allowing ED physicians not certified in EM to join will fulfill our mission—and ultimately help patients

by SULLIVAN SMITH, MD, FACEP, CHAIR OF THE ACEP CAREERS SECTION

Courage is what it takes to stand up and speak. Courage is also what it takes to sit down and listen.

—Sir Winston Churchill

Should ACEP reopen membership to non–emergency medicine board-certified physicians? Absolutely. Before we get started, this is not an issue of emergency medicine board certification and whether that is considered the gold standard. Rather, it is an issue about who can join ACEP, our professional organization, and whom it represents.

Why must we reopen the College? Easy—it is our mission: "ACEP promotes the highest quality of emergency care and is the leading advocate for emergency physicians, their patients, and the public."

Why must we reopen the College? Easy—it is our mission. Have you ever really considered ACEP's mission statement? Here it is: "The American College of Emergency Physicians promotes the highest quality of emergency care and is the leading advocate for emergency physicians, their patients, and the public."

Consider who this includes and what it says. "Promotes the highest quality of care." Where? Everywhere. For whom? For all emergency physicians, their patients, and the public. "Advocate for emergency physicians, their patients, and the public." The same group is addressed here. One could argue that, in order to be an emergency physician, you must be American Board of Emergency Medicine or American Osteopathic Board of Emergency Medicine certified or eligible, or members of ACEP as defined by the ACEP Board of Directors in 2011. If so, all of the patients and public who are served by the non–EM boarded physicians or physicians who aren't ACEP members are left out, according to our mission statement. That doesn't make sense. In order to fulfill our mission, we must embrace all emergency department physicians, their patients, and the public—not just a few, not some, not in certain places, not just EM board certified, but all the physicians who regularly provide emergency care, their patients, and the public.

All across America, 24-7-365, there are professional men and women who cannot join our College but saddle up anyway and go to work in their local, often small, rural EDs—places where resources are often few, payment for work is often wanting, and recruiting is, at best, difficult. If they do not answer the call, who will? Often, these are the very physicians who cannot join our College. Like it or not, these physicians are necessary to fill the gaps in staffing at the nation's emergency departments. It is the world we live in today and most likely tomorrow. These physicians, patients, and public need the full resources, advocacy, and support of ACEP. They deserve to be under the umbrella of the nation's premier emergency medicine organization, ACEP.

ACEP needs them. These physicians have unique and important perspectives.

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CON

HOLDING THE LINE IN DEFENSE OF OUR SPECIALTY

The case for maintaining strict membership requirements for ACEP

by RUSSELL RADTKE, MD, FACEP, CHAIR OF THE ACEP YOUNG PHYSICIANS SECTION

The discussion on opening up ACEP membership to non–emergency medicine boarded physicians is not a new one, but it is one that is important to continue. When considering this issue, I feel it's important to question why a non–emergency medicine boarded physician would want the ACEP affiliation in the first place. The answer is simple: the affiliation means something now more than ever.

When our specialty was in its infancy, there were no "emergency medicine" physicians. There were certainly people who worked in the emergency environment, however, who had the wisdom to recognize the need for something better. Those pioneers saw the need for specific emergency medicine training, and over time, the emergency room became the emergency department, and the specialty was born. Since that time, there has been a marked evolution of what is expected from the emergency department and of those who provide emergency care. We are now the gatekeepers to the hospital and the providers of the bulk of ambulatory care in this country. Certainly, this is a far cry from the emergency room of old.

To state that ACEP needs to incorporate non–residency-trained physicians into emergency medicine discounts the effort, knowledge, and dedication of emergency medicine–trained residents. It also sets a dangerous standard for the care of our patients.

Our founders had to "learn on the job," as new doctors in emergency department roles, without the benefit of formal emergency medicine training, are still doing the same thing. Although this is still an unfortunate reality, I do not feel it is in the best interest of the College to support this method of meeting our patients' needs by endorsing the individuals who did not train in emergency medicine. Emergency medicine training prepares us to work up complaints in a different manner. The ordering of our differential diagnosis is different. Our skill set for approaching problems is different. These differences matter—period. Just because physician shortages force us to accept non–emergency-trained physicians in emergency department roles does not mean that we should fail to recognize that emergency medicine is best practiced by emergency-trained physicians and that those who work in the emergency environment who lack our specialty training are markedly dissimilar from us. On-the-job training is no longer appropriate just as simply passing written and oral exams is insufficient to demonstrate knowledge. To state that ACEP needs to incorporate non–residency-trained physicians into emergency medicine discounts the effort, knowledge, and dedication of emergency medicine–trained residents. It also sets a dangerous standard for the care of our patients.

Non–emergency-trained physicians working in an emergency department often say, "I am an emergency physician who does the same work as you; I just don't have the residency training." Endorsing this mentality

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PRO CONTINUED

Without representation of the physicians who staff these smaller EDs, the perspective of the College shifts. It shifts to the experiences, opinions, and issues of the academic and larger centers and staffing groups. How about political advocacy? Who can better advocate for the patients and the public in rural and remote locations than those who work there? Often, these are the non–EM boarded physicians. These non–EM boarded physicians are well-known in their communities and to their political leaders. These physicians represent community opinions. They vote. They get heard!

So, why don't we just send our residency-trained emergency physicians out into these places? We don't have enough, and we won't for a long time. The studies are compelling. Review them for yourself.[1,2] You should check into the pay, the available resources, and the struggles of these physicians in these smaller EDs. Better still, come visit me in rural Tennessee. I'll be happy to show you around. Visit any number of other smaller or rural EDs in the country; speak to those emergency physicians. The stories will be pretty similar.

So what do we do to promote and advocate for these non–member-eligible physicians, their patients, and the public? We should not "let" them join? No, we shouldn't. Rather, we should "ask" them to join and participate in the College. Let's all work together to advocate for and provide the highest quality care to all emergency physicians, patients, and the public. ACEP then best fulfills its leadership role and lives up to its mission statement. All emergency physicians, patients, and the public benefit alike. It's hard to see much wrong with that. Sure, ACEP's meetings, sections, and educational resources are available to members and non-members alike. Non-members are assessed additional fees for their non-membership despite a willingness to join.

ACEP's logo represents the missing specialty within the house of medicine. Within our College, it looks like that logo could have additional meaning if ACEP limits membership to only EM board-certified physicians. The missing piece is that group of emergency physicians who cannot join. They are very real, not going away, and very much missing. Let's open the College so ACEP represents all emergency physicians, their patients, and the public. After all, it is our mission.

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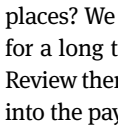

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sends the wrong message. In our department, we have physician assistants and nurse practitioners working alongside us who also do "emergency physician" work; they work under our supervision while the non–emergency medicine boarded physicians work independently. Just because I set fractures in the emergency department, deliver babies, and interpret ECGs doesn't make me an orthopedist, obstetrician, or cardiologist. Likewise, there is a distinction between being an emergency medicine physician and being a physician who practices emergency medicine.

Fortunately, we have reached a point where the medical community at large understands this distinction. Many hospitals already require emergency medicine–trained and –boarded physicians for staffing their departments, and when it comes to good jobs for our residents completing training, they are out there. Until we reach a point where there are enough emergency physicians available to fill every emergency department across the country, it is still necessary for non–emergency physicians to fill these positions in underserved areas. So why is it important that we continue to recognize the difference between "us" and "them"? And, more important, why not embrace them into our ranks?

If we allow non–emergency physicians the benefit of membership, what is it that they would hope to gain? They are already able to come to our conferences. They can receive our publications. They can publish in our journal. They already receive the benefits of our advocacy efforts even if they are not held to our standards. They will not provide a financial windfall to the College through their membership. The only reason to invite them is that we feel we need them at the table when we make decisions about the future of our specialty. I would argue, however, that we don't.

Where the line must be drawn is the final remaining benefit that affiliation with the College would bring: a seat at the table. ACEP is recognized as the voice of emergency medicine, and our advocacy efforts put us in a position to make our voice heard when policies affecting us are being made. The important thing for us now is to make sure "our" message is the one being heard. No one is better equipped to determine the needs of our specialty than we are. No one is better able to develop clinical guidelines that we should follow than us.

DR. RADTKE is chair of the ACEP Young Physicians Section and a pediatric emergency physician at St. Joeseph's Children's Hospital in Tampa, Florida.

fever, rash, muscle pain, or joint pain. Providers in the urgent care facility diagnosed the patient with anxiety and prescribed clonazepam. No electrocardiogram (ECG) was performed.

The following day, the patient collapsed and died. Serum obtained at autopsy revealed a strong serologic response to infection with *Borrelia burgdorferi* spirochetes, the causative agent of Lyme disease. Examination of decedent heart tissue revealed characteristic histopathologic findings of Lyme carditis (see Figure 1). *B. burgdorferi* sensu stricto spirochetes were seen after Warthin-Starry stain of heart tissue (see Figure 2) and confirmed by immunohistochemistry and polymerase chain reaction.

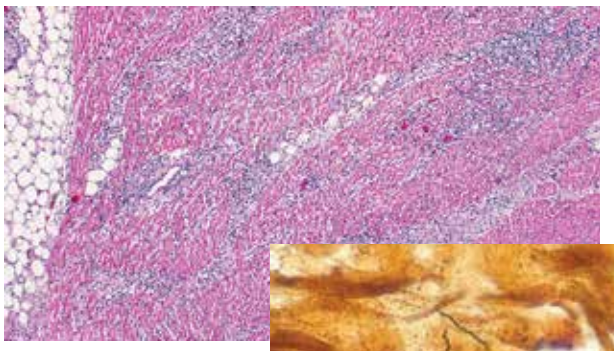

Figure 1.
ABOVE: Hematoxylin and eosin stain at 6.25x magnification of decedent heart tissue demonstrating characteristic interstitial perivascular lymphoplasmacytic pancarditis.

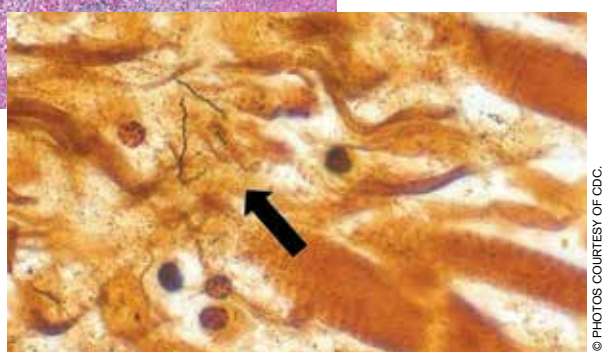

Figure 2.
BELOW: Warthin-Starry stain of decedent heart tissue at 158x magnification demonstrating Borrelia burgdorferi spirochetes (arrow).

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Discussion

On Dec. 13, 2013, the Centers for Disease Control and Prevention (CDC) published a report describing three cases of sudden cardiac death associated with Lyme carditis in otherwise healthy young adults ages 26 to 38.[1] While two of the case-patients described in the *Morbidity and Mortality Weekly Report* did not seek care before their deaths, one did but was not diagnosed with or treated for Lyme disease.

Lyme disease is a zoonotic, multisystem illness caused by the spirochete *B. burgdorferi*, which is transmitted by certain *Ixodes* spp ticks. Approximately 30,000 cases are reported to the CDC each year, primarily from high-incidence states located in the northeast (Connecticut, Delaware, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, and Vermont) and north central (Minnesota and Wisconsin) United States.[2] The actual number of annual infections is estimated to be tenfold higher; Lyme disease is the most common vectorborne disease in the United States.[3]

Acute clinical illness is usually characterized by fever and constitutional symptoms combined with a distinctive rash, erythema migrans (EM), which develops at the site of the tick bite in approximately 70 to 80 percent of patients.[4] However, without early appropriate antibiotic therapy, infection can disseminate to other tissues, causing peripheral and central neuropathy, arthritis, and carditis.

> Emergency physicians are in a unique position to recognize and diagnose Lyme disease before it progresses.

Lyme carditis, which most commonly manifests as atrioventricular (AV) conduction block, results from the host inflammatory response directed at spirochetes in cardiac tissue. Among Lyme disease case-patients reported to the CDC, approximately 1 percent had documented Lyme carditis (defined as associated second- or third-degree AV block). Although death is extremely rare, second- and third-degree AV block can progress to fatal arrhythmias if not managed and treated appropriately, underscoring the need for accurate and timely diagnosis.

Certain demographic groups appear to be at higher risk of developing Lyme carditis. Males and young adults are disproportionately affected by Lyme carditis [CDC; unpublished data]. Common symptoms of Lyme carditis include lightheadedness, palpitations, shortness of breath, chest pain, and syncope and can occur several days to six months after onset of disease (median of 21 days).[5] Patients with Lyme carditis typically present during the summer months. Notably, a history of an EM lesion is reported less frequently in patients with Lyme carditis for unknown reasons [CDC; unpublished data]. However, absence of an EM lesion should not rule out Lyme carditis in an otherwise appropriate clinical scenario, although recommended serologic evidence of Lyme disease should be obtained to ensure correct diagnosis.

Emergency health care providers should consider Lyme disease in patients with cardiac symptoms who are residents of, or have recently traveled to, regions with high incidence of Lyme disease. Additionally, emergency health care providers should investigate heart block in patients with Lyme disease if clinically indicated. Importantly, providers are advised to consider obtaining an ECG in men and young adults from, or with recent travel to, high-incidence Lyme disease areas who present with symptoms of Lyme carditis, such as chest pain, palpitations, lightheadedness, shortness of breath, and syncope, particularly during summer and fall months.

Recommended treatment algorithms for Lyme carditis have been established by the Infectious Diseases Society of America, and readers are directed there for additional therapeutic information (see Table 1).[6] Hospitalization and continuous cardiac monitoring should be considered for symptomatic patients, any patients with second- or third-degree heart block, or those with first-degree block with a prolonged PR interval (≥30 milliseconds).[6] Confirmatory laboratory evidence of infection should not delay supportive care in appropriate clinical scenarios. Recommended parenteral antibiotics should be administered during hospitalization.[6] For patients with severe heart block, a supportive temporary pacemaker may be required. The prognosis is generally excellent with appropriate antibiotic therapy. Most patients will experience resolution of symptoms and ECG abnormalities within one to six weeks, depending on the degree of initial conduction disturbance.[7,8] An oral antibiotic regimen can be used to complete a course of therapy upon hospital discharge.[6]

While Lyme carditis is an uncommon manifestation of Lyme disease, it is also one of the most serious. Emergency health care providers are in a unique position to recognize and diagnose this potentially life-threatening illness before it progresses. Additional information about the prevention, diagnosis, treatment, and epidemiology of Lyme disease can be found at www.cdc.gov/lyme.

Acknowledgements

The author would like to thank the coauthors of the *Morbidity and Mortality Weekly Report* describing this investigation:[1] Gregory Ray, MD, Thadeus Schulz, MD, Wayne Daniels, DO, Cryolife, Inc., Kennesaw, Georgia; Elizabeth R. Daly, MPH, New Hampshire Department of Health and Human Services; Thomas A. Andrew, MD, New Hampshire Office of the Chief Medical Examiner; Catherine M. Brown, DVM, Massachusetts Department of Public Health; Peter Cummings, MD, Massachusetts

Table 1. Recommended Antimicrobial Regimens for Treatment of Patients With Lyme Disease

The management options considered included oral antimicrobial therapy for patients with a single erythema migrans skin lesion and oral versus parenteral therapy for patients with clinical evidence of early disseminated infection (ie, patients presenting with multiple erythema migrans lesions, carditis, cranial nerve palsy, meningitis, or acute radiculopathy).

DRUG	DOSAGE FOR ADULTS	DOSAGE FOR CHILDREN
PREFERRED ORAL REGIMENS Amoxicillin	500 mg 3 times per day[a]	50 mg/kg per day in 3 divided doses (maximum, 500 mg per dose)[a]
Doxycycline	100 mg twice per day[b]	Not recommended for children aged <8 years For children aged ≥8 years, 4 mg/kg per day in 2 divided doses (maximum, 100 mg per dose)
Cefuroxime axetil	500 mg twice per day	30 mg/kg per day in 2 divided Doses (maximum, 500 mg per dose)
ALTERNATIVE ORAL REGIMENS Selected macrolides[c]	For recommended dosing regimens, see footnote *d* in table 3	For recommended dosing regimens, see footnote in table 3
PREFERRED PARENTERAL REGIMEN Ceftriaxone	2 g intravenously once per day	50–75 mg/kg intravenously per day in a single dose (maximum, 2 g)
ALTERNATIVE PARENTERAL REGIMENS Cefotaxime	2 g intravenously every 8 h[d]	150–200 mg/kg per day intravenously in 3–4 divided doses (maximum, 6 g per day)[d]
Penicillin G	18–24 million U per day intravenously, divided every 4 h[d]	200,000–400,000 U/kg per day divided every 4 h[d] (not to exceed 18–24 million U per day)

a Although a higher dosage given twice per day might be equally as effective, in view of the absence of data on efficacy, twice-daily administration is not recommended.
b Tetracyclines are relatively contraindicated in pregnant or lactating women and in children <8 years of age.
c Because of their lower efficacy, macrolides are reserved for patients who are unable to take or who are intolerant of tetracyclines, penicillins, andcephalosporins.
d Dosage should be reduced for patients with impaired renal function.

Reprinted with permission from *Clin Infect Dis.* 2006;43:1089-1134.

WHEN TO PROVIDE PROPHYLAXIS

For prevention of Lyme disease after a recognized tick bite, routine use of antimicrobial prophylaxis or serologic testing is not recommended. A single dose of doxycycline may be offered to adult patients (200 mg) and to children ≥8 years of age (4 mg/kg, up to a maximum dose of 200 mg) when **all** of the following circumstances exist:

A. The attached tick can be reliably identified as an adult or nymphal *I. scapularis* tick that is estimated to have been attached for ≥36 hours on the basis of the degree of engorgement of the tick with blood or on certainty about the time of exposure to the tick.

B. Prophylaxis can be started within 72 hours of the time that the tick was removed.

C. Ecologic information indicates that the local rate of infection of these ticks with B. burgdorferi is ≥20 percent.

D. Doxycycline is not contraindicated.

Source: *Clin Infect Dis.* 2006;43:1089-1134.

Office of the Chief Medical Examiner; Randall Nelson, DVM, Matthew L. Cartter, MD, Connecticut Department of Public Health; P. Bryon Backenson, MS, Jennifer L. White, MPH, Philip M. Kurpiel, MPH, Russell Rockwell, PhD, New York State Department of Health; Andrew S. Rotans, MPH, Christen Hertzog, Linda S. Squires, Dutchess County Department of Health, New York; Jeanne V. Linden, MD, Wadsworth Center, New York State Department of Health; Margaret Prial, MD, Orange County Office of the Medical Examiner, New York; Jennifer House, DVM, Pam Pontones, MA, Indiana State Department of Health; Brigid Batten, MPH, Dianna Blau, DVM, PhD, Marlene DeLeon-Carnes, Atis Muehlenbachs, MD, PhD, Jana Ritter, DVM, Jeanine Sanders, Sherif R. Zaki, MD, PhD, Division of High-Consequence Pathogens and Pathology, National Center for Emerging and Zoonotic Infectious Disease; Paul Mead, MD, Alison Hinckley, PhD, Christina Nelson, MD, Anna Perea, MSc, Martin Schriefer, PhD, Claudia Molins, PhD, Division of Vector-Borne Diseases, National Center for Emerging and Zoonotic Infectious Disease.

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DR. FORRESTER is an epidemic intelligence service officer with the CDC Division of Vector-Borne Diseases in Fort Collins, Colorado. His work involves epidemiologic investigations related to Lyme disease, plague, tickborne relapsing fever, tularemia, and other infectious diseases. He is a categorical general surgery resident at Stanford University.

THE COUNCIL RESPONDS

CONTINUED FROM PAGE 9

requests have ever been received. Thus, this would be a material and substantive change for our campaign process that the Steering Committee did not feel would be appropriate to decide without further consideration and broader input. Some may ask how this differs from other campaign rule changes. An excellent example is the removal of social media restrictions. The ACEP Council candidate campaign rules have always disallowed any use of social media for campaigning. This year, the ban was lifted, allowing unrestricted use of personal social media sites to promote candidacies. This sounds like a "material and substantive" change, doesn't it? It certainly is. However, in contrast to outside publications conducting campaign interviews, the use of social media for campaigning has been discussed for the past three years (by three different Steering Committees) and has been fully evaluated, with Council consensus supporting this change reached.

To effect meaningful change, I would respectfully request that we conduct our discussions in the most appropriate context, that of a medical specialty society's campaign process, and avoid expanding the conversation beyond what is applicable. Some have raised questions regarding First Amendment Constitutional rights, in particular freedom of expression (speech) and freedom of the press. For clarification, freedom of speech allows individuals to express themselves without constraint or interference from the federal government, while freedom of the press prohibits the federal government from interfering with the printing and/or distribution of information and/or opinions. Neither of these is impacted by our campaign rules. In addition, our candidates were not requesting to do interviews; they were being asked to grant them, and two candidates expressed concern about the process and the request, necessitating careful consideration of the concept.

The Steering Committee has discussed this at great length and has appreciated the input provided to date. If the Council and membership would like to see this process modified, we'll certainly modify it. If the Council and membership feel that ACEP's current communication tools may not be adequate for disseminating campaign information, we will consider including other innovative strategies within ACEP and in collaboration with non-ACEP organizations/publications. However, we ask for your understanding with respect to the process to make certain we make appropriate changes and that all of those are desired or necessary.

Personally, I have contacted several members and past leaders to poll their opinions and interest in changing the ACEP campaign processes. I have received many excellent suggestions, including consideration of broad reform of the process. To effect meaningful change as quickly as possible, the Steering Committee has appointed a task force of various stakeholders to evaluate the campaign process and make recommendations for change. The task force will have its recommendations finalized prior to the ACEP Council meeting in Chicago. Thank you for your interest, input, and participation in making certain the ACEP candidate campaign process meets the needs of our membership.

DR. KLAUER is speaker of the ACEP Council and chair of the Council Steering Committee.

ACEP to Build New Home

New ACEP headquarters means more member benefit

BY ALEXANDER M. ROSENAU, DO, CPE, FACEP, AND DEAN WILKERSON, JD, MBA, CAE

In 1983, when the current ACEP headquarters was built, emergency medicine was fairly new as a recognized specialty. Now, with more than 33,000 ACEP members, the needs of this dynamic, growing medical organization have greatly evolved.

Just as many aspects of emergency medicine were different 30 years ago, our building was designed for a very different organization with different staffing and space needs as well as different technological requirements. In the 21st century, ACEP needs a headquarters that better represents the specialty and meets the needs of its members and its mission.

In advance of the June meeting of the ACEP Board of Directors, the Finance Committee provided due diligence to make sure we could continue to advance and meet our financial benchmarks. The Board analyzed the options and decided that the best course of action is to buy land in Irving, Texas, near the Dallas/Fort Worth (DFW) International Airport, and build a new headquarters.

The ACEP headquarters plays an important role in the work of ACEP's Board of Directors, many committees, task forces, workgroups, and the Texas College of Emergency Physicians. Important educational trainings such as the Emergency Medicine Basic Research Skills Workshop are already held at the headquarters, and we hope these can be expanded to the Emergency Department Directors Academy, Teaching Fellowship, and other small to medium educational opportunities.

The current ACEP building is dated, requires frequent and costly maintenance, and is energy inefficient.

More important, the current space is already inadequate for staff work critical to support the growing membership and mission-critical activities of ACEP. Any future growth would make it even more challenging. There are insufficient conference rooms and workrooms, and the building lacks state-of-the-art audio/visual equipment.

Out of necessity, ACEP has begun leasing space across the street for some of its staff, which is not optimal for efficiency and collaborative work. ACEP expects to add four to five employees per year over the next five years and projects to have around 150 employees at its headquarters in about 10 years.

After discussing the subject of a new headquarters in varying degrees for more than two years, along with a substantial amount of due diligence, considerable planning and progress have been made.

ACEP commissioned a top-level space-needs analysis and found that at ACEP's current staff size, we need a building of approximately 42,527 square feet; currently we have 30,474 square feet. If staff grows by 25 percent in the next five years, we would need approximately 50,000 square feet. If we were to grow by 40 percent in 10 years, we could use a building of approximately 57,000 square feet.

After an extensive request-for-proposal process, a real estate consulting firm was selected for the project. It provided a thorough lease-versus-own analysis that concluded ownership of the headquarters is financially more favorable than leasing over a 20-year time horizon. It also conducted an exhaustive analysis of buildings for sale in the area and found no building deemed to be suitable for purchase as they were in the same outdated condition as our current location.

Several tracts of land for potential build-to-suit projects were identified, and in April 2014, the ACEP Board approved pursuing this option.

The preferred 5.8-acre tract of land is close to DFW International Airport and two miles from the current headquarters. For the convenience of our Board, committees, and members who visit, it is adjacent to a full-service hotel. It can hold a 55,000–60,000 square-foot office building with adequate parking.

The Board approved a plan to meet the total project cost of $14.5 million, with $7 million down and financing of $7.5 million. ACEP has healthy financial reserves, with a substantial portion in very low-yielding CDs and fixed-income investments. Additionally, when the current building is sold, ACEP can expect to net about $3.5 million.

Provided that the ongoing land-acquisition negotiations continue favorably, it will likely be spring 2015 before we can break ground, and it will be 18 months or more before we move in.

We believe value to our members and future members will be the result of this investment, and we anticipate more effective and efficient service for our Board, committees, and chapters. A newer, modern headquarters presents further opportunities for ACEP to reflect, develop, and disseminate our values and goals.

How ACEP Has Grown in 30 Years

	JUNE 30, 1983	JUNE 30, 2014
Total membership	11,170	33,085
Dallas full-time employees	55	111
Revenues	$5.5 million	$31,1 million*
Expenses	$4.4 million	$29.3 million*

**These revenues and expenses do not include NEMPAC or the Emergency Medicine Foundation.*

DR. ROSENAU is President of ACEP and practices emergency medicine at Lehigh Valley Health Network in Allentown and Bethlehem, Pennsylvania.

MR. WILKERSON is Executive Director of ACEP.

THEN & NOW

1

2

3

WE'VE COME A LONG WAY SINCE 1974! Here is a glimpse of the cutting edge of emergency medicine research from 40 years ago, and how these EM roots influence patient care today.

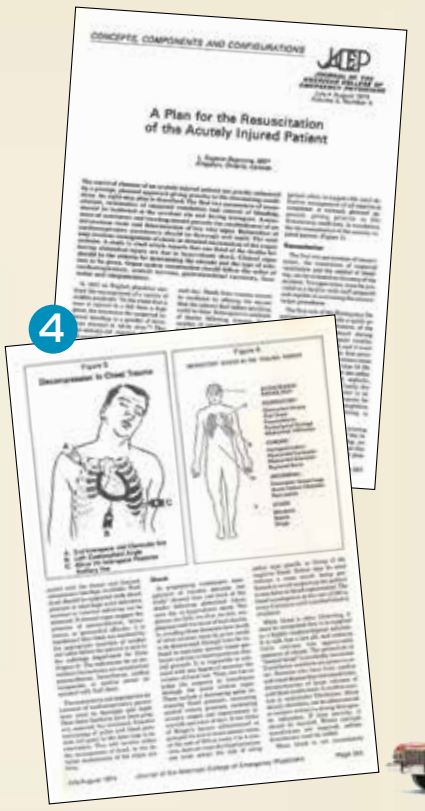
1. Cover of the *Journal of ACEP* (JACEP) August 1974.

2. Crazy! Isn't it? Well, maybe not. This 2014 article reports a low complication rate of 0 to 2 percent: Abdurehim Y, Yasin Y, Yaming Q, Hua Z. Value and efficacy of foley catheter removal of blunt pediatric esophageal foreign bodies. *ISRN Otolaryngol.* 2014;2014:679378.

3. Who is Motorola? State-of-the-art emergency medical services communication in 1974.

4. The roots and basis for trauma resuscitation today.

Compliments of Bruce Walmsley, MD, FACEP.



4

Dr. Steven Stack Named President-Elect of AMA

Emergency medicine plays a key role in the house of medicine

BY THE AMA SECTION COUNCIL ON EMERGENCY MEDICINE

On June 7, 2014, another glass ceiling was broken for emergency medicine. On that date, the AMA announced that Steven J. Stack, MD, FACEP, would be its 170th President, the first emergency physician to ever hold that position. When he assumes office in June 2015, Dr. Stack will be the youngest president in the past century and may, in fact, be the youngest president since the AMA's founding in 1847. Though just one of many accomplishments made by emergency physicians, this one has special significance, tracing back to the founding of our specialty.

EM's AMA History

Forty-five years ago, John Weigenstein, MD, one of ACEP's founders, was accepted as the first emergency physician to represent ACEP in the AMA House of Delegates (HOD). At that time, he was most likely the only physician in the AMA HOD practicing full-time in an emergency department and his early representation in that body was one of many critical first steps to the birth and formal recognition of our specialty within the house of medicine. The road was difficult and many other physicians stood in the way, but in the end, recognition within the AMA helped pave the way for our independent standing and recognition as a distinct specialty.

How the times have changed! ACEP now has five delegates in the EM Section Council of the AMA HOD. Additionally, numerous other emergency physicians serve in the AMA HOD as delegates and alternates representing their state medical associations. Many of these leaders have distinguished our specialty as presidents of their state medical associations or in service on one of the AMA's councils. Moreover, it has become common for numerous students, residents, and young physicians entering our specialty to hold leadership positions within AMA sections and in designated "lifecycle" seats on the AMA councils. From a challenged beginning, emergency medicine has clearly reached maturity and stands proudly alongside its fellow specialties.

And now, without an opposing candidate and by acclamation with a standing ovation, Dr. Stack was elected President-Elect of the AMA at the annual HOD meeting in Chicago in June. While this is a well-earned election by an outstanding physician leader who has every right to be proud of his achievement, this is also a giant step in the evolution of the specialty of EM as one of our own has risen to the pinnacle position of leadership in the big house of medicine: President of the AMA.

Bright Future for Medicine

Now is the time to capitalize on this achievement. The AMA is thriving and has enjoyed three consecutive years of increasing membership. Further, through a bold new strategic plan, the AMA has set out to catalyze audacious and necessary change to benefit patients and physicians. Just to mention a few major current AMA activities:

- In 2013, in partnership with 11 leading medical schools across the nation, the AMA launched its Accelerating Change in Medical Education initiative, an **$11 million competitive grant** endeavor designed to jump-start the complex process of creating the medical school of the future.
- The AMA is investing substantial resources to evaluate long-term paths to **physician-practice sustainability and professional satisfaction**. Through research, data, and analytics, the AMA is identifying effective care delivery and payment models to improve the quality of patient care, reduce health care costs for the nation, and increase professional satisfaction.
- In partnership with the YMCA and Johns Hopkins University (and others to come), the AMA is committing its resources, expertise, and reach to preventing heart disease and type 2 diabetes and to improving outcomes for those with these diseases. The toll of these two diseases—both in dollars and human suffering—is staggering.

Join the Efforts

In the midst of this new burst of innovation and vibrancy at AMA, however, your representatives to the AMA HOD are troubled by the paucity of emergency physicians who have chosen to help "carry the water" as members of the AMA. We are certainly thankful for the outstanding job that ACEP does representing EM interests and supporting our specialty. We do not, though, exist alone in the house of medicine, and ACEP alone is not positioned to completely represent EM's interests in Washington, D.C., and within organized medicine in general. This is where a strong EM voice within a strong and growing AMA is vital to all of us.

If you are not an AMA member, now is the time to join. If you are already a member, please make certain that you have balloted on the AMA website to designate ACEP as your representative at the AMA. ACEP's five-year membership review at the AMA is this year, and the number of delegates we get in the AMA HOD is determined by the number of AMA members we have. Sadly, at this time of so much accomplishment by our specialty and with so many challenges facing us in Washington and elsewhere, we are subject to losing one or more delegates absent an improvement in our EM membership within the AMA membership. Fewer delegates means that the future of medicine could be shaped to a greater extent by other specialties such as radiology, surgery, family practice, internal medicine, pediatrics, and many others—others that do not have the expertise of our specialty and that do not necessarily have the best interests of our specialty in mind.

With one of us about to assume the pinnacle of leadership within organized medicine, it is now time for each of us to make an additional press forward on behalf of emergency medicine by joining the AMA to ensure our voice remains strong and grows stronger still.

You can further enhance emergency medicine's AMA influence by joining the AMA now at https://commerce.ama-assn.org/membership.

OTHER HIGHLIGHTS FROM THE 2014 AMA ANNUAL MEETING

1. **Emergency physicians are serving in a number of significant leadership positions in AMA councils and sections. At this AMA Annual Meeting:**
   - Marilyn Heine, MD, FACEP, was appointed to the AMA Council on Legislation.
   - Paul Pukurdpol was elected vice speaker of the Medical Student Section Governing Council.
   - Hilary Fairbrother, MD, MPH, was elected Young Physician Section Delegate to the AMA House of Delegates.
   - Shamie Das, MD, was elected Resident/Fellow Section Governing Council Member at Large.
   - Adam Dougherty, MD, MPH, was appointed to the AMA Council on Science and Public Health.
2. **The AMA resolution 911 Good Samaritan Laws was adopted by the AMA House of Delegates.**
   - This resolution was initiated by the ACEP Council in October 2013 and called upon the AMA to support, endorse, and advocate for policies, regulations, and legislation that provide protection for callers or witnesses seeking medical help for overdose victims.
   - ACEP sought and received the co-sponsorship of this resolution by the College of American Pathologists, the American College of Radiology, and the state medical societies of Connecticut, Kentucky, and Oklahoma.
3. **Modernizing the AMA Code of Medical Ethics update:**
   - The AMA Council on Ethical and Judicial Affairs reported on its effort, initiated in 2008, to critically review and reorganize the AMA Code of Ethics.
   - Subsequent to the AMA meeting, ACEP completed and submitted its recommendations for revisions to the code that ensure the emergency medicine perspective and realities of practice are incorporated into the AMA Code of Ethics.
4. **The AMA Section Council on Emergency Medicine presented the emergency medicine perspective on a broad range of resolutions, including the areas of:**
   - Practice management
   - Reimbursement
   - Medical liability
   - Public health and safety
   - Graduate medical education
   - Health and IT improvements (pharmacies required to accept e-prescriptions, efforts to address data access between electronic health record [EHR] systems, improvements in EHR usability)
5. **The HOD reviewed dozens of AMA Board of Trustees and Council reports and hundreds of resolutions, including resolutions involving how to deal with concussions, guidelines for in-flight emergencies, troublesome Centers for Medicare & Medicaid Services rules and regulations, difficulties with implementation of ICD-10, gun violence, and climate change.**
6. **The following items related to EM were either supported or passed at the AMA meeting:**
   - Putting Price Transparency into Practice
   - Meningococcal Vaccinations for School Children
   - Support for Nutrition Label Revisions of Added Sugars
   - Policy to Define Team-Based Medical Health Care
   - Encouraging the Federal Government to Utilize Private Sector Physicians to Help Solve VA Crisis
   - Adopting a New Policies to Improve Health of Nation on Day Two of Voting at Annual Meeting
   - Adopting a Telemedicine Policy to Improve Access to Care for Patients

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What You Need to Know About POLST

Understanding POLST forms will better enable emergency physicians to verify patients' wishes for end-of-life care are being met

BY MARILYN J. HEINE, MD, FACEP, FACP

As the front line in care, emergency physicians often approach a patient in extremis or with a dramatic change in clinical condition. We may be presented with a Physician Orders for Life-Sustaining Treatment (POLST) form for a patient who has limited or no ability to communicate. Some background and cases will illustrate relevant considerations.[1]

What Is POLST?

The POLST form is part of a program to foster communication and shared decision making about goals of care at the end of life. The conversation is to occur between the patient or surrogate and a health care professional when the patient is diagnosed with a serious illness or frailty where the provider "would not be surprised if the patient died within the next year," an outcome that is difficult to predict precisely.[2,3] The health care professional documents the patient's preferences as medical orders when the POLST form is completed.

Forty-three states currently have a fully endorsed or developing POLST program that is designed along the paradigm with shared core principles and similar form design.[4] States may differ, however, in the terminology (eg, POLST, Physician Orders for Scope of Treatment [POST], Medical Orders for Life-Sustaining Treatment [MOLST], Medical Orders for Scope of Treatment [MOST]); color of the form (eg, bright pink, green, white, or copies); which health care professional is authorized to sign (eg, physician, nurse practitioner, physician assistant); whether the patient or surrogate must sign; action prompted by a blank section of the form; whether the program is delineated in statute, in regulation, or by a consensus panel; how to address a conflict between a POLST form and an advance directive; the degree of immunity; duty to comply; and the level of reciprocity with other states' POLST programs. To understand many states' specifics, visit the National POLST Paradigm's website at www.polst.org.

Details of the POLST Form

Not all POLST forms are identical. The POLST form (see Figure 1) should include the patient's name and authorized signatures of the health care provider and patient or surrogate. The top section, with a selection regarding resuscitation, applies if the patient is in cardiac arrest. The next sections usually describe goals of treatment, level of medical interventions, antibiotics, artificially administered hydration, and nutrition. The lower portion includes discussion of care goals.

A patient's POLST form should be readily accessible by caregivers and EMS to facilitate its implementation. The form should accompany the patient on transfer. In states with POLST programs, most hospitals honor the POLST form that accompanies a patient until the patient is reassessed. In an emergency where the attending physician is precluded from discussion with the patient, the orders expressed on the POLST form should be followed. Challenges include when the POLST form is unavailable, incomplete, unsigned, or with a seeming inherent contradiction (eg, DNR/full treatment, attempt cardiopulmonary resuscitation, and comfort measures only).[5,6]

How Does a POLST Form Differ From an Advance Directive?

The POLST form complements an advance directive (see Table 1). It is not necessarily a request to withhold resuscitation. In the prehospital setting, POLST expands out-of-hospital DNR orders, which only apply when the patient is in cardiopulmonary arrest.

Case 1: A 55-year-old male with aggressive lymphoma responding well to treatment is visiting from out of state. He presents to the ED with cough, fever, rigors, and dyspnea. He develops hypotension, hypoxemia, and increased respiratory distress but retains decision-making capacity. He brings his POLST form completed in his home state that states, "Do Not Attempt Resuscitation and Limited Additional Interventions (which excludes mechanical ventilation)." You discuss with him whether he would reconsider and be intubated. He consents to intubation, and you proceed accordingly.

The patient with decision-making capacity has authority to override a prior POLST order. It is essential whenever possible to pause and review with the patient or surrogate to assess if they want to change their request from what is on the POLST form. This patient's expressed decision (or, in another case, confirmation) makes moot the question of whether the form is valid outside the jurisdiction in which it was created.

Figure 1. POLST form for Pennsylvania, available at http://www.polst.org/educational_resource/pennsylvania-polst-form.


SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

pennsylvania DEPARTMENT OF HEALTH

Pennsylvania Orders for Life-Sustaining Treatment (POLST)

A CARDIOPULMONARY RESUSCITATION (CPR): Person has no pulse and is not breathing.
☐ CPR/Attempt Resuscitation ☐ DNR/Do Not Attempt Resuscitation (Allow Natural Death)

B MEDICAL INTERVENTIONS: Person has pulse and/or is breathing.
☐ COMFORT MEASURES ONLY
☐ LIMITED ADDITIONAL INTERVENTIONS
☐ FULL TREATMENT
Additional Orders:

C ANTIBIOTICS
Additional Orders

D ARTIFICIALLY ADMINISTERED HYDRATION / NUTRITION
Additional Orders

E SUMMARY OF GOALS, MEDICAL CONDITION AND SIGNATURES:
Discussed with: ☐ Patient ☐ Parent of Minor ☐ Health Care Agent ☐ Health Care Representative ☐ Court-Appointed Guardian ☐ Other
Patient Goals/Medical Condition:
By signing this form, I acknowledge that this request regarding resuscitative measures is consistent with the known desires of, and in the best interest of, the individual who is the subject of the form.

Table 1. Comparison of Advance Directives and POLST

	ADVANCE DIRECTIVES	POLST FORMS
Applicable population	All adults	Adults with advanced illness or frailty
Time frame of care	Future care or condition	Current care and condition
Where completed	Any setting	Medical setting
Product	Legal document by patient, surrogate appointment, statement of preferences	Medical order by health care professional based on decision making shared with patient
Surrogate role	Cannot complete	Can consent if patient lacks decision-making capacity
Responsible for portability	Patient, family	Health care provider
Periodic review by	Patient, family	Health care provider
Document interpretation	Required	More clearly defined

Case 2: An 82-year-old female with a history of congestive heart failure presents with new onset confusion and a headache. CT shows a large intracerebral hemorrhage, which causes her to lose her decision-making capacity and from which she is not expected to recover. She is accompanied by her health care surrogate and a POLST form that indicates the patient wants CPR. The surrogate points to a notation that the form was completed when the patient had hoped to attend her great-granddaughter's wedding, which has now already occurred. The POLST form is revised to reflect the new health condition and advise DNR, comfort measures only, and she receives palliative care.

This highlights the surrogate's instrumental role in ensuring the goals of the patient are implemented. While there may be instances where the view of the surrogate and the intent of the patient differ, each state can establish safeguards to help ensure that the surrogate carries out the patient's wishes. Such steps may require that a surrogate consult with the treating physician before authorizing a change to the patient's POLST form, that the patient's advance directive is reviewed, that good-faith efforts are made to act consistently with the patient's known wishes, and that the reason for a change in the patient's POLST is carefully documented.

Do we have legal protection? Emergency physicians are generally reassured by statutory immunity associated with a state's laws on advance directives and surrogates. In states without a similar level of explicit immunity from criminal prosecution, civil liability, and disciplinary sanctions when POLST orders are followed in good faith, the liability climate may influence the acceptance of POLST orders.[7] It is important to familiarize yourself with the protections in your state.

As POLST programs become more established in communities, emergency physicians are increasingly likely to care for patients with POLST forms. Better understanding of these programs may enhance the end-of-life care we provide.

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RUNNING THE GAUNTLET

Emergency physicians sign on for challenge and camaraderie of extreme obstacle races

BY GRETCHEN HENKEL

"The greater the obstacle the more glory in overcoming it." – Molière

On May 17, emergency physician Sudip Bose, MD, FACEP, FAAEM, along with three nurses and two other physicians from his emergency department at Medical Center Hospital in Odessa, Texas, each paid a $190 entry fee to spend the day slogging across muddy streams, crawling in mud under barbed wire, running up 40-degree inclines, and jumping over fire pits, among other barriers, in a nine-mile endurance race. The occasion was the Spartan Super in Austin, Texas. For Dr. Bose, who was a state-ranked mile runner in high school and won physical fitness awards during his military service, the race was an "all-around fitness event and a great way to build camaraderie within our department." He also pointed out that the ailments he treats as an emergency physician bring home the importance of staying fit and healthy.

Dr. Bose and his team are part of a growing trend of Americans incorporating obstacle races into their fitness goals. According to the *Los Angeles Times*, such events have become more popular than marathons, with an estimated 1.6 million participants in 2013 who signed on to test their physical and mental stamina. While major events such as Tough Mudder, the Warrior Dash, the Spartan races, and the Volkslauf (with the motto "Pain Is Good") offer different course and obstacle configurations, they share common themes of physical and mental challenge and often emulate the military training model.

Events such as Tough Mudder's Boa Constrictor, where racers crawl through a series of pipes, and Electroshock Therapy, where participants run through an obstacle field hung with electrified wires, are designed to elicit a maximum fear factor. The Artic Enema, for example, entails jumping into frigid water and swimming under a wooden plank before pulling oneself out of the water.

Howard Mell, MD, MPH, chair of ACEP's EMS Section, pointed out that such events are actually "haunted-house scary" and that obstacle races pose no greater risk to participants than do more standard marathons. "These types of obstacle courses have been done for years in the military and by SWAT teams as they prepare for what they do," he noted. "[These events] are for 'weekend warriors' doing the same. There will be broken bones, bruises, cuts, and scrapes, and there are going to be a couple of people who give themselves angina because they're just not in the condition to do these things. But the same can be said of a marathon."

© PHOTOS COURTESY OF THE REEBOK SPARTAN RACE

Above: Dr. Bose crawls through the mud to get under a barbed wire obstacle in the Spartian Super. Right: Dr. Bose and colleagues jump over fire.

In fact, fatal injuries sustained during obstacle races are rare. There have been two reported deaths: a man who drowned after jumping into ice-cold muddy water at a Tough Mudder event and a cardiac event sustained by a rescue worker at another. However, some physicians have questioned the safety of these extreme racing events. In a published case series of Tough Mudder participants treated at the Lehigh Valley Hospital in Allentown, Pennsylvania, the authors summarized participants' diverse injuries requiring transport to the emergency department. The injuries ranged from moderate dehydration to contusions and dislocations to near syncope and electrical injuries.[1] Although the injuries were not excessive compared with other endurance competitions or military training exercises, the authors did "strongly encourage" participants to obtain sign-off from their physicians before enrolling in such competitions.

PREPARING FOR ENDURANCE EVENTS: PARTICIPANTS AND PHYSICIANS

Those planning to participate in an obstacle race should follow a common-sense training regimen, advised Dr. Bose. Participants should aim for building stamina through cardiovascular exercise and upper-body strength for multiple climbing events, as well as flexibility, to head off injury.

Dr. Mell advised emergency physicians to be prepared if marathon or endurance race events are planned for their area and to insist that the hospital's EMS director be involved in communication with event sponsors.

For the race itself, minimum requirements should include:

- A planned and coordinated response for integrating medical staff into the hospital's 911 system
- Automated external defibrillators positioned within a two-minute response radius throughout the race course
- EpiPens and tourniquets to handle other basic emergency situations.

Benefits Outweigh Risks

Participants often cite the benefits of camaraderie and accomplishment that they gain from completing such courses. Trina Flores, 37, of Atascadero, California, began participating in mud runs five years ago after shedding 50 pounds. She has now completed 17 races and enjoys the fun and teamwork required to help others surmount obstacles. "I like mixing it up," she said. "Doing marathon runs would be boring for me, and the part I like is that [mud runs] really push you out of the box." Next spring, Dr. Mell will participate with two other emergency department colleagues from medical school in a GORUCK event, founded by a former Navy SEAL, which features running with 40 pounds of bricks in a rucksack and emphasizes team building through accomplishment of a mission.

Dr. Bose said part of his motivation for participating in the Spartan Super was to raise awareness for his nonprofit foundation, The Battle Continues (www.thebattlecontinues.org), which provides aid to wounded veterans and advocates for health care issues. (Dr. Bose is also a motivational speaker, applying lessons learned from combat as a template for surmounting other life challenges. Proceeds from corporate leadership lectures also go to injured veterans.)

Teamwork and Challenges

In November, Dr. Bose and his team will tackle the Spartan Beast, a 13-mile course with different obstacles. He has added another goal to his regimen. He is seven pull-ups shy of winning a pull-up competition. "I'm gonna try to nail those pull-ups!" he says. Beyond that, though, he believes there is a psychological benefit to embracing the challenges of extreme racing. "I think it's inspirational when people push their limits," he said. "Whether it's a physical race or another obstacle, you can take that same skill set and apply it to other aspects of your life. I also think what our injured veterans or patients overcome is much more difficult than any extreme race."

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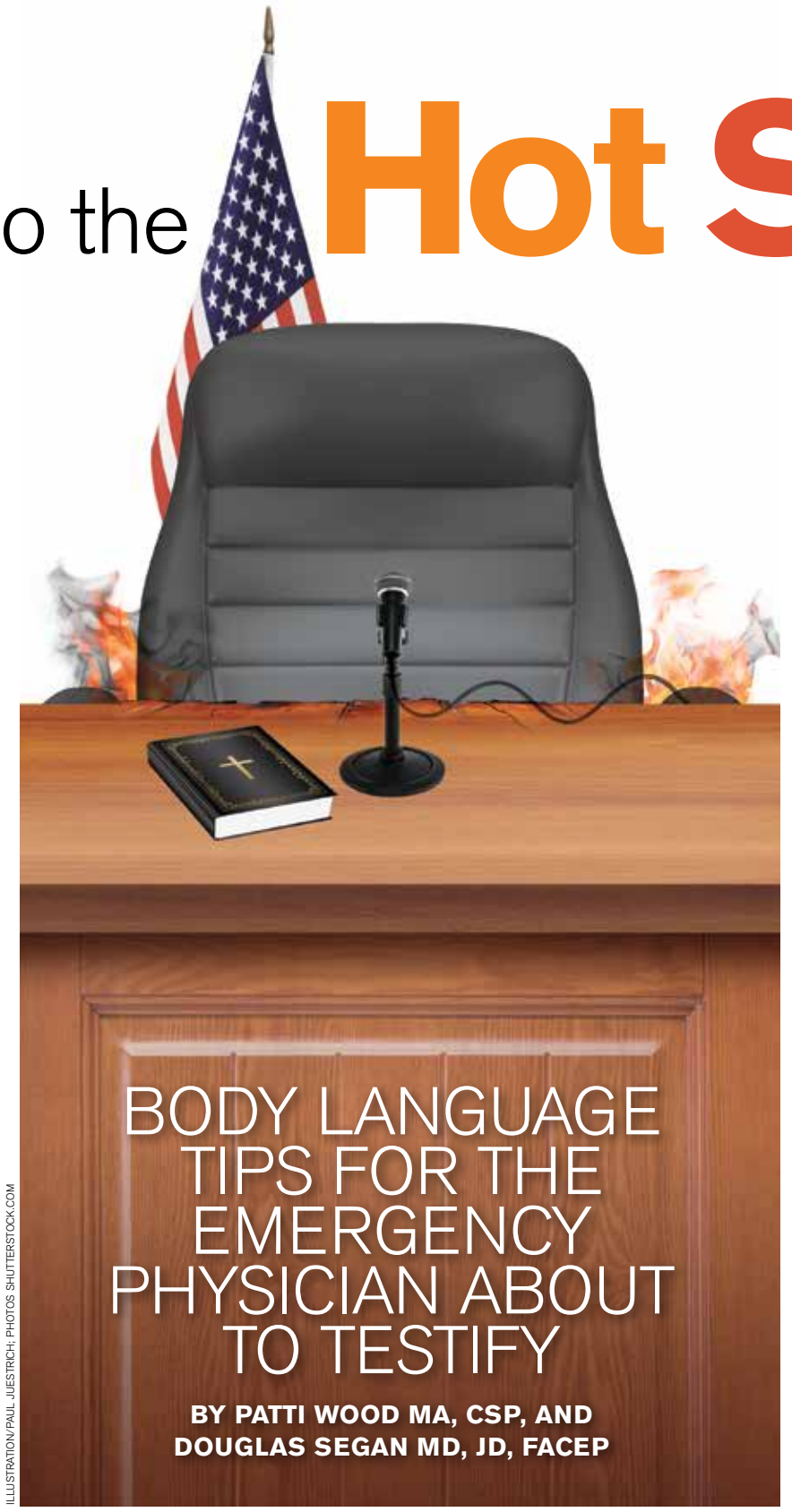
Welcome to the Hot Seat



BODY LANGUAGE TIPS FOR THE EMERGENCY PHYSICIAN ABOUT TO TESTIFY

BY PATTI WOOD MA, CSP, AND DOUGLAS SEGAN MD, JD, FACEP

ILLUSTRATION/PAUL JUESTRICH; PHOTOS SHUTTERSTOCK.COM

You are sitting in a hard chair on a raised platform being asked question after question by a hard-hitting attorney while a courtroom full of people watches your every move. Welcome to the hot seat! As a physician testifying as a defendant or serving as an expert witness, your experience on the stand can be daunting. Understanding how to use nonverbal communication to exude confidence and credibility will make a difference in the outcome.

Here are the keys to ensuring your nonverbal communication conveys the same message of impeccable integrity as your words.

It is important to know that how you hold your body can actually change how you feel. You can influence how you look and feel on the stand by consciously controlling your nonverbal cues.

Under stress, the limbic brain normally makes us freeze, flee, fight, faint, or give up. You may react by freezing in place, pulling your body back so you appear to be fleeing, or folding in your limbs to look small. Other reactions to stress may include becoming tense and angry or going limp and giving up. You can take steps to reduce those stress responses and improve your credibility.

You want to be aware of the dance between you and the opposing counsel and avoid being reactive to the opposing team's attorney.

Take Up Space

You want to look powerful, like a true expert, but not appear arrogant. Instead of going still and getting small, take up space and get big. When you need a shot of confidence, put your arms on the armrest of your chair or stretch out your feet a bit. Research says that women on the stand tend to perch on the edge of the seat and arch their backs, which makes them look less powerful. Men tend to slouch and rely more on the backrest, which makes them appear disrespectful. Purposefully vary your position to be in control, but when you feel stressed, get big.

Project Openness

Imagine that there are "windows" on the front of your body: on the knees, pelvis, heart, mouth, eyes, and palms of the hands. These body windows can be open or closed. You want to keep your windows open to look honest and unafraid. The most important windows for credibility are on the palms of the hands. The limbic brain of the viewer senses danger and dishonesty when the palms of someone's hands are hidden. Keep your hands open and in view on the table or the arms of the chair.

> You want to look powerful, like a true expert, but not appear arrogant.

Gesture normally, but don't use sharp, cutting, or poking motions that can be read as symbolic weapons.

Stay Up

When you're confident and honest, your gestures move up, your head comes up, your shoulders come up and back, and you sit and move in a way that directs your energy upward. People who are afraid and/or are lying have difficulty moving and staying up.

Get Grounded

When people are nervous, they tend to either move a lot or freeze. Here's a trick: when you're in the thick of the most difficult questions and want to achieve the highest levels of cognition, place both feet firmly on the ground, setting them slightly apart. This placement actually makes it easier to utilize both hemispheres of the brain—the rational and the creative/emotional. If you feel yourself freeze, move your feet apart and/or forward to feel strong.

Lean Into It

We tend to pull back when we are fearful or offended by a question. Lean forward as you listen to show you are interested and confident. You can lean forward with your head, your upper torso, or your whole body to show you are connecting to what the lawyer is saying and you are not afraid. Lean in when you are being questioned by your team to show respect, but don't overdo it—you're not trying to "get in their face." So don't lean forward quickly or aggressively; just aim for gentle timely leans.

Speak With Strength

Everyone, but especially women, should be sure that their voices stay strong until the end of each sentence. Going up in pitch at the end of your sentences makes you sound unsure of yourself. Practice answering questions with a confident voice going down in pitch, steady and strong in volume, until the end of your sentences.

Match Your Movement and Your Words

Make sure your gestures and movements match what you are saying. If you say, "That is accurate," and shake your head "no," the jury will believe your body language, not your words. Be careful of being too scripted or automatic. If your emotions, facial expressions and gestures do not match, you seem less genuine.

Keep Your Hands Away From Your Face

Be careful of showing "stress cues." When we feel stressed, the nerve endings fire at the tip of the nose, edge of the ears, around the mouth, and around the eyes. You may have an urge to touch or rub your face. Don't! It makes you look uncertain or dishonest. If you need to comfort yourself, briefly place a hand on your leg out of view, which will help you feel anchored.

Mind Your Mouth

The mouth is the source of truth and lies. Avoid licking your lips or pressing your lips tightly together. Keep hydrated, and keep your lips relaxed.

Giving a deposition or testifying in a trial is an experience that is part of being an emergency physician. Knowing the nonverbal messages that people use to ascertain whether you are telling the truth will help ensure you are perceived as being the credible witness you are.

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Video Killed Direct Laryngoscopy?

Eighty-seven percent of intubations were performed by emergency physicians. In more than two-thirds of cases, rapid sequence intubation was utilized.

by KEN MILNE, MD

The Skeptics Guide to Emergency Medicine (SGEM) is a knowledge translation project. Its goal is to cut the knowledge translation window down from an average of 10 years to one year. The SGEM uses a validated and reliable tool to turn a skeptical eye on the literature. This information is then disseminated using social media to provide high-quality, clinically relevant, evidence-based information so that you can deliver the best care to your patients.

The Case: A 21-year-old male presents collared and boarded from a motor vehicle collision. He is combative, with an obvious head injury, several extremity fractures, and a surgical abdomen. It is clear that he needs to be intubated. You set up your equipment for intubation, and one of the nurses asks you, "Are you going to use DL [direct laryngoscopy] or the GlideScope?"

Question: Which is better for intubation in trauma patients: video or direct laryngoscopy?

Background

Emergency medicine owns the acute airway. A 2011 paper by Walls et al from the National Emergency Airway Registry showed that 87 percent of intubations were performed by emergency physicians. In more than two-thirds of cases, rapid sequence intubation (RSI) was utilized. There have been a number of advances in the last few years. Many of these advances have been in new airway management devices. There are a variety of video laryngoscopy (VL) tools that are displacing traditional DL. For an excellent discussion on the complexities of DL versus VL, check out the 2011 paper by Levitan et al in the *Annals of Emergency Medicine*. Another good resource is by Levitan and Weingart in the *Annals of Emergency Medicine* in 2012.

Relevant Article

Yeatts DJ, Dutton RP, Hu PF, et al. Effect of video laryngoscopy on trauma patient survival: a randomized controlled trial. *J Trauma Acute Care Surg*. 2013;75:212-9.

- **Population**: Trauma patients at Shock Trauma in Baltimore
- **Intervention**: Video laryngoscopy (GlideScope)
- **Comparison**: Direct laryngoscopy
- **Outcomes**:
- **Primary**: Mortality
- **Secondary**: Survival among subgroups, duration of intubation attempt, desaturation during procedure, first-pass success rates
- **Authors' Conclusions:** VL and DL are similar for mortality; post-hoc analysis showed possible increased mortality in those with the most severe head injuries who were randomized into the VL group.

Quality Checklist for Randomized Control Trials

1. Were these ED patients? **Yes, but only the most injured get transferred to Shock Trauma so they may have higher Injury Severity Scores than the average ED**
2. Were the patients adequately randomized? **Yes**
3. Was the randomization process concealed? **Yes**
4. Were the patients analyzed in the groups to which they were randomized? **Yes**
5. Were patients recruited consecutively? **No**
6. Were patients in both groups similar with respect to prognostic factors? **Yes**
7. Were participants unaware of group allocation? **No**
8. Were groups treated equally except for the intervention? **Yes**
9. Was follow-up complete? **Yes**
10. Were all patient-important outcomes considered? **Yes**
11. Was the treatment effect large enough and precise enough to be clinically significant? **No**

Key Results

- **Primary Outcome**: Mortality was the same.
- **Secondary Outcomes**: VL resulted in a longer time to intubation (56 seconds versus 40 seconds). Post-hoc analysis showed that those with the most severe head injuries had a higher mortality and more frequent desaturations below 80 percent (50 percent in VL versus 24 percent in DL). However, this was not included in the original study design. First-pass success was the same in both groups at 80 percent

Comments

This was a well-done study with one significant weakness. The one weakness is that attending physicians were permitted to not enroll patients if they did not want to take part of this study, even if they were eligible. This could have introduced significant selection bias because the more difficult airways may not have been included due to the attending physicians wanting to use the technique that they were more comfortable with. According to the authors, those excluded did not differ significantly from the enrolled patients.

The treating physicians knew the treatment assignments, but this is not a concern because it is not possible to blind the clinicians given that VL and DL are different procedures that require different equipment.

The strengths include that it was a randomized trial, all patients were followed up for the primary endpoint, and the study used video to record the resuscitation to avoid any bias inherent in a chart review.

The Bottom Line

VL leads to the same outcome as DL in trauma patients. VL takes longer to accomplish and may be associated with higher mortality in patients with severe head injuries. However, this relationship will require more study to confirm.

Case Resolution

You decide to use the GlideScope in this case because you feel that it might be better since the patient is in a cervical collar. Knowing that it may take a little longer to pass the tube, you make sure to properly pre-oxygenate the patient with high-flow oxygen with a non-rebreather mask at 30 to 60 liters per minute and use a nasal cannula set at 15 liters per minute kept on during your intubation attempt. You get an excellent view with the GlideScope and pass the tube on your first attempt.

Thank you to Dr. Steve Carroll from EM Basic for his help on this review.

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

ILLUSTRATION/PAUL JUESTRICH; PHOTOS SHUTTERSTOCK.COM

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PROTECT YOUR POT OF GOLD FROM BAD ADVICE

THE END OF THE RAINBOW

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

Shaq Shoots and Scores—So Can You

You can live like you are rich or you can be rich, but very few will ever be able to do both.

by JAMES M. DAHLE, MD, FACEP

Question. *What are the keys to long-term financial success?*

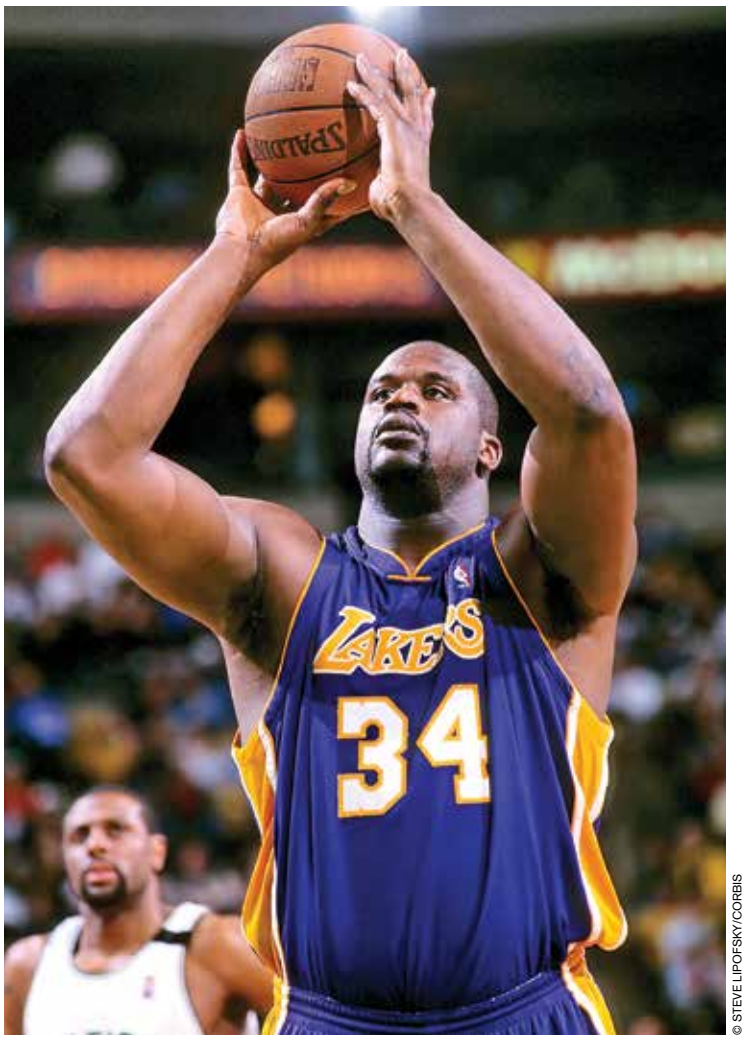
Answer. Achieving financial independence is remarkably simple: make a lot of money, don't spend a lot of money, and make the difference between what you make and what you spend work as hard as you do. Believe it or not, a great example of this method is basketball great Shaquille O'Neal.

Shaq, like many incredible basketball talents, left college early to start playing in the NBA. Although well-known as a terrible free-throw shooter, he was a prolific scorer and won many awards, including Rookie of the Year, league MVP, and 15 invitations to the NBA All-Star Game, in addition to four championships. However, if you listened to him on TV after a game, you wouldn't be surprised to learn that he spent a million dollars within 30 minutes of joining the league. This led to a call from his banker, chastising him and warning him he would end up broke like so many other NBA athletes if he kept it up. Shaq apparently took it to heart and decided to learn about business and finance. He went back to school, finished his bachelor's, and then did an MBA. In 2012, he finished a doctorate degree. That's right: he is now Dr. Shaq. More important, he applied those lessons and turned his high income into a high net worth by purchasing hundreds of businesses, including 172 restaurants, 150 car washes, 40 fitness centers, a shopping mall, a theater, and some nightclubs. I suspect he now earns far more money than he ever did as an NBA star.

Physicians have a lot in common with successful artists and athletes. All three groups enjoy a high income due to unique talents and skills rather than any significant business acumen. All three groups are also well-known to end up broke despite earning millions of dollars over their careers. This is not a coincidence.

Continuing medical education (CME) is a mandatory part of being a physician. There is another type of continuing education you should be doing: continuing financial education (CFE). This is far easier and requires much less time than CME. It can be as simple as forcing yourself to read a financial book once a year, following a financial blog, or meeting frequently with a good advisor who educates you. The vast majority of physicians find personal finance, investing, and taxes incredibly boring and painfully dry. However, if you recall, so was organic chemistry, but you forced yourself to learn that because you had to. You also have to do CFE, or else it may cost you hundreds of thousands, or even millions, of dollars over your career.

Most physicians would love nothing more than to be able to pay a fair price for good advice and have their financial expert take care of all of these financial chores. As I have previously discussed in this column, it is perfectly fine to use a financial advisor, but that does not exempt you from doing CFE. First, it requires a certain amount of financial education to pick a qualified financial planner and/or asset manager among the many salespeople out there masquerading as advisors. It also requires some knowledge to identify a fair price for those services. Second, and more important, your advisor cannot do the most important financial tasks ahead of you, like spending much less than you earn, without your help.



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Dr. Shaq might have blown his first million in a half hour. But after he wised up, he became quite good at converting his high income into income-producing assets. Physicians who wish to become financially independent someday must do the same. That means you cannot spend it all; you must carve out a significant portion of your income and dedicate it toward building wealth by paying off debt; funding retirement accounts; and purchasing income-producing assets like stocks, bonds, small businesses, and real estate. If you aren't sure how much you should be saving, start with 20 percent of your gross income.

Any time you have a lump sum of money, you are faced with a choice. You can spend the lump sum now, or you can invest the money and instead spend the increase from the investment. Your choice isn't $20,000 now or $20,000 later. It's $20,000 now or $2,000 per year (or whatever return you achieve) for the rest of your life. The best part about investing (at least successfully investing) is that the original $20,000 is still there. If you change your mind, you can always blow it on a boat later after it produces some income for a few years. Successful personal finance is a lot like weight loss. It is the cumulative effect of thousands of tiny decisions. It is simple but not easy. Just as weight loss follows the first law of thermodynamics, continually spending much less than you earn eventually leads to wealth and, more important, financial freedom.

Frugality is the cornerstone of personal finance. The great thing about frugality, at least when applied both to Shaq and the typical doctor, is that it is all about relative frugality, not absolute frugality. Doctors don't have to wear secondhand clothes or clip coupons in order to spend much less than they earn. Following a simple, reasonable budget will do. I often receive inquiries from residents wondering who they can borrow money from to meet their living expenses. I try to gently remind them that their resident salary alone is the equivalent of the average American household income. Half of the people in our country live on less than a resident salary; there is no reason they should not be able to do so for a few years, even in a high-cost-of-living area. However, they can't expect to put their four kids into private school, own three cars, have two smart phones with expensive data plans, and still live within their means. You can live like you are rich or you can be rich, but very few will ever be able to do both.

You might not be able to learn much about shooting free throws from the example of Shaquille O'Neal, but you can certainly learn a lot about properly managing your finances. Educate yourself about personal finance, investing, business, and taxes by regularly doing CFE. Convert your high income into wealth by carving out a portion and dedicating it to wealth-building pursuits. Minimizing financial worries will enable you to better care for your patients, your family, and yourself. As Dr. Shaq says, "It's not about how much money you make. The question is, 'Are you educated enough to *keep* it?'"

BRINGING DATA TO THE BEDSIDE

BENCHMARKING ALLIANCE

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

Data for Next-Generation ED Design

by JAMES J. AUGUSTINE, MD, FACEP

The design of emergency departments (EDs) is evolving with the changes in patients served, diagnostic testing utilized, and the process of managing higher volumes of patients.

The National Hospital Ambulatory Medical Care Survey has been providing insight into ED patient volume, acuity, testing, treatment, and disposition since 1992. The 2010 summary tables of this survey have been published,1 and the 2011 data tables will be released shortly. The survey has recorded growth in patient volumes of between 2.5 and 3 percent per year since 1992. The number of EDs has not been increasing, and this steady growth in patient volume has challenged the physical resources of many departments in the United States.

The roles of the ED as a diagnostic center, a buffer for many other hospital units, and the boarding center for admitted patients all combine to change ED design needs. Because 68 percent of inpatients are processed through the ED, boarding of admitted patients poses significant flow challenges if there is little space for patients.

The Emergency Department Benchmarking Alliance (EDBA) is now reporting on the data survey for 2013, with data from 1,100 EDs that saw 42 million patients.[2] The results of this survey allow ED leaders to find data to support renovation and redesign projects.

The most common data parameters used to guide ED design are the number of visits per patient care space and visits per square foot. The figures in Table 1 reflect the results of the EDBA survey in the design area and the use of team triage intake processes. EDs are built (and typically expanded a few times) into a physical space that contains a gross square footage, but more functional metrics, such as visits per square foot, are often not considered. The visits per square foot is calculated by dividing the annual patient volume by the square footage. It is a crude surrogate for how space compact an ED really is. It has not been reported in any available literature.

Most EDs are sized so they see 3 to 3.5 visits per square foot. Small EDs generally have a relatively larger size. For those EDs that are very small relative to volume, the space compression can result in higher walkaway rates. More visits are seen per square foot in EDs with volumes of more than 100,000 patients and in pediatric EDs.

There is currently no basis to compare these numbers, but most emergency physicians realize that an ED with an unusually small footprint is noisy, is cramped, has relatively little privacy, and has little room for families. It is possible that sophisticated analysis would show that these EDs have higher infection rates, lower rates of staff satisfaction due to cramped workspaces and constant noise, and less need for sophisticated staff communication systems. EDs that have a very low number of visits per square foot need sophisticated staff communication systems, Segway transporters for the physicians, and monitor systems that will help patients or families not get lost.

Visits per patient care space is calculated by dividing the annual patient volume by the number of patient care spaces. The number of beds is often used as the number of patient care spaces, and in some states that is the number that is licensed. Because many EDs now designate spots for care that are not beds, the more useful term is patient care spaces. The definition will include all spots, including chairs and vertical treatment areas used routinely for patient care.

> Many hospital CEOs will insist that the ED be built for 2,000 encounters per bed because that rate is a known fact. Like many "facts" about the ED, this one is wrong.

The ED cohorts average 1,350 to 1,750 visits per patient care space. The exception is pediatric EDs, which flow patients more quickly, resulting in about 1,800 visits per patient care space. Small EDs tend to have a relatively smaller number of patients seen per care space. Those EDs that have high numbers of visits per bed generally have higher walkaway rates. For full-service EDs that saw more than 1,900 visits per space, the walkaway rate jumps.

Note that many people were in hospital administrator school when the visit rates were reported at 2,000 patient encounters per bed. There are many hospital CEOs who will insist that the ED should be built to those visit rates because that is a known fact. Like many other "facts" about the ED, this one is wrong.

There are many areas that now design their space and process to essentially eliminate triage process and space. These new processes use a greeting model that is expanded beyond traditional nurse-based triage, including initial treatment decision-making. In EDs over 40,000 volume, there is a growing use of team triage models, which feature emergency physicians or advanced practice providers (APPs). The higher the volume, the more likely it is that the ED is using either physicians or APPs in the greeting model.

There are important decisions that must be made about the design of functional areas within or around the ED. Many EDs have patient volumes and needs that justify the development of fast-track areas for low-acuity patients, trauma-receiving areas, mental health suites for safe management of those patients, and clinical decision or observation units. Most EDs that see more than 40,000 patients per year have one or more of these functional areas. Smaller-volume EDs typically don't have the need for designated service areas. Functional areas are reported in Table 2.

Emergency physicians and ED leaders must able to use and understand the elements of ED design that provide an environment for high-quality emergency care and have comparison data available for their peers. This will accommodate higher patient volumes, acuity, and management of patients through the diagnostic and treatment phase of their emergency care.

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Table 1. EDBA Data Survey 2013—ED Design and Greeting Elements

ED TYPE	PATIENTS SEEN PER SQUARE FOOT	PATIENTS SEEN PER ED BED	PHYSICIANS AND/OR APPS USED IN GREETING
More than 100K volume	4.2	1,648	35%
80–100K	3.2	1,717	40%
60–80K	3.0	1,603	38%
40–60K	3.3	1,653	27%
20–40K	3.0	1,640	6%
Adult EDs	3.0	1,368	72%
Pediatric	3.8	1,836	12%

Table 2. EDBA Data Survey 2013—Operating Areas of U.S. EDs

ED TYPE	FAST TRACK	TRAUMA AREA	CLINICAL DECISION OR OBSERVATION UNIT
More than 100K volume	84%	77%	58%
80–100K	78%	71%	33%
60–80K	74%	57%	29%
40–60K	64%	30%	13%
20–40K	36%	16%	6%
Adult EDs	62%	51%	24%
Pediatric	27%	33%	0

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SPECIAL OPs

DR. WELCH is a practicing emergency physician with Utah Emergency Physicians and a research fellow at the Intermountain Institute for Health Care Delivery Research. She has written numerous articles and three books on ED quality, safety, and efficiency. She is a consultant with Quality Matters Consulting and her expertise is in ED operations.

The SuperTrack Is SUPER!

Patient segmentation can improve efficiency, patient care, and other key ED metrics

Other newer examples of patient segmentation include:
- Geriatric ED
- Chest pain center
- Pediatric ED
- Critical decision unit
- Observation unit
- SuperTrack

by SHARI WELCH, MD, FACEP

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For emergency departments seeing medium to high volumes of patients, the concept of patient segmentation is becoming popular as a flow strategy.[1-3] Patient segmentation means grouping patients requiring similar levels of care and having similar anticipated lengths of stay (LOS) into a geographic area with dedicated staff and resources. The earliest example of patient segmentation is Fast Track, which now has a very compelling body of literature behind it.[3-6] Other newer examples of patient segmentation include:

- Geriatric ED
- Chest pain center
- Pediatric ED
- Critical decision unit
- Observation unit
- SuperTrack

SuperTrack was pioneered by Jody Crane, MD, in the Mary Washington Hospital Emergency Department in Fredericksburg, Virginia, as part of a complete patient-flow makeover.[7] The Mary Washington ED was seeing more than 100,000 visits when it opened its new doors in 2006 and was plagued with front-end waits and delays. As part of a complete overhaul of its ED patient flow, Crane and his colleagues assigned patients to different patient streams in geographic zones based on their acuity. This included a so-called SuperTrack for the lowest-acuity patients. They saw a reduction in LOS, improvement in patient and staff satisfaction, and dramatic reductions in patients leaving without being seen (LWBS).

Similarly, Parkland Urgent Care ED (UCED), part of the Parkland Health & Hospital System in Dallas, tackled its patient-flow issues by employing a variation of SuperTrack in December 2012. Parkland representatives presented its findings at the ED Innovations 2014 Conference held in Las Vegas in Feb. 2014. The team reported experiencing staggering arrival surges. These arrivals were overwhelming existing processes, causing high LWBS rates (7.8 percent) and door-to-provider times (158 minutes) in Dec. 2012. The team decided to revamp both intake processes and the streaming of patients. It created processes and designated space for focusing on the lowest-acuity patients (Emergency Severity Index Level 5). It dedicated six rooms as SuperTrack from 8 a.m. to 6 p.m., where identified patients would be seen by a patient care team consisting of nurses and technicians. Patients had already undergone a medical screening exam by an advanced practice provider in triage. SuperTrack was also populated by other low-acuity patients who had protocol-driven orders. The SuperTrack chief complaints and criteria were very specific and included:

- Cold symptoms/congestion
- Headache, under 50 years of age
- Purified protein derivative placement or reading
- Suture/staple removal
- Dental pain
- Dysuria with positive urinalysis results
- Asymptomatic hypertension
- Sore throat
- Hemorrhoids
- Medication refill (with labs resulted)
- Cough less than two weeks' duration
- Earache
- Pinkeye
- Sinus congestion

Once patients were found to meet the SuperTrack criteria, they were quickly placed in a room, and a patient care tech (PCT) would expedite this process and alert the provider. This pull-to-full system for expediting SuperTrack patients was owned by the PCT and was an important feature of the new process. Providers can always reroute a patient if they feel that other information indicates a higher level of care is required. Providers simply place additional orders and communicate with the main ED team.

One of the key aspects of the initiative was having clearly defined resources allocated to the geographic space dedicated to the SuperTrack. Increasing the PCT staffing was also critical to the success.

The results of the initiative were remarkable! By December 2013, the LWBS rate had decreased to 1.4 percent, the door-to-provider times had decreased by almost a full hour (52 minutes), and patient satisfaction scores had improved. Other improvements included more efficient bed utilization, rapid room turnover, and increased nursing time with patients.

Using a new process, space, supplies, and staff dedicated to the care of very low-acuity patients, Parkland UCED improved all of its performance metrics, improved the overall flow of the department, and improved patient and staff satisfaction. I'd say this is a successful improvement initiative and that the SuperTrack is SUPER!

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BE A MEDICAL DETECTIVE– BONE UP ON YOUR FORENSIC SKILLS

FORENSICS FACTS

What to Call a Wound

by HEATHER V. ROZZI, MD, FACEP

The Case: A 24-year-old male presents to the emergency department sustaining the wound shown in Figure 1 from a broken beer bottle. He states that someone broke the bottle and cut him with it. What is the correct discharge diagnosis for the chart?

Answer: Incised wound or cut.

KEY POINTS

- From a forensic perspective, it is important to use the correct terminology when describing wounds.
- Lacerations are caused by blunt-force trauma.
- The hallmark of lacerations is the presence of tissue bridging.
- Incised wounds are caused by sharp-force trauma, usually by a sharp-edged object.
- The wound edges can help distinguish a laceration from an incised wound/cut.

Discussion

Although emergency medicine providers commonly describe any break in the skin as a laceration, this terminology is forensically and technically incorrect. A laceration is defined as a tear in tissue caused by a shearing or crushing force.[1,2] Therefore, a laceration is the result of a blunt-trauma mechanism. A laceration is further characterized by incomplete separation of stronger tissue elements, such as blood vessels and nerves. These stronger tissue elements account for "tissue bridging" which is seen in lacerations (see Figure 2). In addition, lacerations commonly occur over bony prominences and tend to be irregularly shaped with abraded or contused margins. Lacerations are typically caused by hard objects like a pipe, rock, or the ground. The crushing mechanism may have an effect on wound healing and scarring and increased risk of infection from the devitalized tissue.

A cut or incised wound is produced by a sharp edge and is usually longer than it is deep (see Figure 3).[1,2] Because of the sharp-force mechanism of injury, incised wounds lack tissue bridging and often display very clean, sharp wound edges. Knives, box cutters, glass, and metal typically cause incised wounds. In contrast, stab wounds are sharp-force injuries produced by a pointed instrument where the depth of the wound is greater than the length of the wound on the skin. Once again, there is no tissue bridging.

An easy way to remember the difference is to think of a glass beer bottle. If someone takes the bottle and smashes it over someone's head and the skin is opened, that is a laceration. If a person breaks the bottle on a table and uses the piece to slash someone, it is an incised wound.

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Figure 1. Wound from a broken beer bottle.

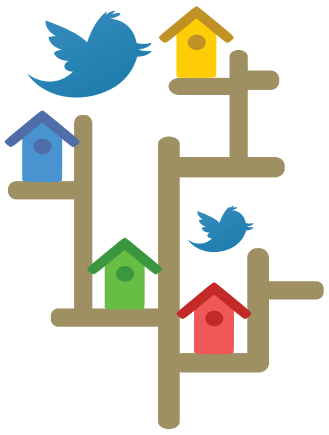
Figure 2. Laceration (caused by blunt force trauma), mimicking a sharp force injury. The presence of "tissue bridging" (arrows) helps to differentiate a laceration from a sharp injury.

Figure 3. An incised wound of the face. Note that the wound is longer on the skin surface than it is deep.

SERVING UP THE BEST EM TWEETS

THE FEED

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



Keeping Up With Health Care on Twitter

by JEREMY SAMUEL FAUST, MD, MS, MA

LAST MONTH, I ATTENDED the Aspen Ideas Festival at the Aspen Institute (@aspenideas) in Colorado for its first-ever Spolight: Health session. This was a three-day event, that brought together leaders in health care for discussion-based seminars and interviews. Additionally, 100 scholars were invited. As a member of this group of younger professionals and students, my only responsibility was to listen and learn. Naturally, I found this next to impossible, and I was able to ask questions of several experts who know a thing or two about American health care. As usual, I did a fair amount of live-tweeting from this event. I also added to my Twitter feed a handful of accounts that have very little overlap with my normal list and the world of #FOAMed and medical education. These accounts highlight some individuals and organizations that are focused on big-picture health care topics. Follow them if you're interested in health care policy or want to start keeping up. Alternatively, you can simply conduct a search for the topic(s) you are interested in. Try searching #ACA or #Medicare for articles about the Affordable Care Act. One of the pros (and cons) of Twitter's search function is that it tends to curate its searches of high-volume hashtags. This feature is particularly appreciated when searching for gems among the legions of tweets with popular hashtags such as #ACA or #Medicare. On the other hand, the main con with curation is that you can't always find a tweet that you once saw. Sometimes you have to dig to find a particular tweet. Another con is that you can't cross search tweets (say, by searching for #ACA and #Obamacare).

ILLUSTRATION/PAUL JUESTRICH; PHOTOS SHUTTERSTOCK.COM

In the spirit of Aspen, I'd like to start by sharing three thought-provoking tweets that appeared in my feed.

1 The first is from Atul Grover, MD, PhD (@AtulGroverMD), chief public policy officer of the Association of American Medical Colleges. At the festival, Dr. Grover tweeted a question for Princeton economist and health care expert Uwe E. Reinhardt: "How much should you ask taxpayers to pay to save a year of life for someone they don't know? #AspenIdeas." It's a simple question that nobody seems to want to answer despite the fact that how much taxpayers are already spending to save one life has recently been estimated. Summarizing recent data, Forbes.com health blogger Michael Cannon reports that the rollout of RomneyCare in Massachusetts had a number needed to treat of 830 to save one life; that is, 830 people had to enroll in a new insurance plan to save the life of one person age 20–64. Using an average premium of $5,000 per person, Cannon estimates that Massachusetts taxpayers paid around $4 million per life saved. The question Dr. Grover asked Mr. Reinhardt was, therefore, startlingly basic: can we save lives for less, and can we afford to save them for so much more?

2 Anne F. Weiss (@annefweiss), a director at the Robert Wood Johnson Foundation, tweeted an interesting idea from WebMD founder Jeff Arnold. Mr. Arnold proposes that we "look outside health tech for what attracts and engages users. Imagine making a doc appointment on OpenTable! #AspenIdeas." Convenience is indeed crucial for patients when choosing among qualified specialists. Apps like this could easily limit these searches to availability among specialists who accept a patient's particular health care plan. This idea is so simple that I can't imagine it not being part of business as usual within a few years, but remember, you heard it here first.

3 I attended a debate about Colorado's new Right to Try law. This recently passed law gives terminally ill patients the right to try experimental drugs that have not yet received FDA approval. The law further opens access to investigational drugs even beyond the FDA's expanded-access (compassionate-use) regulations, which were enacted in 2009. This debate was unique in that both participants appeared to be undecided on the issue. Colorado Lieutenant Governor Joe Garcia (@LtGovGarcia) voiced some support for the law but seemed concerned that the law might have passed not because of careful debate but rather because of the emotional impact of the recent film *Dallas Buyers Club* about access to HIV/AIDS medication that predates the expanded-access law. He noted that the Right to Try law passed unanimously. Co-panelist Diane E. Meier, MD (@DianeEMeier), director of the Center to Advance Palliative Care, professor of geriatrics and palliative medicine at Icahn School of Medicine at Mount Sinai in New York City, a palliative care leader, and a MacArthur Fellow, at first seemed cautiously in favor of the law. By the end, she, too, began to express concern as tough questions from the audience poured in. I later tweeted at Dr. Meier that I had been "undecided on Right to Try law prior to [this discussion]; now I'd say I'm somewhat opposed. @Aspenideas." Dr. Meier later replied, "me too!" More conferences should be this way: with true debates that move opinions and where audience interaction both in person and via Twitter changes the conversation.

4 Finally, I added a few health care–associated Twitter accounts to my feed. From the nonprofit Kaiser Family Foundation (@KaiserFamFound) comes, "How is the Affordable Care Act impacting #Medicaid enrollment? http://kaiserf.am/1qH4glN #ACA." In short, the ACA is increasing Medicaid enrollment. That's good news if you believe in expanding such programs. The Kaiser account provides consistently high-quality health care data. I also added @NPRHealth: "Got questions about the #ACA? There's a new @NPR app for that. http://n.pr/1kUZScC." And if you are having trouble just keeping it all straight, then the new venture, Vox.com (@voxdotcom), from journalist Ezra Klein (@ezraklein) may be perfect for you. The site uses short slide decks to explain complicated news topics, including health care. It promises "everything you need to know, in two minutes." Its 33-slide deck explaining the nuts and bolts of the ACA by Vox senior editor Sarah Kliff (@sarahkliff) is among the best you'll find for describing the legislation and how it is supposed to work: www.vox.com/cards/obamacare/what-is-obamacare.

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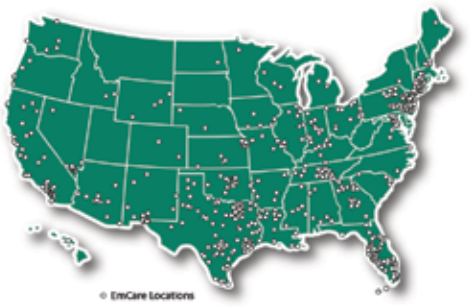

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University Medical Center *(Nashville, TN)* 30K annual visits.

NEW! TriStar Parkridge West *(Jasper, TN)*18K annual visits. **Medical Director.**

CHRISTUS St. Elizabeth *(Beaumont, TX)* 50K annual visits. **Medical Director.**

Valley Regional *(Brownsville, TX)* 33K annual visits. **Medical Director.**

CHRISTUS Spohn Health System *(Corpus Christi & surrounding areas)* 6 Hospital System. 21-48 annual visits.

East Houston Regional *(Houston, TX)* 51K annual visits.

West Houston Regional *(Houston, TX)* 46K annual visits.

CHRISTUS Jasper *(Jasper, TX)* 23K annual visits.

CHRISTUS St. Mary *(Port Arthur, TX)* 27K annual visits.

Metropolitan/Northeast Methodist *(San Antonio, TX)* 47K/50K annual visits. Third campus - **Methodist Texsan.** 7K annual visits.

LewisGale Health System *(Roanoke/Blacksburg area, VA)* 13-41K annual visits. **Medical Director** (Montgomery).

Henrico Doctors' Hospital *(Richmond, VA)* 3 Hospital System. 14-34K annual visits. Brand new affiliated freestanding ED - **Hanover Emergency Center** **Estimated 10K visits in year one.**

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For details, contact: **SoutheastOpportunities@EmCare.com**

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The Emergency Group, Inc

The Emergency Group, Inc.
Honolulu, Hawaii

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QMC's newest medical center opened in west Oahu in May and is expected to see an additional 40,000 ED patients annually.

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College of Medicine - JACKSONVILLE

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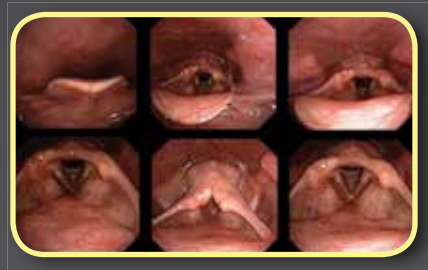



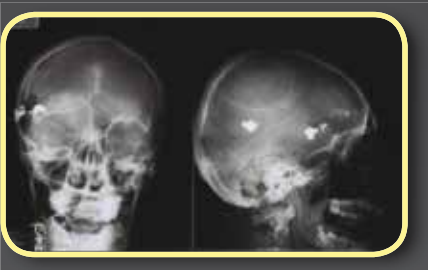

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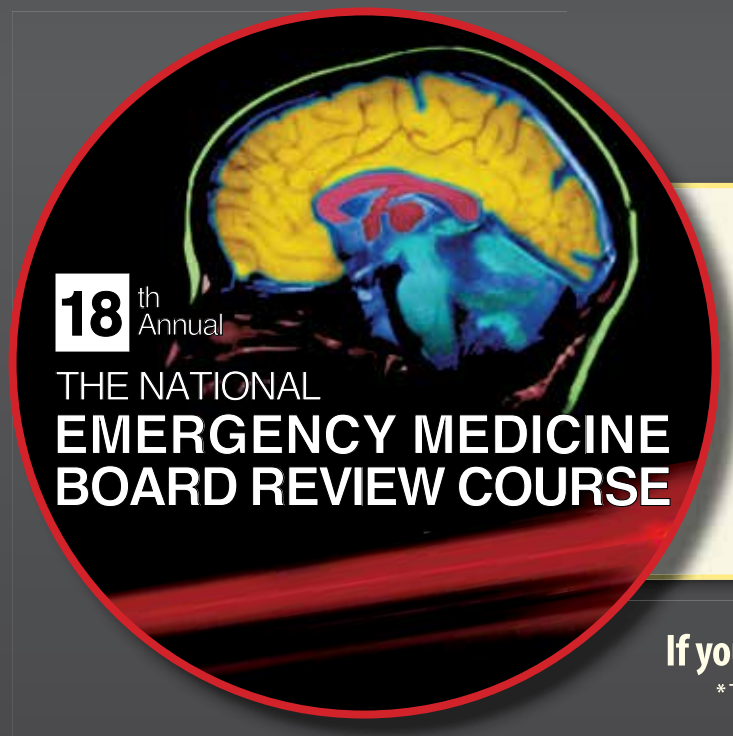

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