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ACEP Council Speaks Out on Controversial Topics

2014 Council Resolutions

SEPTEMBER 2014
Volume 33 Number 9

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www.acepnow.com

BEFORE YOURE FOR THE "CULTURAL" DEBATE
The evidence against blood cultures

by MICHELLE P. LIN, MD, MPH, AND JEREMIAH D. SCHUUR, MD, MHS

Your last patient on a shift is a 55-year-old well-appearing woman with fever and cough in whom you suspect community-acquired pneumonia. As she steps in to draw labs, your nurse asks you, “Doc, two sets of cultures, right?”

In 2010, 4.1 percent of emergency department patients received blood culture testing. Each set of blood cultures costs $28 to process, with additional costs for microscopy and pathogen identification if there is growth, amounting to more than $151 million in annual medical costs based on Medicare reimbursement rates (a low estimate as many insurers and the uninsured are charged more than Medicare reimbursement rates). Blood cultures test for bacteremia, a condition associated with high mortality. However, they are frequently ordered on patients with clinical diagnoses for which they add little value. The true-positive rate of blood cultures based on prospective studies is as low as 4.1 percent to 7 percent. Up to 40 percent of positive blood cultures are false-positive from contaminants, resulting in prolonged hospital stays,

CONTINUED on page 21

2014 ACEP ELECTIONS
Meet the Candidates

Each October at ACEP’s annual conference, the ACEP Council elects new leaders for the College. The Council, which represents all 53 Chapters, 33 Sections of Membership, the Association of Academic Chairs of Emergency Medicine, the Council of Emergency Medicine Residency Directors, the Emergency Medicine Residents’ Association, and the Society for Academic Emergency Medicine, will elect four members to the ACEP Board of Directors and the College’s President-Elect.

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THE TRIPLE AIM FOR EMERGENCY MEDICINE

SEE PAGE 12

American College of Emergency Physicians
ADVANCING EMERGENCY CARE

SEPTEMBER 2014
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Three peas in a pod.

Actually, make that 709 peas in a pod.

At EMP, we’re all in. Every physician in our group has an equal voice day one, and becomes an equal equity partner. Our 100% EM physician ownership allows us to fully focus on our mission: To care for patients. It also empowers us to create the lives we’ve always dreamed of living. We enjoy a fully-funded 401k worth nearly 250K in five years, and the peace of mind that comes from having the best med-mal around. We’d love to make our pod 710. Join us.
ACEP Council Speaks Out

ACEP Councillors were surveyed about several topics that will be addressed* at this October’s Council meeting. Here were their responses.

1. Do you believe that ACEP should, in some way, allow membership for physicians not board certified in EM?

<table>
<thead>
<tr>
<th>TOTAL RESPONSES: 270</th>
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<tbody>
<tr>
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</tr>
<tr>
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<td>35.2%</td>
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2. Do you believe that ACEP should develop a category of membership for advanced practice providers?

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<td>68.9%</td>
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<tr>
<td>NO</td>
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3. Do you believe that emergency physicians should prescribe naloxone to patients at risk for opiate overdose?

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<tr>
<td>NO</td>
<td>49.4%</td>
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4. Do you believe marijuana should be legalized?

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</tr>
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<td>YES</td>
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</tr>
<tr>
<td>NO</td>
<td>57%</td>
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5. Do you believe marijuana should be decriminalized?

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<th>RESPONSE PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
<td>64.8%</td>
</tr>
<tr>
<td>NO</td>
<td>31.6%</td>
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</table>

6. Do you believe that ACEP should support a single-payer health insurance system?

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<tr>
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<th>RESPONSE PERCENT</th>
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<td>39.2%</td>
</tr>
<tr>
<td>NO</td>
<td>60.8%</td>
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</table>

*Survey questions based on general topics and not specific resolutions.

Many Opinions Under the Big Tent

Our pro-con on “The Big Tent of Emergency Medicine” (Aug. 2014, p. 1), which examined the benefits and drawbacks of requiring certification in emergency medicine for ACEP membership, drew an overwhelming response from readers. Here are just a few of the letters we received.

Visit www.ACEPNow.com to read all the responses, and email acepnaw@acep.org with your thoughts to keep the debate going!

I’m personally against allowing non-emergency medicine–certified physicians acceptance into the College.

Why can’t I get acceptance into the American College of Surgeons? Or Cardiology? There are plenty of regions throughout the country that are in need of specialists and the services that they provide. This is hardly a problem unique to ER and, pardon my sarcasm, a lazy reason to allow someone admission into what is supposed to be a crowning achievement.

I’m a pretty smart guy. I know my anatomy, I am procedurally adept, and I learn fast. I can’t I just start practicing?

What? You mean to tell me that even if I began practicing in some rural area where no specialist wants to go, performing successful cardiac caths, appendectomies, etc., I still wouldn’t be “accepted” into their college? Strange, that is.

The fact is all other specialties would (appropriately) scoff at the idea that I be accepted as an equal into their college without formal training. You can’t lower your standards just because there is a shortage of board-certified physicians—in any specialty. If we did, it would basically undermine everything our predecessors fought for (and we still do) in order to be considered something beyond simple triage monkeys. To do otherwise essentially says that anyone can do this job. And if that’s true, then why go through residency? And if you’re the hospital, why spend exorbitant sums on a “board-certified physician” when it’s own College states that non-emergency medicine–certified physicians have the same rights and privileges as those that are?

—Kurt Kaczander, DO
Laingsburg, Michigan

*Open membership to all those who practice EM.

——Saul F. Weinstein, MD, FACS
Jacksonville, Florida

I do not think that we should allow nonboard-certified physicians to be members of ACEP. I am not a member of the College of Surgeons or any other specialty because I am not a surgeon or any other specialist. Do we think that EM board certification stands for nothing? Why have it if it means nothing? Start another group called doctors who staff EDs if you
want every licensed physician to join. Emergency medicine is a specialty and should be maintained as one, and our College should be just that—our College.

—Charlene A. Doyle, MD
Johnson City, Tennessee

The major reason to consider opening ACEP membership to non-boarded physicians is that it is best for the specialty and for our patients. The editorialists by Dr. Smith and Dr. Radtke are both articulate and rational. They both wisely recognize that the issue is not about board certification, it’s about membership. Debates over board certification are part of our past and shouldn’t affect this issue.1 In the early years of our specialty’s development, there may have been reason to be paranoid about our scope of practice, but we should now be proactive about what is best for the specialty and for our patients.

The question is not what is best for me or you or for these physicians. (They don’t care. I can say this for certain because I am, or at least was, one of them.) Mostly, I want to do what is best for our specialty, and for ED patients, there are compelling reasons to reopen membership. Dr. Radtke correctly identifies that “there is a distinction between being an emergency medicine physician and being a physician who practices emergency medicine.” (Bold added for emphasis.) Emergency physicians who are residency trained in EM are true specialists in EM. Maybe we need new terminology to make this clear, but most physicians, and certainly most patients, care less about titles than competence. For example, rural EDs are still dependent on physicians who trained in family medicine, and many of these physicians are family physicians who provide emergency care who don’t care about a title. They think of ACEP as an elitist organization. Dividing the workforce of EM into categories of us and them is not a new idea, and it is part of the reason that the history of EM included a stage where there was intense controversy over who was an emergency physician.

Emergency medicine has expanded scopes of practice, many of which include on-the-job training (eg, critical care, hospitalist medicine, palliative care, urgent care, etc.). But the phrase “on the job training” is a dysphemism that minimizes many important issues in medical education. Lifelong learning is crucial for all physicians, and unlike the pioneers of EM in the 1970s, many of whom did not complete a residency, the majority of non-ABEM-boarded EP’s are residency trained in other specialties.

Both Dr. Smith and Dr. Radtke alluded to the workforce data that compel us toward unique features/acep-open-wide-the-gates. Accessed September 2, 2014.

REFERENCES

ADASUVE® (loxapine) inhalation powder 10 mg
THE FIRST AND ONLY... Orally inhaled medicine indicated for the acute treatment of agitation associated with schizophrenia or bipolar I disorder in adults

INDICATIONS AND USAGE
ADASUVE® (loxapine) inhalation powder, for oral inhalation use, is a typical antipsychotic indicated for the acute treatment of agitation associated with schizophrenia or bipolar I disorder in adults. Efficacy was demonstrated in 2 trials in acute agitation: one in schizophrenia and one in bipolar I disorder.

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

• ADASUVE is contraindicated in patients with the following:—Current diagnosis or history of asthma, chronic obstructive pulmonary disease (COPD), or other lung disease associated with bronchospasm—Acute respiratory signs/symptoms (eg, wheezing)—Current use of medications to treat airways disease, such as asthma or COPD—History of bronchospasm following ADASUVE treatment—Known hypersensitivity to loxapine or amoxapine. Serious skin reactions have occurred with oral loxapine and amoxapine
• ADASUVE must be administered only by a healthcare professional
• Prior to administration, all patients must be screened for a history of pulmonary disease and examined (including chest auscultation) for respiratory abnormalities (eg, wheezing)
• Administer only a single 10 mg dose of ADASUVE within a 24-hour period by oral inhalation using the single-use inhaler

ADASUVE [package insert]. Horsham, PA: Teva Select Brands, a division of Teva Pharmaceuticals USA, Inc; December 2013.
ACEP Launches 2014 PQRS Registry Reporting System

ACEP announced in late August that it has developed a Physician Quality Reporting System (PQRS) registry reporting option and is providing it to ACEP, the Emergency Medicine Residents’ Association (EMRA), and the Society of Emergency Medicine Physicians (SEMPA) members at a discount. The registry comes in response to the Centers for Medicare & Medicaid Services (CMS) announcement that failure to satisfy the 2014 PQRS requirements may lead to a penalty of up to 4 percent of Medicare payments, approximately $2,500 per provider.

In 2014, a group of 10 or more eligible professionals may avoid the 2 percent PQRS penalty as well as the 2 percent value-based modifier (VBM) penalty (both applied to 2016 payments) if at least 50 percent or more of the individual eligible professionals in the group meet PQRS reporting requirements in 2014. Even one Medicare fee-for-service claim for the calendar year qualifies a provider (physician or non-physician) as an eligible professional in a group for purposes of the 50 percent threshold.

However, emergency physicians should note that those eligible professionals in the group who do not submit PQRS measures will still be subject to the PQRS payment adjustment of 2 percent. To avoid the 2 percent VBM penalty, at least 50 percent of individual EPs in a group must meet the minimum PQRS reporting requirements.

For more information on these requirements, please visit www.acep.org/pqrs.

Groups that decide to participate in the 2014 PQRS group practice reporting option (GPRO) are required to register through the Physician Value-Physician Quality Reporting System (PV-PQRS). ACEP members pay $12 per provider and nonmembers pay $25 per provider to register for 2014.

CPE credits can be earned for participating in PQRS reporting through ACEP and EMRA. To check your participation eligibility, visit www.acep.org/pqrs and www.emra.org/pqrs.

For more information about ADASUVE, visit ADASUVE.COM or call 855-755-0492.

IMPORTANT SAFETY INFORMATION

• After ADASUVE administration, patients must be monitored for signs and symptoms of bronchospasm at least every 15 minutes for at least 1 hour
• ADASUVE can cause sedation, which can mask the symptoms of bronchospasm
• Antipsychotic drugs can cause a potentially fatal symptom complex called Neuroleptic Malignant Syndrome (NMS), manifested by hyperpyrexia, muscle rigidity, altered mental state, irregular pulse or blood pressure, tachycardia, diaphoresis, and cardiac dysrhythmia. Associated features can include escitalopram serum creatinine phosphokinase (CPK) concentration, rhabdomyolysis, elevated serum and urine myoglobin concentration, and renal failure. If NMS occurs, immediately discontinue antipsychotic drugs and other drugs that may contribute to the underlying disorder, monitor and treat symptoms, and treat any concomitant serious medical problems
• ADASUVE can cause hypotension, orthostatic hypotension, and syncope. Use with caution in patients with known cardiovascular disease, cerebrovascular disease, or conditions that would predispose patients to hypotension. In the presence of severe hypotension requiring vasopressor therapy, epinephrine should not be used
• Use ADASUVE with caution in patients with a history of seizures or with conditions that lower the seizure threshold. ADASUVE lowers the seizure threshold. Seizures have occurred in patients treated with oral loxapine and can also occur in epileptic patients
• Use caution when driving or operating machinery. ADASUVE can impair judgment, thinking, and motor skills
• The potential for cognitive and motor impairment is increased when ADASUVE is administered concurrently with other CNS depressants
• Treatment with antipsychotic drugs caused an increased incidence of stroke and transient ischemic attack in elderly patients with dementia-related psychosis; ADASUVE is not approved for the treatment of patients with dementia-related psychosis
• Use of ADASUVE may exacerbate glaucoma or cause urinary retention
• The most common adverse reactions (incidence >2% and greater than placebo) in clinical studies in patients with agitation treated with ADASUVE were dysgeusia, sedation, and throat irritation
• Pregnancy Category C. Neonates exposed to antipsychotic drugs during the third trimester of pregnancy are at risk of extrapyramidal and/or withdrawal symptoms after delivery, ADASUVE should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus
• Nursing mothers: Discontinue drug or nursing, taking into account the importance of the drug to the mother
• The safety and effectiveness of ADASUVE in pediatric patients have not been established


AT 10 MINUTES

<table>
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<th>ENDPOINT</th>
<th>SCHIZOPHRENIA</th>
<th>BIPOLAR DISORDER</th>
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</thead>
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<td>AT 2 HOURS</td>
<td>10%</td>
<td>12%</td>
</tr>
<tr>
<td>AT 10 MINUTES</td>
<td>19%</td>
<td>10%</td>
</tr>
</tbody>
</table>

The mean baseline PEC scores in all treatment groups were 17.3 to 17.7.

FAST ONSET

Statistically significant reduction in agitation at 2 hours, with improvement rapidly achieved at 10 minutes post-dose.

HELP DEFUSE THE SITUATION BEFORE AGITATION ESCALATES FURTHER

ADASUVE® (loxapine) inhalation powder

For more information about ADASUVE, visit ADASUVE.COM

The Official Voice of Emergency Medicine

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September 2014

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The Official Voice of Emergency Medicine

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Updates and Alerts from ACEP

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

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 (4.4)).

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 (4.4)).

5 WARNINGS AND PRECAUTIONS
5.1 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 (4.4)).

5.2 ADASUVE REMS to Mitigate Bronchospasm
Because ADASUVE is available only through a restricted program under a REMs (see Boxed Warning and Warnings and Precautions (5.1)) Required compo- nents 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 REMS program and distribute only to enrolled healthcare facilities. Further information is available at www.adasuverms.com or 1-855-755-0442.

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. ADASUVE is not approved for the treatment of patients with dementia-related psychopa-

5.4 Neutropenic Malignant Syndrome
Antipsychotic drugs can cause a potentially fatal symptom complex termed neuroleptic malignant syndrome (NMS). Clinical features 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 creatinine 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, septicemia, septic shock, 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.

5.5 Hypotension and Syncope
ADASUVE can cause hypotension, orthostatic hypotension, and syncope.Use ADASUVE with caution in patients with known cardiovascular disease (e.g., myocardial infarction or ischemic heart disease, heart failure or conduction abnormalities), cerebrovascular disease, or conditions that may be compromised by orthostatic hypotension (e.g., postural hypovolemia, or treatment with antihypertensive medications or other drugs that affect blood pressure or reduce heart rate). In patients with postural hypotension, ADASUVE is administered concurrently with other anticholinergic drugs, revealed a risk of death in drug-treated patients compared to placebo-treated patients. ADASUVE is available only through a restricted program under the 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 REMS program and distribute only to enrolled healthcare facilities. Further information is available at www.adasuverms.com or 1-855-755-0442.

5.6 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. Analysis 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 cardiovascular (e.g., heart failure, sudden death, or heart attack) and infectious (e.g., pneumonia) in nature. Observational studies suggest that similar to atypical antipsychotic drugs, treatment with conventional antipsychotics may also be associated with a risk of death. The risk of death in placebo-treated patients was about 0.8%.

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.

5.7 NMS in Elderly Patients with Dementia-Related Psychosis
Antipsychotic drugs can cause a potentially fatal symptom complex termed neuroleptic malignant syndrome (NMS). Clinical features 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 creatinine 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, septicemia, septic shock, 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.

5.8 Sodium and Water Retention
ADASUVE can cause sodium and water retention. ADASUVE is a sedative and should be used with caution in patients with a history of edema or those with a disease associated with edema.

5.9 Anticholinergic Reactions Including Exacerbation of Glaucoma and Urinary Retention
The concomitant use of other anticholinergic drugs may exacerbate anticholinergic reactions, including urinary retention. ADASUVE is contraindicated in patients who have a known sensitivity to loxapine.

The concomitant use of other anticholinergic drugs or other treatments that block the central or peripheral actions of anticholinergic drugs may cause additive anticholinergic effects, including urinary retention, constipation, dry mouth, blurred vision, or decreased sweating. The physician should inform the patient of the increased risk of these anticholinergic effects before treatment with ADASUVE.

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.
The efficacy of ADASUVE was established in one study of acute agitation [see Clinical Studies (14)] associated with schizophrenia or bipolar I disorder in adults. 1

INDICATIONS AND USAGE

The following is a brief summary only; see full prescribing information and Administration (2.4). Minimum of one hour following treatment with ADASUVE. Monitor patients for symptoms and signs of bronchospasm [See Dosage and Administration (2.2) and Contraindications (4)].

5 WARNINGS AND PRECAUTIONS

WARNING: BRONCHOSPASM and INCREASED MORTALITY

Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at increased risk of agitated behavior and suicidality (suicidal ideation and suicide) (see Warnings and Precautions (5.6)).

The following is a brief summary only; see full prescribing information for NMS. There were no cases of orthostatic hypotension, postural symptoms, or syncope. A systolic blood pressure decrease of ≥ 20 mm Hg occurred in 1.5% and 1.1% in the ADASUVE and placebo groups, respectively. A diastolic blood pressure decrease of ≥ 10 mm Hg occurred in 5.3% and 5.3% in the ADASUVE and placebo groups, respectively.

6.6 Seizures

ADASUVE lowers the seizure threshold. Seizures have occurred in patients treated with oral loxapine. Seizures can occur in epileptic patients even during antiepileptic 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 risk for cognitive and/or motor impairment reported when ADASUVE is administered concurrently with other CNS depressants [see Drug Interactions (7.7)].

6.7 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 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 effects, including exacerbation of glaucoma or urinary retention. The concomitant use of other anticholinergic drugs (e.g., antiparkinsonian 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 (5.4-5)]
• Hypotension and Syncope [see Warnings and Precautions (5.5)]
• Seizures [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 hours), placebo-controlled clinical trials (Studies 1, 2, and 3) of ADASUVE 10 mg and placebo groups, respectively. A diastolic blood pressure decrease of ≥ 10 mm Hg occurred in 0.8% (2/259) of patients in 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 active 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 decrease in FEV1 and % predicted FEV1 were 303 mL and 9.5% respectively). Furthermore, the effect on FEV1 was greater following the second dose (maximum mean decrease in FEV1 and % predicted FEV1 were 537 mL and 14.7%, respectively). Respiratory-related adverse reactions (bronchospasm, chest discomfort, cough, dyspnea, throat tightening, 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 (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 decrease in FEV1 and % predicted FEV1 were 125 mL and 4.5%, respectively). Respiratory-related 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 1 of 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 nebulizer) was administered to 25% of patients in the ADASUVE group and 12% in the placebo group, respectively.
7. Anticholinergic Drugs

ADASUVE has anticholinergic activity. The concomitant use of ADASUVE and other anticholinergic drugs can increase the risk of anticholinergic adverse effects and Pseudocholinosis. ADASUVE is not approved for any anticholinergic indication.

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

ADASUVE has demonstrated increased embryofetal toxicity and death in rat fetuses and offspring exposed to doses approximately 0.5-fold the maximum recomended human dose (MRHD) on a mg/m² basis. ADASUVE should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

ADASUVE is not known whether ADASUVE is present in human milk. Loxapine, the active ingredient in ADASUVE, has demonstrated increased embryofetal toxicity and death in rat 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, embyrolthal toxicity (increased fetal resorptions, reduced weights, and hydropsphrenosloss with hydroutoder) 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/d on a mg/m² 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 1.5-3 mg/kg/day. This dose is approximatively half the MRHD of 10 mg/d on a mg/m² 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-, 60-, and 396-fold the MRHD of 10 mg/d on a mg/m² basis, respectively.

8.2 Nursing Mothers

ADASUVE should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

ADASUVE has anticholinergic activity. The concomitant use of ADASUVE and other anticholinergic drugs can increase the risk of anticholinergic adverse effects and Pseudocholinosis. ADASUVE is not approved for any anticholinergic indication.

For the most up to date information on the management of ADASUVE in overdose, please see the Management of Overdosage section.

Management of Overdosage

The national poison control center recommends that the decision to accept primary care board certification from candidates lies solely in the hands of hospital clients and is often based on their bylaws. Most of these groups understand that until there are enough residency-trained and board-certified emergency physicians to go around in rural and less geographically desirable areas, they must remain flexible to fulfill their needs. One of the bigger players, TeamHealth, is providing a wide variety of clinical education, as well as leading development and training programs to optimize the effectiveness of their physicians, according to Susan Master.
MEET THE CANDIDATES | CONTINUED FROM PAGE 1

PRESIDENT-ELECT
The following Board members are candidates for the office of President-Elect.

Jay Kaplan, MD, FACEP (California)
Current Professional Position: Director of Service and Operational Excellence, CEP America; Attending Physician, Department of Emergency Medicine, Marin General Hospital; Medical Director, Studer Group

Internships and Residency: Family Medicine Residency, University of California, Davis, Sacramento Medical Center, 1975-1978; Teaching Fellowship, University of California, Davis, Sacramento Medical Center (1978–1979)
Medical Degree: MD, Harvard Medical School (1975)
Years Elected to the Board: 2009, 2012

Rebecca B. Parker, MD, FACEP (Illinois)
Current Professional Position: Attending emergency physician, Centegra Health System, McHenry and Woodstock, Illinois and Presence Covenant Medical Center, Urbana, Illinois. Vice President, EmCare North Division, President, Team Parker LLC, Consulting Group Coding, Billing, and Compliance, Clinical Assistant Professor, Texas Tech El Paso Department of Emergency Medicine

Internships and Residency: Texas Tech University Health Sciences Center at El Paso (1998)
Years Elected to the Board: 2009, 2012

Robert O’Connor, MD, MPH, FACEP (Virginia)
Current Professional Position: Professor, Chair, Physician-in-Chief, Department of Emergency Medicine, University of Virginia Health System, Charlottesville, Virginia; Emergency Physician, Culpeper Regional Hospital, Culpeper, Virginia

Internships and Residency: Emergency Medicine Residency, Medical Center of Delaware (1982–1985)
Medical Degree: MD, Medical College of Pennsylvania (1982)
Years Elected to Board: 2010, 2013

Stephen Anderson, MD, FACEP (Washington)
Current Professional Position: Emergency Attending, MultiCare, Auburn Medical Center, MAMC Director of Emergency Medicine Student and Resident Rotations, ATSU; Chair and Director of Stroke Services at South King County MultiCare Health Foundation

Medical Degree: MD, University of Michigan (1981)

BOARD OF DIRECTORS
ACEP’s Board of Directors provides day-to-day management and direction of the College. The ACEP Board Nominating Committee nominates members to three-year terms.

Stephen Anderson, MD, FACEP (Washington)
Current Professional Position: Emergency Attending, MultiCare, Auburn Medical Center, MAMC Director of Emergency Medicine Student and Resident Rotations, ATSU; Chair and Director of Stroke Services at South King County MultiCare Health Foundation

Medical Degree: MD, University of Michigan (1981)

CONTINUED on page 10
MEET THE CANDIDATES | CONTINUED FROM PAGE 9

Jon Mark Hirshon, MD, PhD, MPH, FACEP (Maryland)

Current Professional Position: Associate Professor, Departments of Emergency Medicine and of Epidemiology and Public Health, University of Maryland School of Medicine; Attending Physician at the University of Maryland Medical Center and Baltimore VA Medical Center; Senior Vice Chair, University of Maryland Baltimore Institutional Review Board


Medical Degree: MD, University of Southern California Keck School of Medicine (1990)

Hans House, MD, FACEP (Iowa)

Current Professional Position: Professor of Emergency Medicine and Vice Chair for Education, University of Iowa; former Residency Program Director, University of Iowa Emergency Medicine Residency

Internships and Residency: Emergency Medicine/Internal Medicine Residency, Olive View-UCLA Residency Program

Medical Degree: MD, University of Southern California Keck School of Medicine (1997)

Year Elected to Board: 2011 (incumbent)

Mark Mackey, MD, MBA, FACEP (Illinois)

Current Professional Position: Vice Chairman, Clinical Affairs, Department of Emergency Medicine, University of Illinois Hospital and Health Sciences System, Chicago, Illinois.

Internships and Residency: Emergency Medicine, Olive View-UCLA Residency Program

Medical Degree: MD, University of Southern California Keck School of Medicine (1997)

Year Elected to Board: 2011 (incumbent)

John Rogers, MD, CPE, FACEP (Georgia)

Current Professional Position: Co–ED Medical Director, President of the Medical Staff, and Emergency Physician at Coliseum Northside Hospital, Macon, Georgia; Co–ED Medical Director and Emergency Physician, Coliseum Medical Center, Macon, Georgia; Board of Trustees of Coliseum Health System

Internships and Residency: Surgery, Medical Center of Central Georgia, Macon (1983)

Medical Degree: MD, University of Iowa College of Medicine (1978)

Year Elected to Board: 2011 (incumbent)

Mark Rosenberg, DO, MBA, FACEP, FACOEP-D (New Jersey)

Current Professional Position: Chairman, Department of Emergency Medicine; Chief, Geriatric Emergency Medicine, and Chief, Palliative Medicine at St Joseph’s Healthcare System, Paterson, New Jersey; Associate Professor, Emergency Medicine, at the University of New England, Biddeford, Maine; Assistant Professor of Clinical Emergency Medicine, New York Medical College, Valhalla, New York

Internships and Residency: Emergency Medicine, Metropolitan Hospital, Philadelphia, Pennsylvania (1978–1980)

Medical Degree: DO, Philadelphia College of Osteopathic Medicine (1978)
<table>
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<tr>
<th>RESOLUTION NAME</th>
<th>SUBMITTED BY</th>
<th>PREVIOUSLY DISCUSSED BY THE COUNCIL</th>
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<td>Commendation for Marilyn Bromley, RN</td>
<td>Emergency Ultrasound Section</td>
<td>No</td>
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<td>Commendation for W. Calvin Chancy, JD, CAE</td>
<td>Washington Chapter</td>
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<td>Commendation for Andrew E. Sama, MD, FACEP</td>
<td>New York Chapter</td>
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<td>In Memory of Ben C. Corbault, MD, FACEP</td>
<td>Delaware Chapter</td>
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<td>In Memory of Noelie A. Rotonos, DO, FACEP</td>
<td>Pennsylvania Chapter</td>
<td>No</td>
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<td>Election Procedures</td>
<td>Council Steering Committee</td>
<td>Yes</td>
<td>Council Standing Rules Amendment</td>
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<tr>
<td>Fellow Status–Housekeeping Changes</td>
<td>Bylaws Committee, Board of Directors</td>
<td>Yes</td>
<td>Bylaws Amendment</td>
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<tr>
<td>Fellow Status Continued vs. Continuous Membership</td>
<td>Mark DeBard, MD, FACEP; Todd Taylor, MD, FACEP</td>
<td>No</td>
<td>Bylaws Amendment</td>
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<td>Membership Classification Restructure</td>
<td>Membership Restructuring Task Force, Board of Directors</td>
<td>No</td>
<td>Bylaws Amendment</td>
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<td>Subspeciality Certification &amp; ACEP Fellow Status</td>
<td>Board of Directors</td>
<td>Yes</td>
<td>Bylaws Amendment</td>
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<tr>
<td>Eligibility Criteria for Fellow Emeritus</td>
<td>Bylaws Committee, Board of Directors</td>
<td>Yes</td>
<td>College Manual Amendment</td>
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<tr>
<td>Candidate Members in Fellowship Training</td>
<td>Emergency Medicine Residents’ Association</td>
<td>Yes</td>
<td>Amended resolution adopted in 2013.</td>
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<tr>
<td>Medical Student Voice in ACEP Council</td>
<td>Texas College of Emergency Physicians</td>
<td>No</td>
<td>Medical students are not currently eligible</td>
</tr>
<tr>
<td>National and Chapter Does Waived First Six Months of Practice</td>
<td>Texas College of Emergency Physicians</td>
<td>No</td>
<td>Graduated residents currently pay reduced dues for the first three years of practice.</td>
</tr>
<tr>
<td>Communication Rules for Fair and Open Dialogue</td>
<td>Howard Met, MD, FACEP; Avand Swaminathan, MD, FACEP; Liam Yore, MD, FACEP</td>
<td>No</td>
<td>Pertains to ACEP’s Candidate Campaign Rules.</td>
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<tr>
<td>Freedom of Speech</td>
<td>Larry Bedard, MD, FACEP; Jerome Hoffman, MD, FACEP</td>
<td>No</td>
<td>Pertains to ACEP’s Candidate Campaign Rules.</td>
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<tr>
<td>Advocacy for Professional Licensure of EMS Providers</td>
<td>EMS-Prehospital Care Section</td>
<td>No</td>
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<tr>
<td>Assistant Physician Designation</td>
<td>Howard Met, MD, FACEP; Harry Shulid, MD, FACEP</td>
<td>No</td>
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<tr>
<td>Cannabis Recommendations by Emergency Physicians</td>
<td>Kerry Forrester, MD, Erika Powell, MD, FACEP</td>
<td>No</td>
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<tr>
<td>ED Mental Health Information Exchange</td>
<td>Washington Chapter, CAL/ACEP (California Chapter)</td>
<td>Yes</td>
<td>Similar amended resolution adopted in 2013.</td>
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<tr>
<td>Establishment of a Registry for PURS and VBM Programs for ACEP Members</td>
<td>Minnesota Chapter</td>
<td>Yes</td>
<td>Multiple resolutions have been adopted pertaining to EMTALA and liability reform.</td>
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<td>Examination of Stark Law Potential Implications</td>
<td>EMS-Prehospital Care Section</td>
<td>No</td>
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<tr>
<td>Future Funding for ACEP Report Cards in the Emergency Care Environment</td>
<td>Maryland Chapter</td>
<td>No</td>
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<tr>
<td>Human Trafficking</td>
<td>Florida College of Emergency Physicians</td>
<td>No</td>
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<tr>
<td>Impact of High-Deductible Insurance Plans</td>
<td>Massachusetts College of Emergency Physicians</td>
<td>No</td>
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<tr>
<td>National Decriminalization of Possession of Marijuana for Personal and Medical Use</td>
<td>Larry Bedard, MD, FACEP; Joseph Fastow, MD, FACEP; Dan Morhain, MD, FACEP</td>
<td>Yes</td>
<td>Resolutions pertaining to marijuana not adopted in 2009, 2010, 2011, and 2013.</td>
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<tr>
<td>Parity in Reimbursement for Telemedicine Services</td>
<td>Iowa Chapter; Rural Emergency Medicine Section; Emergency Telemedicine Section</td>
<td>No</td>
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<tr>
<td>Safe Citizen Day</td>
<td>New Jersey Chapter, James Pruden, MD, FACEP; Mark Rosenberg, DO, FACEP</td>
<td>No</td>
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<tr>
<td>Sexual Assault Victims’ DNA Bill of Rights</td>
<td>Louise Andren, MD, JD, FACEP; Larry Bedard MD, FACEP</td>
<td>No</td>
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<tr>
<td>Single-Payer Health Insurance</td>
<td>Larry Bedard, MD, FACEP; Kathleen Cowling, DO, MD, FACEP; James Mitchner, MD, MPH, FACEP; Charles Pappas, MD, FACEP; Megan Ranney, MD, MPH, FACEP; Robert Solomon, MD, FACEP; Nicholas Vasquez, MD, FACEP; Bradford Walters, MD, FACEP</td>
<td>Yes</td>
<td>Similar resolutions not adopted in 2012, 2011, and 2009. Similar resolutions referred to the Board of Directors in 2007 and 2005.</td>
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<tr>
<td>Anonymous Expert Physician Testimony for a State Medical Licensing Board</td>
<td>Texas College of Emergency Physicians</td>
<td>No</td>
<td>Several resolutions on expert testimony adopted previously, but none related to anonymous testimony.</td>
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<tr>
<td>Bariatric Emergency Department Guidelines</td>
<td>Maryland Chapter</td>
<td>No</td>
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<td>Clinical and Academic Equivalence Among Pediatric Emergency Physicians</td>
<td>Dual Training Section</td>
<td>No</td>
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<tr>
<td>CME for Nurses Practitioners and Physician Assistants</td>
<td>Nicholas Jouriles, MD, FACEP; Sandra Schneider, MD, FACEP</td>
<td>No</td>
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<tr>
<td>Development of Telemedicine Policy for EM</td>
<td>Emergency Telemedicine Section</td>
<td>No</td>
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<td>EDs as Primary Sites for Organ Donation Registration</td>
<td>Pennsylvania Chapter</td>
<td>No</td>
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<tr>
<td>Geriatric Emergency Department Accreditation</td>
<td>Mark Rosenberg, MD, FACEP; Geriatric Emergency Medicine Section</td>
<td>No</td>
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<tr>
<td>Naloxone Prescriptions by Emergency Physicians</td>
<td>Larry Bedard, MD, FACEP; Richard Bukata, MD, FACEP; Jerome Hoffman, MD, FACEP; Kathryn Hawk, MD, Megan Ranney, MD, MPH, FACEP; Lauren Whiteside, MD, Trauma &amp; Injury Prevention Section</td>
<td>Yes</td>
<td>Similar resolution not adopted in 2013.</td>
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<tr>
<td>Pain Management in the Emergency Department</td>
<td>New Jersey Chapter</td>
<td>Yes</td>
<td>Multiple resolutions have been adopted regarding pain management.</td>
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<tr>
<td>Pediatric Injuries Are Preventable</td>
<td>New York Chapter</td>
<td>No</td>
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<td>Reverse an Overdose, Save a Life</td>
<td>New York Chapter</td>
<td>No</td>
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<td>State Medical Licensing Board Anonymous Complaint</td>
<td>Texas College of Emergency Physicians</td>
<td>No</td>
<td>Several resolutions on expert testimony adopted previously, but none related to anonymous testimony.</td>
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<tr>
<td>Support for Clinical Pharmacists as Part of the Emergency Medicine Team</td>
<td>New York Chapter</td>
<td>No</td>
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<tr>
<td>Trauma Center Certification Task Force</td>
<td>CAL/ACEP (California Chapter)</td>
<td>No</td>
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<tr>
<td>Triage Screening Questions</td>
<td>Pennsylvania Chapter</td>
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The Official Voice of Emergency Medicine

SEPTEMBER 2014

ACEPNow 11
Donald Berwick, MD, first coined the term “Triple Aim” for the goals of the emerging health care world. Emergency medicine has clinical ABCs as cornerstones of the specialty. Today, as the new health care world emerges, there are significant challenges and opportunities that will redefine the meaning of EM’s practice management ABCs; a new “EM Triple Aim” is at hand.

The first significant impetus to change was the Centers for Medicare & Medicaid Services (CMS) announcement making provider payment data available to the public. This change now provides critical information to everyone on how physicians have been paid by Medicare. In the context of other changes, this initial move by CMS will likely stand as an industry cornerstone/landmark change as it will have an impact throughout the provider community.

The second industry move of importance for physicians was the recent announcement by Aetna, Humana, and UnitedHealthcare of virtually the same change, namely the release of their payment data to the public.

Along these same lines, it is important to recognize a very important article by Bob Herman, in which he potentially links the first two and begins exploring the potential for Medicare to become the health care industry’s sole payer. Although the article itself addresses hospital finances, it is prudent to take note of it. This may not be as far-fetched as one might think. Emergency physicians need to be armed with the facts and prepared to aggressively deal with several related changes and industry maneuvers that could potentially have a dramatic impact on the finances and even the survival of individual EM practices (see sidebar).

What might these changes mean for EM? These are major structural changes and shifts in the macroeconomic and demographic landscape that could have significant impact EM practices. The big-picture issues involve hospitals maneuvering to engage the insurance industry. Medicaid expansion certainly offers the potential to significantly change the acuity mix of the EM practices (see sidebar).

The necessity of monitoring practice acuity mix of the EM practices is warranted by the macro industry shifts noted above. The urgent care boom will certainly drain some of the lower acuity mix patients from the ED. However, until the primary care network is capable of handling the newly insured, the ED remains the option of choice for these patients. As the former change (the urgent care boom) erodes the lower ED acuity, the overall practice acuities stand to increase. The combination of these patient acuity changes and the coincidental demographic changes absolutely mandates these practice indices be watched constantly because they can have significant impacts on the financial standing of EM practices.

Changes to the Health Care Industry That Could Impact Emergency Medicine

1. Hospitals moving into the insurance business. • Most recent major move is Ascension Health.8

2. The explosion of the urgent care industry.

3. Patients being able to self-direct portions of their care (eg, lab studies).10

4. Patients being able to negotiate with providers ahead of treatment. • The health care version of Priceline.com.11

5. Medicaid expansion for the uninsured.

6. Increase in high-deductible insurance plans.

7. The overall trend toward the retailization of health care. • Major health systems contracting with pharmacy retailers.12 • Insurers seeing no other option.13

8. The overall trend toward the retailization of health care.
possibility and to be ready with both a strong data and quality/value position when engaging payers. EM simply cannot survive as we know it at Medicare reimbursement rates. It is imperative we be fully armed with strong data metrics coupled with a quality/value proposition when engaging payers.

Regarding payments, there is a new special case today for EM. The ever-increasing incidence of the new self-pay patient, engendered by the increasing incidence of high-deductible insurance patients, requires new patient follow-up techniques and protocols. As a first step, the quality of patient ED registration data and information becomes critical. As a first step, the quality of patient ED registration data and information becomes critical. The insurance industry poses a challenge that necessitates constant vigilance of critical indices of EM practices.

The insurance industry poses a challenge that necessitates constant vigilance of critical indices of EM practices. This impacts cash flow and the overall financial strength of EM practices. Payments by these patients need constant monitoring and new and creative follow-up protocols.

The issue of claims denials and appeals is important even along with a move toward a move toward a practice management ABC protocol. Acuities, baseline/benchmark payments, and appeals/denials analysis require strong management, constant monitoring, and sophisticated tools to ensure the financial strength and longevity of EM practices. As the landscape continues to substantially change, EM practices must adapt and so as to meet these challenges. It is an opportunity to emerge as strong financial leaders in this new world.

References
4. Herman R: What if Medicare were the only payer? Becker’s Hospital Review Web sites. Available at: http://www.beckershospitalreview.com/finance/what-if-medicare-were-the-only-payer.html. Accessed August 1, 2014.
10. Snow B. Online blood work: no doctor’s visit required. Fox News Web sites. Available at: http://www.foxnews.com/
SOME THINGS CHANGE, SOME STAY THE SAME
Emergency physicians in 1976 were gearing up for the ACEP annual meeting, too, although the cutting edge of knowledge and education was a little different back then.

3. Nerve Blocks of the Foot: Outstanding! Why are they not mainstream practice in 2014?!
5. Practical Reviews in EM? Great source of Education! Put the 3x5 card with the abstract into your file drawer at home and listen to the tapes in your car, while rocking a fancy pair of double knit pants!

—Compliments of Bruce Walmsley, MD, FACEP
Timing is everything in the emergency room. But for women of childbearing age, many medical procedures must wait until these patients have been tested for pregnancy.

The Siemens CLINITEST® hCG pregnancy test helps ED clinicians quickly clear women for further procedures. Paired with a CLINITEK Status® Connect analyzer, the CLINITEST® hCG test provides the only truly connected, CLIA-waived solution. Since no manual documentation or visual interpretation is required, the chance for error is greatly reduced.

Test results take just two to five minutes and can be transferred to electronic health records, enabling hospitals to quickly move ahead with X-rays or other routine procedures. Less time spent on pregnancy tests leaves more time for critical patient care.

Want to streamline your emergency department with more efficient pregnancy testing? Take our online product tour and learn how Siemens can help. Visit www.usa.siemens.com/cliniteshcg
Small Batteries, Big Problem
With the proliferation of small electronic devices, button batteries have become more prevalent, and the number of battery-related ED visits has increased significantly over the past 20 years. In 2009, about 6,000 children were seen in U.S. emergency departments for battery-related complaints; that’s more than 16 visits per day. Not surprisingly, cases involving children under four years of age, lithium batteries, and batteries more than 20 mm in diameter are more likely to result in poor outcomes.

Presentation, Imaging, and Diagnosis
Button battery ingestion often presents similar to ingestion of other foreign bodies, with such symptoms as cough and gagging, drooling, dysphagia, labored breathing, or stridor. Patients may exhibit symptoms that are related to tissue damage, including vomiting, fever, irritability, or listlessness. In addition to obstruction/compression, batteries can cause chemical (especially alkaline) and electrical tissue damage; liquefaction necrosis and other damage can occur in a little as two hours. Vigilance and care are needed in diagnosing button battery ingestion. Fully 54 percent of fatalities due to button battery ingestion were misdiagnosed; many had nonspecific presentations, or the batteries were diagnosed as a swallowed coin. Fortunately, button batteries are radiopaque, coin-like objects that are evident on most plan films. Viewed en face, a button battery will have a halo rim (a ring of radiolucency just inside the outer edge of the object). Viewed on edge, a button battery may have a central bulge or step off (this can be difficult to appreciate if seen obliquely or with the newer, thinner lithium batteries).

A 3-year-old male was well until he vomited bright-red blood and became unresponsive; EMS transported the patient to the hospital. He arrived in asystole cardiac arrest, with blood around his nose and mouth, and received continuous pediatric advanced life support. Despite this, he expired.

At postmortem, a button battery was found impacted in the esophagus at the level of the transverse aorta. There was a fistula connecting the esophagus and aorta, with the esophagus packed with bright-red blood and with gastric content of large dark-colored blood clots. The small and large bowels were also found to be packed with dark-colored stool.

Case submitted by Eugene Varghese, MD, Rutgers New Jersey Medical School in Newark, and David Woodkotch, MD, chief resident of emergency medicine at Rutgers.
A 5-year-old female who was “playing around” with her grandma’s battery while hanging out in her grandma’s car ingested a button battery. She waited a few hours before telling anyone and was seen about six hours after ingestion. She complained of a sore throat and had no difficulty with secretions or breathing. Lateral and anteroposterior chest X-rays showed a battery lodged in her upper esophagus (see Figure 1).

We used propofol for endoscopiccopy done by a pediatric gastroenterologist while in the ED. She was admitted by pediatrics and had no difficulty with secretions or breathing. Lateral and anteroposterior chest X-rays showed a battery lodged in her upper esophagus (see Figure 1).

Figure 1. Anteroposterior chest X-ray showing button battery lodged in upper esophagus.

Figure 2. Intraoperative photo of upper esophagus showing necrotic damage.

Figure 3. Button battery post-retrieval.

and/or mediastinitis (which did not occur). Figure 3 shows the button battery after retrieval.

Case and photos submitted by Peter Chase, MD, PhD, assistant professor of pharmacy practice and science at The University of Arizona in Tucson.

Management

Treat any button battery ingestion as an emergency—time is of the essence to minimize local tissue damage. Removal can be difficult, especially because local tissue damage can lead to fistulous structures that can be further damaged by instrumentation. A battery should be removed under direct visualization. A surgical team often needs to be called. A helpful algorithm is found on the National Capital Poison Center website, http://www.toison.org/battery/guideline.asp.

In an asymptomatic patient, a battery in the stomach or beyond can be monitored and allowed to pass. Repeat radiographs are reasonable: repeat in four days for patients less than 6 years of age or for larger button batteries (more than 15 mm in diameter), and repeat in 10–14 days for older children or for a smaller battery. After that time, if the battery is still in the stomach, endoscopic removal is recommended. Note that strict anticipatory guidance and return precautions should be given, emphasizing the need for patients to be evaluated for any abdominal pain, fever, or vomiting.

Co-ingestion of a magnet with a button battery necessitates removal. After removal, some advocate for a delayed second-look endoscopy to ensure no damage has occurred. It is important to note that perforations and fistulas may develop up to 18 days after removal. Strictures can develop weeks and months after removal.

Even though button batteries represent a genuine hazard, emergency physicians alert to the signs and symptoms of button battery ingestion can effectively manage them and help their patients achieve good outcomes.

References


DR. FOX is associate professor of adult and pediatric emergency medicine at Carolinas Medical Center in Charlotte, North Carolina.

A 14-month-old male was seen at an outside hospital on a Saturday in late April for a choking episode. An X-ray (see Figure 1) was done, and physicians there thought the round metallic foreign body was a coin and asked the family to return in 24 hours. The patient was seen again on Sunday. Another chest X-ray (anteroposterior only) was done, and the esophageal coin was seen again. Because it had not moved, the patient was transferred to our hospital. On arrival, we looked at the X-ray and saw that the foreign body was clearly a battery.

Surgery was called, and the patient was taken to the operating room. An initial swallow study done the day after retrieval appeared normal. The patient did well but returned two weeks later with coughing and aspiration and had developed a tracheoesophageal fistula (see Figure 2). Visit www.ACEPNow.com for a video of this case.

Figure 1. Anteroposterior X-ray showing button battery in upper esophagus.

Figure 2. A tracheoesophageal fistula caused by button battery.

Case, photos, and video submitted by Cindy Nielsen, MD, The Children’s Hospital at OU Medical Center in Oklahoma City.

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Warning to the “Experts”
A look at expert witness guidelines and tort reform

BY KEVIN M. KLAUER, DO, EJD, FACEP, AND JENNIFER L’HOMMEDIEN STANKUS, MD, JD

Where is tort reform headed? Caps, safe harbors—perhaps nowhere? The jury is out. Caps (financial limits) on noneconomic damages, review panels, and many other seemingly viable strategies have been implemented with mixed but overall disappointing results. Safe harbors, providing legislative protection for following decided upon standards, are a far-reaching goal that has gained some traction in the past year. However, if you’re waiting for a safe harbor, you’ll run aground with respect to liability reform while waiting for its protection. Perhaps the most viable solution at our fingertips is adjusting the standard for negligence (ie, ordinary negligence to gross negligence) in medical liability tort claims. This is often confused with the “burden of proof” required to prove your position. The burden of proof for “ordinary negligence,” the current standard in medical malpractice cases, is defined as a “preponderance of evidence.” The other end of the spectrum is “beyond a reasonable doubt,” the standard for criminal cases. Somewhere in between is the “clear and convincing” standard in which plaintiffs would need to prove that it is substantially more likely than not that their allegation is true. Although this is beyond the scope of this article, several states have or are pursuing adjustments to the standards for the burden of proof.

A Possible Solution? Perhaps the most enticing avenue, which is also related to burden of proof, is the duty standard. If you have a duty to act, what is the standard of care required to fulfill that duty? For ordinary negligence, the standard is one of reasonableness: what a reasonable provider with similar training would do in a similar situation. Doesn’t it sound reasonable that much of what we do while practicing the art of medicine could be deemed reasonable? Yes, if someone else wasn’t trying extra hard to prove exactly the opposite. Herein lies the problem—and the ray of hope with changing the duty standard. While practicing the art of medicine could we all try very hard to provide the highest quality of care possible, reasonably unreasonable that what would be required under an ordinary negligence standard, and it would identify cases in which little or no care at all is being taken to provide acceptable quality of care. Such a standard should result in identifying those cases in which the duty to the patient was clearly breached, avoiding labeling cases of medical nuance as negligent. Gross negligence is defined as reckless behavior or conscious disregard for the risk of one’s actions, actions so unreasonable that a layperson without medical training could easily recognize the negligence with little or no need for expert witness testimony. In addition, when the allegation is more serious (eg, gross negligence), the burden of proof is often simultaneously increased. In most jurisdictions, the burden of proof for gross negligence requires clear and convincing evidence as opposed to just the preponderance of evidence, which is most common with the ordinary negligence standard. Legislatively, these are hard-fought battles, and even when won, sometimes the new laws are overturned on appeal to state supreme courts by a tenacious plaintiff’s bar. Forces undermining these new standards are even closer than we think. Our colleagues providing expert witness testimony for plaintiffs may knowingly or unknowingly undermine the use of increased negligence standards and the burden of proof. They are the expert witnesses who testify falsely, misleadingly, or in a biased way, propagating and fueling our litigious medical-legal environment. We have an obligation to identify those who are violating the ethical obligations of the expert witness and to ensure unbiased testimony in our courts for a more level playing field, guaranteeing the most appropriate legal outcomes.

Case in Point
As an illustrative example, in 2010, Georgia passed a major tort reform measure. This measure requires a plaintiff to present “clear and convincing evidence” to prove gross negligence has occurred. The legislative initiative is applied to emergency medicine cases.

“[G]ross negligence is the absence of even slight diligence, and slight diligence is defined...as that degree of care which every man of common sense, however inattentive he may be, exercises under the same or similar circumstances. In other words, gross negligence has been defined as equivalent to the failure to exercise even a slight degree of care or lack of diligence that even careless men are accustomed to exercise.” Johnson v. Omondii GA Sup Ct, decided Nov. 14, 2013, p. 7. O.C.G.A. § 51-1-4 Even the Supreme Court of Georgia recognizes that this is a confusing definition, particularly as applied to medical malpractice cases. However, many other courts have simply stated that gross negligence is a significant deviation from negligence. While it may yet be ill-defined by case law, it is meant to be a very high hurdle to overcome. This legislative change is a very positive movement in tort reform and has the ability to prompt meaningful tort reform in many other states. However, a single expert witness who convinces a jury that a case constitutes gross negligence, even if the majority of the medical community would disagree, can nullify the risk-management benefits and legislative momentum gained. When we hear or see such testimony, be it from the defense or plaintiff, we have an obligation to scrutinize it and act accordingly.

Remember, if the standard of negligence in Georgia is one of gross negligence, then the testimony provided is to support the allegation that the defendant physician was grossly negligent. An argument could be made that if gross negligence is not clear, then this matter is not appropriate for advancement in the legal system, and summary judgment may be awarded. However, when it is determined that sufficient evidence exists to support the gross negligence allegation, then this may become a matter of fact and not of law. A jury deliberates matters of fact, and matters of law are decided by the court (ie, judge). In order to find sufficient evidence to pursue the question of gross negligence, qualified expert witnesses must have provided testimony to that exact fact. So the plaintiff’s experts in this case were willing to testify that the physician was grossly negligent. Although admittedly an oversimplification of the facts, the patient presented with an unusual left-sided chest pain. A history was obtained, and he was examined. Several tests (eg, electrocardiogram, chest radiograph, etc.) were ordered, and the patient improved with symptomatic treatment and was discharged. He died two weeks later from a pulmonary embolism. An ideal outcome? Of course not. A complicated case? Probably. Grossly negligent (reckless care)? Not even close.

Testimony that goes beyond what is medically certain or reasonable may result in unfair outcomes in individual cases, but more important, such testimony undermines the validity of the gross negligence standard and the clear and convincing burden of proof, thus damaging our ability to achieve meaningful tort reform nationally. All expert witnesses need to be aware of the far-reaching implications of their testimony and must read and comply with the ACEP policy “Expert Witness Guidelines for the Specialty of Emergency Medicine,” available at http://www.acep.org/ Clinical—Practice-Management/Expert-Witness-Guidelines-for-the-Specialty-of-Emergency-Medicine.

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DR. STANKUS is an emergency physician for Group Health Physicians in Seattle; chair of the ACEP Medical Legal Committee; a former medical malpractice defense attorney; a medical legal consultant; and a member of the editorial board of ACEP Now.
What’s Your Diagnosis?

A 65 year old with fever, bloating, and a rash

BY JARED H. BROCK, BS, BLAINE M. HANNAFIN, MD, RDMS, AND FRANK LOVECCHIO, DO, MPH

The Case
A 65-year-old man with a history of psoriasis presents to the emergency department with a three-day history of subjective fever, polydipsia, and swelling of his face and extremities. Current medications: adalimumab and moxifloxacin.

His vital signs are remarkable for temperature of 100.3°F and tachycardia at 122 beats per minute. His skin is noted to have a generalized beet-red, scaling rash that covers the majority of his body (see Figures 1 and 2). Severe anasarca is noted and was most pronounced in his face and extremities (see Figures 3 and 4).

The patient’s labs demonstrate a white blood cell count of 10.7x10^9/L and an elevated lactic acid of 5.8 mmol/L. The electrolyte panel shows evidence of acute renal insufficiency, with a creatinine of 2.45 mg/dL, and the albumin is noted to be low at 2.7 g/L. Chest X-ray and urinalysis are normal.

Diagnosis
The patient’s presentation is consistent with an erythrodermic psoriasis flare. Erythrodermic psoriasis is the most severe form of psoriasis and is potentially life-threatening. It is characterized by a widespread, fiery erythematous rash and exfoliation often affecting the majority of the patient’s skin. Severe itching and pain, fluctuating body temperatures, and tachycardia are common.1

Acute management focuses on restoring intravascular volume, managing anasarca, and monitoring temperature instability. Recent research indicates that medications such as intravenous cyclosporine and infliximab that regulate epithelial cell growth and immune system response are usually effective, but therapy will be dictated by the patient’s condition and comorbidities.2 Secondary infection and development of septic shock can cause significant morbidity and mortality with erythrodermic psoriasis flares. Therefore, evaluation for underlying infection is critical.3

To restore the patient’s intravascular volume, he is given aggressive intravenous hydration with normal saline. A 500 mL 5% albumin solution is also infused to mitigate the anasarca and hypoalbuminemia. Vital signs are monitored, and his tachycardia gradually resolves. The patient is pan cultured, and after consultation with the patient’s dermatologist, the patient is admitted to the hospital and started on intravenous cyclosporine.

During his hospital stay, the patient is seen by the infectious disease and nephrology services. The patient initially responds favorably to therapy, but subsequently develops worsening renal insufficiency, and the cyclosporine is discontinued in favor of adalimumab. The patient is started on intravenous antibiotics because some of the involved areas of skin appeared cellulitic.

On day four in the hospital, the patient is transferred to another facility to continue therapy under the direct care of his dermatologist. The anasarca has lessened, and his lactic acidosis and acute kidney injury have resolved. Blood cultures are negative, and the generalized fiery red rash has significantly improved.

There is disagreement on the epidemiology of psoriasis, but a recent meta-analysis concluded that the adult prevalence in the United States ranges from 2.7 percent to 3.45 percent.4 Erythrodermic psoriasis is estimated to affect between 1 percent and 2.25 percent of those who have psoriasis.5 While erythrodermic psoriasis can be associated with a high risk of deterioration and mortality due to secondary infection and sepsis, there are no data on mortality rates, due to the overall low incidence of erythrodermic psoriasis flares.6

References
Positive Pressure High-Flow Oxygen for Nasal Foreign Body Removal Using Standard Suction Tubing

by JUSTIN MCNAMEE, DO, AND JORDAN JEONG, DO

The Case
A 3-year-old female presents to the emergency department after placing a small bead into her left nostril. The bead became lodged, and the child is unable to move any air out of the left naris. All efforts to remove the foreign body prior to arrival have failed. The child is currently cooperative but apprehensive. Is there a minimally invasive way to safely, quickly, and easily remove or dislodge the foreign body?

Background
Children often present to the ED with foreign bodies lodged in their nares, with various explanations as to how they got there. On occasion, parents will have given a valiant effort to remove the object prior to arrival in the ED, usually without success. While some of the techniques attempted are more successful than others, there is one such method that may, in fact, straddle the line between anecdotal and evidence based. The Parent’s Kiss is a technique that has been perpetuated by social media and word of mouth as a way for parents to attempt removal before presenting to the ED. With this method, parents or guardians place their mouth over the child’s mouth while at the same time occluding the child’s nonoccluded nostril. They then blow forcefully into the child’s mouth in hopes of dislodging the nasal foreign body.

The question is, does this technique have any merit? Looking at the evidence, it seems that it might. As it turns out, the use of positive pressure techniques for removal of nasal foreign bodies is not a novel concept. In 2002, Navitsky et al were the first to report the use of high-flow oxygen to remove a nasal foreign body. The technique, referred to as the Beamsley Blaster, is well-described and utilizes equipment easily found in every emergency department. This technique allows for a quick, clean, and painless way to dislodge a nasal foreign body with a high rate of success.

The Technique
Use wall oxygen or medical air (positive pressure technique) to dislodge a unilateral nasal foreign body with the use of standard suction tubing and a suction adapter.

While there are several ways to attempt removal, using high-flow oxygen or medical air in the contralateral nostril delivered through suction tubing is a safe alternative to more traditional techniques and utilizes equipment easily found in every emergency department.

This technique allows for a quick, clean, and painless way to dislodge a nasal foreign body, as the one described, the risk of aspiration is always a risk. In theory, by using positive pressure techniques such as the one described, the risk of aspiration should be lessened. Forcing air from the contralateral side should help expel the foreign body out of the nose as opposed to pushing it posteriorly into the airway. This is one advantage over the traditional methods of extraction such as Foley balloon catheters, Katz extractors, and other forms of mechanical extraction that may result in worsening the situation. Some known complications may include mucosal irritation, swelling, and bleeding.

1. Have the patient sit up, lean slightly forward, and tilt the head down.
2. Ensure wall oxygen is available, and attach one end of the standard suction tubing to the wall oxygen or compressed air. The opposite end of the suction tubing should have the plastic suction tubing adapter piece firmly implanted (see Figure 2).
3. Place the tubing with the attached adapter into the nostril contralateral to that containing the foreign body (see Figure 3).
4. Titrate the wall oxygen or medical air to high flow (usually 10–15 L/min) until the foreign body becomes dislodged. Periorbital emphysema or blowing a globe out of its socket reflects a lack of understanding of the term titration.

Equipment Needed (Figure 1)
- Wall suction unit
- Suction tubing adapter
- Suction tubing
- Yeah, that’s it!

Patient Selection
This technique may be most applicable for cooperative pediatric patients. However, nasal foreign bodies are not always a problem unique to the pediatric population. Often, adult psychiatric patients will place objects where they do not belong, including the nose.

This technique may be inappropriate for patients who are not amenable to having suction tubing inserted into their nostril. In the case of an uncooperative but otherwise nonviolent pediatric patient, this minimally invasive approach is still of value because it can be performed under procedural sedation or with the use of a papoose.

Caution
Complications from removal of nasal foreign bodies are infrequent, regardless of the approach clinicians choose. Navitsky et al reported no known complications from positive pressure techniques, including the Parent’s Kiss, Big Kiss, nasal positive pressure, or Ambu bag. As with any foreign body within or near the airway, aspiration is always a risk. In theory, by using positive pressure techniques such as the one described, the risk of aspiration should be lessened. Forcing air from the contralateral side should help expel the foreign body out of the nose as opposed to pushing it posteriorly into the airway. This is one advantage over the traditional methods of extraction such as Foley balloon catheters, Katz extractors, and other forms of mechanical extraction that may result in worsening the situation. Some known complications may include mucosal irritation, swelling, and bleeding.

References
The true-positive rate of blood cultures based on prospective studies is as low as 4.1 percent to 7 percent. Up to 40 percent of positive blood cultures are false positive.

Blood culture bottles. Bacteriology laboratory.

CONTINUED FROM PAGE 1

Table 1. How to Reduce False-Positive Blood Cultures13

- Use chlorhexidine or iodine tincture (preferred over povidone-iodine).
- Use peripheral venipuncture site.
- Collect at least two sets of cultures and inoculate 20–30 mL of blood per set. Each additional cc increases yield by 7 percent. Quantity is more important than timing (in relation to fever, etc.). If less than 10 mL obtained, send single aerobic culture bottle.

References
The Beloved Bougie

by RICHARD M. LEVITAN, MD, FACEP

In the world of airway devices, there are few that have more fans than the beloved bougie. Although it has a British history—it was first described in 1949 by Sir Robert Macintosh, a New Zealand-er who moved to Britain—it seems wherever I travel people love their bougies. In many of the Commonwealth countries and throughout

Figure 1. Bougies and tube introducers: Tracheal tubes have an inherent arcuate shape (top). A malleable styli can optimally shape a tube to be straight-to-cuff (35 degree bend, second from top). Bougies have long narrow axes with an upturned distal tip (Frova, blue color, allows for insufflation) and Smiths-Portex original design (resin covered fiberglass, beige). Cook Critical Care tracheal tube exchange catheter (straight shape, hollow bore for insufflation, second from bottom). The GlideRite styli is used with a hyperarugulated video blade to get the tube around the tongue, but has too wide a side-to-side dimension to insert into the trachea (bottom).}

Figure 2. Straight-to-cuff stylietted tube. Note the narrow long-axis view. There is a 35-degree bend at the proximal cuff. The styli stops at the distal cuff, leaving the last few centimeters of the tube pliable.

Figure 3. The Shake grip: By folding the bougie in half and gripping the bougie this way, it is easy to determine the direction of the distal tip, prevent tube rotation, and achieve fine control of the device.

most of Europe, airway managers treat this device as mandatory for tube insertion. Enthusiasts promote it for direct and video laryngoscopy, the “bougie-aided cric,” and placement through supraglottic airways. Some folks believe it has magical magnetic properties that guide it exclusive-ly into the trachea (not true).

During direct laryngoscopy, Sir Macintosh observed, “One of the difficulties in pass-ing tubes beyond a certain size is that the body of the tube obscures the view of the cords through which the tip must be direct-ed.” He described use of a “gum-elastic catheter,” which he passed through the cords first, followed by the tracheal tube. Although Sir Macintosh’s device was straight, it can be described shaping it into a curve to aid in cases of poor laryngeal exposure. Portex subse-quently developed a tracheal tube introducer with a Coudé tip made of resin-covered fiberglass, but some-how the device has been labeled the “gum elastic bougie” despite that it is neither gum, elastic, nor a bougie (ie, a dilator). The Portex device can be reprocessed, but as the world of airway devices became disposable, a variety of companies intro-duced single-patient use plastic “bougies” with both straight and Coudé tip designs, such as one by SunMed USA in Grand Rapids, Michigan (see Figure 1). Not only are bou-gies available in different colors of plastic, there are different versions with special features, such as the Frova catheter by Cook Medical Critical Care in Bloomington, Indiana, and the Intorees Pocket Bougie by BOMImed in Benesville, Illinois. The Fro-va has a hollow lumen, allow-ing for oxygen insufflation; the Pocket bougie is made of Teflon and packaged in a rolled shape to fit into a pocket. Bougies are also available in a pediatric version, such as the 10 Fr compared to the 15 Fr diameter bougie from SunMed USA.

What is magical about the bou-gie? Why do we love it? The bougie has three distinguishing charac-
teristics that make it a useful ad-junct for tube delivery. First, it has a smaller outer diameter than a tracheal tube. Most bougies are 5 mm (15 Fr); a tracheal tube of 25 mm inner diameter is almost twice as large as the trachea without hanging up on the tracheal rings. Finally, there is its tactile feel of the trachea on inser-tion. In 90 percent to 95 percent of cases, the bougie provides detec-tion of the “wobble” of the ante-ro tracheal rings, assuming the tip is oriented anteriorly. The posterior narrow axis shape, with a bend an-gle that respects the dimensions of the trachea (straight to cuff and 35 degrees, see Figure 2). When placed into this shape, I find that the distal tip of such a tube can be placed from below the line of sight, and tube in-ser-tion does not need to obscure the cords. I have carried a bougie in my airway tool kit for more than 15 years, and I have never deployed it in anger; I became obsessed with stylet shaping. A stylietted tube can also be inserted faster (tube placed, stylet withdrawn) compared to a bougie intubation, which is gen-erally a three-step process of bou-gie insertion, tube railroading, and bougie withdrawal.

Despite my enthusiasm for a straight-to-cuff styliet, I think a bou-gie should be part of every airway kit. It can be useful in situations of poor laryngeal exposure, for place-ment into a trach, or in an emergent cric. The single-use versions are in-
expensive. Some users complain it is hard to store because of its long length, about 60 cm. I address that issue by folding it in half. Bending the bougie and using a rubber band to keep it in this bent-over shape al-lows it to fit in intubation trays, draws, and jump bags. More impor-tant, when it is pulled out, this bent shape allows good control and pre-serves the long axis narrow dimen-sion of the distal tip as it is inserted. Although the Pocket bougie is easy to carry, straightening may be need-ed depending on its intended use (especially for direct laryngoscopy). In an egglotis-only view, always perform bimanual laryngoscopy (either with direct or video laryngoscopy) to try to visualize the in-tearyntesoid notch, then direct the bougie tip over it to ensure you’re entering the trachea and not the esophagus. In the true egglotis-only situation, make sure you keep the distal tip up (and feel the rings) as it can easily rotate under the egglotis and miss the larynx.

The bougie has historically been held with a pencil grip. I find this not an easy way to keep it from roll-ing over; I want to track which way the distal tip is pointing. Some ver-sions of the bougie place their depth markings (usually every 10 cm) on the same side as the direction of the Coudé tip, but this is not universal. I think the best way to grip the
bougie is what I call the “Shaka” grip (see Figure 3). “Shaka” is the Hawaiian hand gesture with the middle fingers folded over that means “hang loose.” Gripping the device this way, the user has fine control and knows the direction of the distal tip, and the insertion end is the proper length, all of which helps avoid rolling over.

If you work in a setting where you do not have anyone to help with tube placement over the bougie (while you keep the direct or video laryngoscope retracting the tongue), you can use a one-handed bougie/tube grip. I first found out about this from Paul Baker, senior lecturer in the department of anaesthesiology at The University of Auckland in New Zealand and director at Airway Simulation Limited, but I have been since informed he learned of it from an Italian physician. I named it the “Kiwi” grip a few years ago (see Figure 4). With this grip, you place the bougie/tube with your right hand, and after entering the trachea with the exposed distal tip of the device, you drop your laryngoscope, hold the top of the bougie with your left hand, and roll the tube down the bougie into the trachea with your right hand. Jim Ducanto, an anesthesiologist from Milwaukee who has an incredible passion for education and imaging, devised the Kiwi-D grip (tucking the tip of the bougie into the Murphy eye, see Figures 5 and 6).

Whatever grip you use when railroading tubes down a bougie, always do so with a left-handed turn of the tube as you pass the laryngeal inlet (approximately 14 – 16 cm from the mouth). This prevents any hang up on the laryngeal inlet (between the smaller outer diameter of the bougie and the larger inner diameter of the tube). Make the bougie part of your airway kit. You’ll never know when it may come in handy.

Figure 4. The Kiwi grip: A one-handed means of inserting the tube and bougie together, and prevent sliding of the devices on each other. After the bougie tip is inserted, the operator drops the laryngoscope and uses his or her left hand to counterclockwise rotate the tube down the bougie into the trachea.

Figure 5. The Kiwi-D grip, Jim Ducanto’s method of inserting the bougie tip into the Murphy eye of the tube as a one handed means of tube-bougie insertion.

Figure 6. Close up of the Kiwi-D grip showing tip of bougie in Murphy eye.


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Our Collective Antibiotic Shame

by RYAN PATRICK RADECKI, MD, MS

Modern medicine is stuffed full of egregious waste. Whether unnecessary imaging for lower back pain, scandalous improper use of cardiac stents, or the administrative and regulatory burden on clinicians, there is ample opportunity to improve. However, no part of care should cause us greater shame than our incurable addiction to antibiotic prescribing for benign, self-limited conditions. Astoundingly, four years of medical school and three years or more of specialty training have not yet proven sufficient to prevent clinicians from choosing wrongly in the most basic ambulatory complaints—bronchitis, pharyngitis, and sinusitis.

The treatment for acute bronchitis, for example, is very clearly laid out by the Agency for Healthcare Research and Quality and the National Quality Measures Clearinghouse in the Healthcare Effectiveness Data and Information Set. The correct treatment rate for adults ages 18 to 65 who have no comorbid condition is very clearly laid out by the Agency for Healthcare Research and Quality and the National Quality Measures Clearinghouse, available at http://www.qualitymeasures.ahrq.gov/content.aspx?id=47167. Accessed August 11, 2014.

Uncomplicated acute bronchitis has been established as a self-limited condition for which antibiotics confer no benefit. Lastly, the final upper respiratory scourge, acute sinusitis. The prevalence of bacterial infection during acute sinusitis is estimated to be only 2 percent to 10 percent, yet more than 80 percent of the 6 million annual outpatients who visit for acute sinusitis receive antibiotics. Sinusitis is, understandably, frustrating for patients and clinicians, with persistent symptoms lasting several weeks in many cases. However, antibiotics simply don’t provide much value. In clinical trials, only half of patients improved within the first week, and nearly 30 percent continued to have symptoms past 14 days. However, allocation to the antibiotic group did not increase overall cure versus placebo, and antibiotics decrease the duration of symptoms for only one in 20 patients. Considering there are no reliable clinical signs specific for bacterial versus viral etiologies, and it is challenging to select patients for whom intervention will substantially increase the chance of cure, antibiotics are best used judiciously for only the most exceptional cases.

Further complicating all these sins, physicians are persistently using a nuclear antibiotic arsenal for these extraordinarily straightforward conditions, which is akin to smashing a teacup with a sledgehammer. For each of these conditions, the status quo is unacceptable and, frankly, embarrassing.

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Lake City Medical Center (Lake City, FL) 25K annual visits. Medical Director and Staff.

Fishermen’s Hospital (Marathon, FL) 19K annual visits.

NEW Hunter’s Creek ER (Orlando, FL) Brand new freestanding ED affiliated with Orlando Regional. Estimated 19K visits in year one.

Poinciana Hospital (Orlando, FL) 35K annual visits.

Gulf Coast Medical Center (Pensacola, FL) 60K annual visits.

West Florida Hospital (Pensacola, FL) 51K annual visits.

Westside Medical Center (Plantation, FL) 46K annual visits.

Fawcett Memorial Hospital (Port Charlotte, FL) 23K annual visits.

Doctor’s Hospital of Sarasota (Sarasota, FL) 25K annual visits.

GL Hospital Heartland System (Oklahoma City, OK) 3 Hospital System.

Northside Hospital 5K, Petersburg, FL 14K annual visits. Associate. Medical Director and Staff.

Capital Regional (Tallahassee, FL) 10K annual visits. Affiliated freestanding ED - Kadlec Regional Medical Center (Kennewick, WA) 15K annual visits.

Dayport Health (Tarpon Bay, FL) 2 campus system.

Brandona Regional (Tarpon Bay, FL) 20K annual visits; Second campus in Plant City - 15K annual visits.

Medical Center of Trinity (Trinity Bay, FL) 56K annual visits.

NEW! Town & Country Hospital (Trinity Bay, FL) 10K annual visits. Medical Director and Staff.

West Pal Hospital (West Palm Beach, FL) 20K annual visits.

Cortezville Medical Center (Cortezville, GA) 46K annual visits.

Mayo Clinic at Waycross (Waycross, GA) 25K annual visits.

Waycross Medical Center (Waycross, GA) 65K annual visits. Regional Medical Director and Staff.

Greenview Regional (Bowling Green, KY) 32K annual visits.

Murray-Calloway County Hospital (Murray, KY) 15K annual visits.

Tennessee Heart Hospital (Huntsville, AL) 25K annual visits.

NEW! TnStar Parkridge West (Jonesboro, TN) 11K annual visits. Medical Director and Staff.

CHRISTUS St. Elizabeth (Pensacola, FL) 50K annual visits. Medical Director and Staff.

Valley Regional (Orem, UT) 33K annual visits. Medical Director and Staff.

CHRISTUS Spohn Healthcare System (Corpus Christi, TX) 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) 25K annual visits.

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

Metropolitan/Northeast Methodist (Carrollton, TX) 47K annual visits. Third Campus - Methodist Tarrant. 7K annual visits.

LoneStar Health System (Rockwall/ Wylie area, TX) 13-14K annual visits.

Medical Director (Montgomery) and Staff.

Heinbockel Hospitals’ (Redmond, ID) 100 3 Hospital System. 14-18K annual visits. Brand new affiliated freestanding ED - Arrowhead Regional Hospital. Estimated 10K visits in year one.

Sportsville Regional (Prescott/Prescott Valley, AZ) 25K annual visits.

Bayonet Point (Tarpon Bay, FL) 34K annual visits, Level II Trauma.

Christus Santa Rosa Allen & Cressdale (Corpus Christi, TX) 48K annual visits. Medical Director and Staff.

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Texas - Waco

If you have an excellent reputation for high-quality care and patient satisfaction, then look no further than this brand new partnership opportunity in Waco, TX. Providence Health Center is a busy, 75,000 volume ED that offers scribes and mid-level support to make your job easier. Medical director opportunity also available! BC/BE in emergency medicine required.

Work for Emergency Service Partners, LP, a physician-owned partnership offering equity units in as little as one year.

For more details, contact:
Renaldo Johnson today at renaldo@eddocs.com and mention job #259724-11.

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Kevin Dunn: kdunn@cunnasso.com
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Cynthia Kucera: ekucera@cunnasso.com
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Texas - San Antonio/Hill Country

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Enjoy beautiful Texas Hill Country scenery; charming music, wine, and food festivals; fine dining; and a true community atmosphere in Kerrville—all within a short drive of San Antonio.

Modern ED features strong medical director leadership, mid-level support, and high patient satisfaction. Emergency Service Partners, LP offers productivity-based compensation, generous 401(k), and a true physician partnership opportunity allowing you to invest in your future.

Contact Tania Dilkow:
(512) 610-0376 or e-mail tania@eddocs.com for more details, and mention job #10117-11.

Texas - Houston Area

Full-time and PRN openings for emergency physicians in Bellville, TX, just 1 hour from Houston!

Enjoy working with a dedicated, experienced nursing staff in this friendly community. Open to Family Medicine physicians with Emergency Medicine experience, as well as EM-boarded physicians.

ED is undergoing a 3,500 square foot expansion. Flexible scheduling and paid malpractice. Full-time doctors enjoy terrific partnership opportunity with Emergency Service Partners, LP; a respected choice in Texas for more than 25 years.

Contact Dana Friers at dana@eddocs.com and mention job # 241553-11.

Ohio – Northeastern Ohio

Physicians Emergency Services, Inc. is a progressive, single hospital, independent democratic group seeking another BC/BE physician to join its team.

The hospital is located in Ravenna and has a 22 Bed ED with electronic medical record system. Annual census is 37,000. Competitive salary. Excellent benefit package. Equal shareholder at 2 years. Eight-hour shifts rotate amongst all physicians except two existing physicians work exclusively nights. ED Physician coverage is 40 hours per day and PA/NP coverage 20 hours per day.

A description of some of our practice advantages along with a more detailed summary of our salary and benefit package is available.

For more information please contact
Brian Adams, MD, FACEP  440-864-4242 or by email at phyx_app@pesmed.com.

4MEMERGENCY

NORTHEAST OHIO

We are now looking for excellent EM physicians to join our stable and well established group at the following locations:

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Bedford, OH - 20k

UH Twinsburg Medical Center
Twinsburg, OH - 16k

UH Geneva Medical Center
Geneva, OH - 14k

St. Joseph’s Health Center
Warren (Eastland), OH - 38k

Howland, OH - 13.5k
Urgent Care
Warren, OH - 11.5k
Urgent Care

St. Elizabeth Health Center
Boardman, OH - 43k
Austintown, OH - 31k
Youngstown, OH - 41k

UH Geauga Medical Center
Chardon, OH - 19k

St. Joseph’s Family Medical Center
Andover, OH - 7.5k

To learn more about joining our practice, please contact Erin Waggoner at ewaggoner@4mdocs.com or Jeff Mirelli at jmirelli@4mdocs.com.

Reach us by phone at (888) 758-3999 or visit us online at www.4mdocs.com
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Explore emergency medicine and urgent care opportunities in NJ, NY, PA, RI and NC.

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Come Jam with the EMA Partners at Booth #1029

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Chief of Emergency Medicine
Cambridge Health Alliance (CHA), an award winning public health system, is currently recruiting for a BC, FT Chief of Emergency Medicine to oversee a well established and talented emergency medicine department consisting of a faculty of 32 physicians and 16 physician assistants. CHA is a teaching affiliate of Harvard Medical School and the Tufts University School of Medicine.
Under the direction of CHA’s Chief Medical Officer, the Chief of Emergency Medicine will provide clinical, administrative and academic leadership and have oversight of the staff delivering high quality emergency department services. Our health system is comprised of two hospital campuses, an integrated network of both primary and specialty care practices in Cambridge, Somerville and Boston’s Metro North Region and three emergency department sites with approximately 97,000 annual patient visits. CHA is committed to be accountable for the quality, cost and experience of care that we provide. The Chief also oversees the educational programs for Harvard medical students and rotating Emergency Medicine, Pediatric Medicine and Family Medicine residents.
The Chief of Emergency Medicine has both clinical and administrative responsibilities. The ideal candidate will have at least 10 years of post residency experience and 5 years of progressive leadership experience as well as successful track record of professional development and mentoring of junior staff. We seek a candidate with demonstrated ability to implement department wide protocols, identify and support clinical process improvement and quality initiatives in a multi site system. Candidates must have an understanding of the principles and requirements of Accountable Care Organizations, population health management and team based care models such as the Patient Centered Medical Home model of care. Successful experience in interdisciplinary collaboration is necessary and candidates must have excellent clinical and communication skills. Candidates must also have a strong commitment to our underserved, multi-cultural patient population. Experience with developing and overseeing graduate and undergraduate medical education programs is strongly preferred. Previous employment in an academic, multi site, safety net system is a plus.
At CHA we offer a supportive and collegial environment with a strong infrastructure – including an Electronic Medical Record system (Epic), as well as the opportunity to work with dedicated colleagues committed to providing high quality health care to a diverse patient population. Excellent opportunities exist for teaching medical students/residents, and we strongly encourage both women and minorities to apply. Academic appointment will be at the rank of instructor, assistant or associate professor of Medicine at Harvard Medical School, commensurate with experience.

Please forward CV’s to Laura Schofield, Senior Director of Physician Recruitment, CHA, 1493 Cambridge Street, Cambridge, MA, 02139. Email: Lschofield@challiance.org Phone: (617)665-3555, Fax: (617)665-3553. EOE.
www.challiance.org.

SEPTEMBER 2014 ACEP NOW 27
The University of Missouri-Columbia (MU) School of Medicine is seeking board-certified/prepared emergency medicine and pediatric emergency physicians for its growing emergency medicine department. Pediatric candidates should be either emergency medicine or pediatric residency trained, with completion of a pediatric emergency medicine fellowship. We are an energetic and talented faculty creating a patient-centered environment of excellence. We are committed to innovation, quality, collaboration, teamwork, valuing the individual, and honoring the dignity of the human spirit.

Faculty track (tenure or non-tenure) and academic rank will be commensurate with candidate’s experience and career goals. These physicians will practice at MU’s University Hospital, a designated Level I trauma center with more than 40,000 ED visits annually, and MU Women’s and Children’s Hospital, which has approximately 15,000 ED visits annually.

MU is one of the few institutions in the country with colleges of medicine, veterinary medicine, agriculture, engineering, nursing and health professions on one campus. The School of Medicine’s more than 650 faculty physicians and scientists educate more than 1,000 medical students, residents, fellows and other students seeking advanced degrees.

With our burgeoning department having its first year of EM residents in 2014, we are thrilled to be contributing to this legacy. Learn more online at: medicine.missouri.edu/emergency.

The Columbia area offers exceptional outdoor recreation, excellent schools, quality music and cultural events, as well as the excitement and energy of a SEC University town, all conveniently located between St. Louis and Kansas City.

Candidates should send a current CV which includes three listed references to:

Marc A. Borenstein, MD, FACEP
Department of Emergency Medicine University of Missouri - Columbia, School of Medicine
1 Hospital Drive, DC029.10 Columbia, MO 65212
Phone: (573) 882-3496  •  Email: borensteinm@missouri.edu  •  Apply online: hrs.missouri.edu/find-a-job/academic

The University of Missouri-Columbia is an Equal Opportunity/Affirmative Action employer and complies with the guidelines of the Americans with Disabilities Act of 1990. The department welcomes applications from underrepresented physician groups.
A change for the better.

At first Dr. Larry Geisler had doubts about working in a contract management environment. But when St. Mary Medical Center in Langhorne, PA, made a change to TeamHealth in 2005, Dr. Geisler says everything changed for the better. Patient visits are up. He has far fewer administrative headaches than before. And as Assistant Medical Director, he has plenty of opportunity for professional growth. The best part? His close-knit family and church can count on him for what they need most—his time.

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Don’t Miss TeamHealth’s ACEP Physician Reception
Tuesday, October 28 | 7 pm | The Field Museum | Chicago

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Forbes | 2014
AMERICA’S MOST TRUSTWORTHY COMPANIES
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The Emergency Group, Inc.  
Honolulu, Hawaii

The Emergency Group, Inc. (TEG) is a growing, independent, democratic group that has been providing emergency services at The Queen’s Medical Center (QMC) since 1973. QMC is the largest and only trauma hospital in the state and cares for more than 60,000 ED patients per year.

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

TEG is actively recruiting for EM Residency Trained, Board Certified or Eligible Physicians. Physicians will be credentialed at both facilities and will work the majority of shifts at the west Oahu facility in Ewa Beach, HI.

We offer competitive compensation, benefits and partnership track.

Our physicians enjoy working in QMC’s excellent facilities and enjoy the wonderful surroundings of living in Hawaii.

For more information, please visit our web site at www.tegahl.com or email CV to tegrecruiter@gmail.com. For inquiries, contact Jackie Hanzawa at 808-597-8799.

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The University of Florida Department of Emergency Medicine is recruiting motivated & energetic emergency physicians to join our community affiliate in Winter Haven, Florida.

Winter Haven is located in central Florida with easy access to both the Orlando and Tampa areas. It is home to beautiful lakes, a majestic tower, a world-class collection of vintage aircrafts and the largest LEGOLAND in the world. There are plenty of places to play, explore and reflect both on land and on the water.

Winter Haven Hospital has 527 beds and is a nationally recognized Magnet hospital. The 33-bed ED provides services to 60,000 patients each year in a physician friendly environment with full nurse staffing, radiology services located in the ED and dedicated support staff including:

- Full subspecialty backup available 24 hours a day
- Twenty four hour CT, US, and MRI with stat dictation reports
- Nationally accredited stroke and interventional ACS programs
- Integrated EMR systems and ITS team

Join the University of Florida team and earn an extremely competitive community-based salary as a UF assistant or associate professor in a private practice setting. Enjoy the full range of University of Florida State benefits including sovereign immunity occurrence-type medical malpractice, health, life and disability insurance, sick leave, and a generous retirement package.

All physicians are ABEM / ABOEM Board Certified / Board Eligible.

E-mail your letter of interest and CV to Dr. Kelly Gray-Eurom  
Kelly.grayeurom@jax.ufl.edu

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Cynthia Kucera: ckucera@cunnasso.com

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North Shore-LIJ is America’s third largest, non-profit, secular health system, with a network of 16 hospitals serving the greater New York metropolitan area. Our Department of Emergency Medicine Services includes the Emergency Departments of five tertiary care teaching hospitals, a children’s hospital, several community hospitals, urgent care centers and our new Freestanding Emergency Department in Greenwich Village.

If you’re a BC/BE Emergency Medicine-trained physician with outstanding skills, we want you to join our growing team. Whether you’re an experienced physician, a new graduate or an experienced EM leader seeking a Chair or Associate Chair position, there are exciting opportunities throughout the health system for you.

Recent salary increases, along with a generous benefits package, make this a very exciting time to join our EM team.

We offer a competitive salary and benefits package. For further information, please contact Laura Screeney, FASPR, Corporate Director, Office of Physician Recruitment at (888) 685-7545. To apply, please visit www.nsliejEMPhysicians.com

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**ENJOY A HISTORIC EVENING**

TeamHealth’s Physician Reception

Tuesday, October 28 | 7 pm | The Field Museum | Chicago

Enjoy a wonderful evening in a world-class museum in the Windy City! Join TeamHealth at The Field Museum for our Annual Physician Reception during ACEP 2014. Enjoy stunning architecture and travel back in time with 4.6 billion years of exhibits under one roof. And meet Sue, the life of the party. At 67 million years old and 42 feet long, she’s the largest and best preserved T-Rex in the world! Plus we’ll have great food, an open bar and dance floor. It’ll be historic!

**Please visit our ACEP booth #1211 to get your free ticket for this event!**

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**CHIEF, EMERGENCY MEDICINE**

San Francisco General Hospital
University of California, San Francisco

The Department of Emergency Medicine at the University of California, San Francisco (UCSF), School of Medicine, seeks an outstanding leader in Emergency Medicine to serve as Chief of Emergency Medicine at San Francisco General Hospital (SFGH). This position offers an exceptional leadership opportunity as the UCSF Department of Emergency Medicine, and SFGH in particular, are in a phase of expansion. SFGH will open a new hospital, with a 60-bed ED, at the end of 2015 incorporating both adult and pediatric emergency medicine. The Chief will have major responsibilities for faculty recruitment and evaluation, the Division’s budget and overseeing the clinical service, research, residency and medical student programs at SFGH.

The UCSF Department of Emergency Medicine provides comprehensive emergency services to a large local and referral adult and pediatric population with approximately 93,000 visits a year at UCSF Medical Center and San Francisco General Hospital. In early 2015, the Department will also staff a new pediatric emergency department at Mission Bay. SFGH is a level-I trauma center, paramedic base station and training center and currently sees 50,000 patients annually. It is a safety-net hospital serving all of San Francisco, with a clear mission to care for the under-served of the city. It is well resourced and staffed by physicians and residents from UCSF in all medical and surgical specialties. In addition to the opening of a new hospital at SFGH, the Department of Emergency Medicine has a fully-accredited 4-year Emergency Medicine Residency Program with 50 residents and directs fellowship programs in EMS, ultrasound, education, and toxicology. Research is a major priority of the Department, with over 50 ongoing studies and 100 peer-reviewed publications last year.

Successful candidates for this position must demonstrate exceptional leadership, administrative and organizational skills and have a national reputation in academic emergency medicine in the areas of patient care, medical education and research. The applicant must have a minimum of 5 years leadership experience in an academic emergency department and be board certified in Emergency Medicine.

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

Send cover letter and curriculum vitae to:

Neil Powe, MD, Search Committee Chair
c/o Natulya Khait
UCSF Department of Emergency Medicine
533 Parnassus Avenue, Suite U575
San Francisco, CA 94143-0749
Natulya.khait@emergency.ucsf.edu

UCSF seeks candidates whose experience, teaching, research, or community service has prepared them to contribute to our commitment to diversity and excellence. UCSF is an Equal Opportunity/Affirmative Action Employer. The University undertakes affirmative action to assure equal employment opportunity for underutilized minorities and women, for persons with disabilities, and for covered veterans. All qualified applicants are encouraged to apply, including minorities and women. For additional information, please visit our website at http://emergency.ucsf.edu
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Why Take the National Emergency Medicine Board Review Course? The fact is that taking certifying or recertifying board examinations is a stressful and time-consuming experience. The sheer mass of information that needs to be reviewed, combined with the press of occupational and personal responsibilities makes finding the time to study very difficult. Even with adequate time to study, the volume of material to be studied is staggering: Rosen’s 2006 edition is 3179 pages long and the latest edition of Tintinalli has 1917 pages. Bottom line - preparation for these exams can be a daunting process. The National Emergency Medicine Board Review was created 18 years ago to specifically address the needs of busy emergency physicians required to take their certification or recertification examinations and who wanted a highly focused, no-fluff course that delivers the information they need in a concentrated, high-yield manner.

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*That’s right – 100% of your tuition refunded, plus the opportunity to attend selected future CME programs at no charge. There is no fine print and no administrative fees are withheld.

Topics covered include: Cardiology, Dermatology, Endocrine, ENT, Environmental, GI, HEM/ONC, Nephrology, Neuropsych, OB/GYN, Ophthalmology, Orthopedics, Pediatrics, Policies, Procedures & Skills, Pulmonary, Test Taking, Toxicology, and Trauma.

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For more information on all CEME Courses, call toll-free: (800) 651-CEME (2363)
To register online, visit our website at: www.ceme.org