or the last decade and a half, patients presenting with acute ischemic stroke have had one active option for emergency intervention: intravenous tissue plasminogen activator (tPA). In the context of ongoing controversy, pervasive conflicts of interest, and a paucity of conclusive trials, use of tPA for stroke has increased but hardly taken hold. Many professional organizations still oppose its mandated use, and the basic assumptions of its efficacy continue to be challenged.

CONTINUED on page 17
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The Patient-Physician-Body Cam Relationship

“Speak slowly and look directly into the camera”

by KENNETH V. ISERSON, MD, MBA, FACEP, FAAEM, FIFEM

Two fundamental pillars of the Hippocratic Oath have been attacked, not by politicians or faceless bureaucrats but by our own specialty’s leaders.

Jeremy Brown, MD, director of the Office of Emergency Care Research at the National Institutes of Health, recently wrote that not only should police be using body cameras but that “these devices should also be worn by healthcare providers.” Police, of course, have a job that constantly involves legal issues and a high potential for violence; our job doesn’t.

Dr. Brown goes on to claim that wearing “med-cams” would have “a civilizing effect” on patient-physician interactions, decrease lawsuits, and reduce violence in EDs. These assertions are so patently ridiculous that he must use hypotheticals, tangential and off-topic research (coloscopy?), and rare events (significant violence against clinicians) to justify them. His attempt to head off any criticism is likewise ill-advised, comparing any would-be opponents of this technology’s use in the ED to those who ridiculed the technology with natural language-processing.
Obviously, George Orwell’s prescient novel 1984, which described Big Brother watching everyone, did not teach its lesson. While our society increasingly relies on seemingly omnipresent security cameras and government surveillance, that level of invasiveness has not yet routinely entered the clinical examination room.

From the text:

"...so what would be the unintended, but clearly seen, consequences resulting from universal emergency physician body cam use..."
EMF Earns High Rating for Fiscal Management

The Emergency Medicine Foundation (EMF) has received a four-star rating from Charity Navigator, America’s premier charity evaluator. Nonprofit-sector organizations are graded on sound fiscal management and commitment to accountability and transparency. Receiving four out of a possible four stars indicates that EMF adheres to good governance and other best practices that minimize the chance of unethical activities and consistently executes its mission in a fiscally responsible way.

Approximately a quarter of the charities evaluated by Charity Navigator have received the highest rating, indicating that EMF outperforms most other charities in America.

Advanced PEM Assembly Wraps Up in New York

ACEP and the American Academy of Pediatrics teamed up in late March to offer the Advanced Pediatric Emergency Medicine (PEM) Assembly in New York City. In addition to attending ultrasound and pediatric skills workshops, more than 500 physicians, nurses and physician assistants attended the Essentials track and the two days of lectures.

The Advanced PEM Assembly moves to Orlando in 2016, but that doesn’t mean we’ve closed the book on the latest offering. Whether you want to brush up on your pediatric emergency medicine skills or take your dual-boarded training to the next level, the PEPID Virtual Advanced PEMiS and Virtual Essentials in PEMiS offer a wide range of valuable content. Sessions on wound care, pediatric resuscitation, pneumonia in children, and much more are now available at virtual.acep.org/common/tracks.aspx/13.

ACEP Breaks Ground on New Headquarters

ACEP broke ground on new headquarters on April 16, 2015. Located on a six-acre tract of land near the Dallas/Fort Worth International Airport, the new building will be three stories with approximately 57,000 square feet. It will include modern work areas, top-notch audiovisual capabilities and video conferencing, a range of topics but also offer an engaging and popular media journals. He also edits the SMART EM and TheNNT.com web resources. Dr. Shreves is a board-certified and practicing emergency and palliative medicine physician, works as faculty in both the ED and palliative medicine departments with the Icahn School of Medicine, and will soon be the associate program director for the Mount Sinai St. Luke’s–Roosevelt Hospital EM residency. “For us, it feels like a chance to chat about the latest studies and to have some fun,” said Dr. Newman. “And if it helps Annals connect with the global community, well, that’s icing on the cake.”

The podcasts are free and accessible through multiple formats:
1. Play on your computer by clicking on any of the individual podcast files on the Annals Web site.
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3. Subscribe to the Annals of Emergency Medicine podcasts at the iTunes Store and have the podcast automatically download to your iTunes each month.
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The podcasts are an easy-to-use source of information from the journal. One listener said the podcasts “dive into why the article is important. I feel smarter after hearing you ask questions about the research.” Another reader said, “What I love about your podcast is that it is very casual and you explain why certain studies are important and what they did well/poorly. You do this better than any other journal summary I’ve ever listened to.”

Annals podcasts. One of a multitude of benefits for all ACEP members. Smart, engaging, relevant. Easy to listen to while exercising or driving to your shift. Come and hear what you’ve been missing.

Celebrate EMS Week

ACEP is happy to partner with the National Association of Emergency Medical Technicians to celebrate the EMS Strong campaign this month. EMS Strong makes National EMS Week, May 17–23, 2015, a 365-day-a-year initiative to give EMS a significantly greater visibility among other health professions and communities. While EMS Week is an integral part of the campaign, EMS Strong is the vehicle to drive awareness, interest, and excitement about the profession year-round. EMS Week brings together local communities and medical personnel to publicize safety and honor the dedication of those who provide the day-to-day lifesaving services of medicine’s “frontline.” This information can be used throughout the year for public education and safety programs. For more about EMS Week and EMS Strong, go to www.acep.org/emsweek.

Congress Repeals the SGR

After 17 temporary fixes and years of treasured efforts on the part of many of ACEP members, the Senate passed legislation (H.R.2) on April 15, 2015, to permanently replace the flawed Medicare Sustainable Growth Rate (SGR) formula with a payment system that rewards quality, efficiency, and innovation. President Barack Obama signed it into law on April 16.

I want to thank Congressional leaders in both the House and Senate for their leadership in securing passage of this historic legislation, which ends a 13-year annual bandage approach to preventing steep financial cuts to Medicare physician payments. ACEP has long advocated for an end to the fiscally irresponsible cycle of annual short-term patches—and at long last, Congress has achieved it. This legislation will stabilize America’s Medicare system and protect access to medical care by Medicare patients, including the 78 million baby boomers who will enroll over the next few years.

This new system is essential to emergency departments because elderly patients are more likely to need emergency care than any other age group, and the fastest growing segment of the US population is people over 85 years of age.

The legislation also extends the Children’s Health Insurance Program, which provides affordable health care insurance for children in low-income families. This two-year extension is crucial to ensuring that our youngest and most vulnerable patients have access to health care.

It represents a significant accomplishment for all the emergency physicians who actually made their voices heard in Congress.

As president of ACEP I want to thank you—the thousands of ACEP members who over many years responded to our grassroots alerts, came to Washington, D.C., and made thousands of Hill visits—and the staff of ACEP’s public affairs office in Washington. Without everyone’s collective efforts, this tremendous achievement might not have been realized.

Sincerely,

Michael J. Gerardi, MD, FAAP, ACEP President
American College of Emergency Physicians

The Official Voice of Emergency Medicine
ACGME/AOA Merger May Change Osteopathic Training

Challenges are ahead for community-based osteopathic EM residency programs

BY REBECCA PARKER, MD, FACEP, AND RICK ROBINSON, MD, FACEP

On Feb. 24, 2013, the Accreditation Council for Graduate Medical Education (ACGME), the American Osteopathic Association (AOA), and the American Association of Colleges of Osteopathic Medicine (AACOM) announced their agreement to a memorandum of understanding that outlined a single graduate medical education system for residency and fellowship programs in the United States. Together, the organizations embarked upon a journey creating the infrastructure for a smooth transition to merge into a single system, which will transpire over the next five years.

As our allopathic and osteopathic emergency medicine programs undergo this merger together, there are current differences between the two regulatory bodies that may be especially significant to a subset of AOA emergency medicine residency programs: the community hospital–based osteopathic programs. Nearly three-quarters of the AOA EM programs are community based and have trained highly skilled board-certified physicians for many years. However, differences in core faculty requirements, as well as sponsoring institutional support, may threaten their stability and financial viability.

**FACULTY**

The ACGME, unlike the AOA, requires protected time for core faculty. The current ACGME requirements state that core EM faculty cannot work in excess of 28 clinical hours per week on average. Further restrictions are placed on program directors (PDs), who are restricted to 20 clinical hours per week, and assistant or associate PDs, who are restricted to 24 clinical hours per week. The AOA requirements include protected time for their PDs but not for core faculty. Many of the community osteopathic programs pay their core faculty a small stipend, and many of those faculty members donate this stipend back to the school, serving as faculty for free. These osteopathic core faculty members earn their salary mostly over ten hours of their hourly paid clinical shift work. AOA community EM programs are understandably concerned about how to fund core faculty protected time, assuming incorporation of the limits on clinical hours with ACGME as the single accreditation body.

Additionally, ACGME programs previously could select their individual qualifying core faculty members from their rosters at large. The requirement included one core faculty member for every three residents, with the chair/chief, PD, and assistant or associate PDs as automatic core faculty members. However, recently, the definition of core faculty appears to have changed to automatically include all faculty on a given program’s roster who provide at least 15 hours of resident interaction per week on average. Although the most recent iteration of ACGME program requirements for graduate medical education in emergency medicine does not specifically address this qualification for inclusion as core faculty, it is clearly in practice.1

Currently, allopathic programs must provide an annual online update through ACGME’s Accreditation Data System (ADS). When entering/updating the faculty roster, the program is required to report the average number of resident interaction hours per week for all faculty who provide resident education and/or supervision. During the 2014 update, one of the authors noted that the ADS automatically assigned the status of core faculty to all staff meeting the 15 hours per week criteria mentioned above. The author’s program must provide a minimum of 12 core faculty for its 36 residents. The effect of the ADS automated process was to increase the core faculty count to 29 individual staff, representing 88 percent of all regularly scheduled staff. Also of note is that the PD is no longer considered part of the core faculty count for ADS reporting purposes and is therefore not one of the 29 mentioned above. This automated process compounds protected time challenges when considering the strict definition of core faculty and has been the subject of some discussion on the Council of Residency Directors listserv.

**COMMUNITY HOSPITAL SETTING**

The ACGME clearly expects and holds the sponsoring institution accountable to provide a reasonable salary and protected time for core faculty. However, community-based osteopathic programs are concerned that their resources, often the local community hospitals, cannot afford to provide additional funding for their programs. Currently, an SAEM/AACEP work group is exploring alternative funding methods for graduate medical education spots, which could provide assistance. Some PDs and chairs suggest exploring the concept of clinical core faculty whose scholarly endeavors are truly centered at the bedside.

Along with required protected time for core faculty, the ACGME requires that they engage in a significant amount of scholarly activity, with specific requirements related to peer-review publications. In the community-based practice setting, this will be a challenge and a challenge related to the infrastructure of the sponsoring institutions, most frequently community hospitals.

Finally, current ACGME requirements include that the sponsoring institution for an EM program has a major educational commitment as evidenced by existing training programs in other major specialties to include internal medicine, general surgery, pediatrics, and obstetrics and gynecology. Once again, in a community hospital setting, the sponsoring institution may not have this supporting infrastructure in place.

As the ACGME/AOA merger advances, these significant differences will come to light. They are not insurmountable, and a thoughtful discussion aimed at a beneficial compromise for all programs will prevail. In the end, our uncompromising goal remains to provide the highest quality training and preservation of our hard-earned and staunchly supported EM programs.

Special thanks to Robert Hunter, DO, MPH, FACOEP; program director in emergency medicine at Grandview Medical Center in Dayton, Ohio; Thomas Maestas, DO, FACOEP; program director in emergency medicine at St. Lucie Medical Center in Port St. Lucie, Florida; Mark Mitchell, DO, FACOEP; president of the American College of Osteopathic Emergency Physicians; and Sandy Schneider, MD, FACEP, ACEP director of emergency medicine practice and former chair of the University of Rochester Department of emergency medicine.

**Reference**


**DR. PARKER** is chair of the ACEP Board of Directors and clinical assistant professor at Texas Tech University in El Paso.

**DR. ROBINSON** is vice chair and program director in the department of emergency medicine at John Peter Smith Hospital in Fort Worth, Texas, and past president of the Texas College of Emergency Physicians.
Progress on ACEP’s New CEDR

It will support patient care, enable participation in quality improvement programs, and meet value-based reimbursement requirements

BY JAMES J. AUGUSTINE, MD, FACEP, STEVE EPSTEIN, MD, FACEP, MICHAEL A. GRANOVSKY, MD, FACEP, AND STACIE SCHILLING JONES, MPH

A s part of its ongoing commitment to providing the highest quality of emergency care, ACEP has developed the Clinical Emergency Data Registry (CEDR). This is the first emergency medicine specialty-wide registry at a national level, and it’s designed to measure and report health care quality and outcomes. It will also provide data to identify practice patterns, trends, and outcomes in emergency care. CEDR is an evolving registry that will support emergency physicians’ efforts to improve quality and practice in all types of EDs even as practice and payment policies change over the coming years. ACEP CEDR has been qualified by the Centers for Medicare & Medicaid Services (CMS) as a qualified clinical data registry (QCDR) to help emergency physicians and clinicians meet both the CMS Physician Quality Reporting System (PQRS) reporting and other quality reporting requirements.

Quality Care Through Comparative Evidence

CEDR will, for the first time, enable emergency physicians to review their practice patterns and outcomes in comparison with their peers. Starting in 2015, CEDR will provide emergency physicians and clinicians with patient outcomes and health care quality metrics at the physician, ED, and group levels. Initially focusing on ACEP’s Choosing Wisely recommendations and ED throughput, CEDR will gradually expand to include other aspects of emergency care in 2016.

A Physician-Friendly System

CEDR is designed to be physician friendly. With little data entry burden to emergency care in 2016. CEDR will, for the first time, enable emergency physicians to review their practice patterns, trends, and outcomes in comparison with their peers. It will support participating emergency physicians with feedback regarding their individual- and/or ED-level performance on a range of process and outcome quality measures, benchmarked against their peers at national and regional levels. For government policy makers, CEDR will provide further understanding around clinical effectiveness, patient safety, care coordination, patient experience, efficiency, and system effectiveness.

How Will CEDR Data Be Used?

The use of de-identified aggregated data generated by CEDR will support national comparative benchmarks, evidence-based shared decision making, and guideline-informed physician practices. It will provide participating emergency physicians with feedback regarding their individual- and/or ED-level performance on a range of process and outcome quality measures, benchmarked against their peers at national and regional levels. For government policy makers, CEDR will provide further understanding around clinical effectiveness, patient safety, care coordination, patient experience, efficiency, and system effectiveness.

Why Should Emergency Physicians Participate in CEDR?

Instead of miring physicians in an alphabet soup of reporting requirements, CEDR allows for a single data capture to fulfill the requirements of multiple programs, making quality measure reporting more efficient. The health care environment is transitioning from volume-based to value-based payment for care. CEDR will ensure that emergency physicians, rather than other parties, are identifying what practices work best and for whom.

Privacy Policy

Information collected by CEDR is stored in a segregated HIPAA-compliant server in a secure electronic vault with robust backup. Only participating emergency physicians or their designated ED administrator can see their performance with comparisons to national statistics.

Summary

CEDR is being developed under a sophisticated information technology infrastructure and will be implemented in phases over the next year in terms of the number of participating EDs, scope, and functionality. The initial testing and QCDR approval phase began in April 2015 with the participation of five EDs. The pilot phase is expected to begin in May 2015. Through the aggregation and organization of data on clinical effectiveness, patient safety, care coordination, patient experience, efficiency, and system effectiveness, CEDR will provide clinicians with a definitive resource for informing and advancing the highest quality of emergency care.

ADDITIONAL RESOURCES
ACEP CEDR website: www.acep.org/cedr

The first, and only, app to offer guidance about complex bleeding disorders

Since 2011, Coags Uncomplicated™ has offered expert clinical information to thousands of your colleagues.

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89% have used the app as a reference in clinical decision making or case management (average of 12 cases per HCP)

Discover this comprehensive diagnostic resource for yourself
Business Weighs In

The U.S. Chamber of Commerce is one avenue to tap the promise of health–business collaboration

All businesses in the United States, from the mom-and-pop groceries to retail giants like Walmart, have an interest in health care. Whether they are health care providers, innovators, or purchasers, businesses can bring knowledge and a drive for innovation to the health care sphere. ACEP Now Editori- al Advisory Board member Ricardo Martín- ez, MD, FACEP, chief medical officer and vice president of North Highland and assistant professor of emergen- cy medicine at Emory University in Atlanta, recently spoke with Jennifer Pierotti, di- rector of health policy at the U.S. Chamber of Commerce, about how physicians and businesses can work together to create an innovative health care environment and provide the best care for patients. Here are some highlights from their conversation.

Dr. Ricardo Martinez: Tell us about the U.S. Chamber and who it represents.

Jennifer Pierotti: We are the world’s larg- est business association. We represent the interests of over three million businesses from every size, sector, and region. Our members include everyone from local and state chambers, the mom-and-pop stores on the corner, to industry associations and international corporations. We have a broad array of interests as well as policy issues that we develop.

RM: I attended the Chamber’s Annual Health Care Summit on innovation, and it was terrific to see the breadth of peo- ple on the business side and also the entrepre- neurial side who are focusing on health care.

JP: Our Annual Health Care Summit is a chance to step away from looking at the political realities and driving policy issues of the day and look at the folks on the frontlines of delivering health care. We can talk about how doctors use telemedicine to access rural areas and new clinical tri- als happening at places like the Cleveland Clinic—areas we don’t get a chance to look at on an everyday basis.

RM: I think emergency physicians would be surprised at how much the Chamber is involved in health care. Tell us more about where the business community sees itself in the health care landscape.

JP: A lot of businesses in the health care space, like the companies creating cutting-edge pharmaceuticals or hospital systems, are coming up with new delivery models or the latest health care technology. In addition to private-sector innovations, businesses, more employers and care are on the frontlines of being the providers of health care coverage to their employees. They have been dealing with the challenges of our health care system way before the Af- fordable Care Act. Finally, employers are uniquely positioned to deal with some of the wellness and chronic disease issues individuals are facing these days because employees spend about two-thirds of their work day at their place of employment.

RM: The rollout of health care reform has created a changing landscape, and different areas are evolving at various rates. What are the most important issues that the Chamber sees as needing to be tackled?

JP: In order to keep all of this private-sector innovation going, what sorts of regulatory reforms need to take place? What parts of the Affordable Care Act do we need to address so that employers can keep doing what they’re doing? The Chamber as a whole has a regulatory reform agenda that promotes changes like more trans- parency and longer comment periods for the regulatory process. Reforms like this are meant to ensure that businesses aren’t battling red tape and can continue to create health care startups and innovate. Much of the health care law was written through the regulatory process, and it went much faster than it should have gone given the complexity and scope of many of these health care regulations. Our main priority right now is reducing the impact of the em- ployer mandate.

RM: Many of our readers would be sur- prised to know that there are a lot more private health care exchanges than public ones, spawned as business began to move away from defined benefits and toward defined contributions. As busi- ness moves from being the sole source of insurance to being a partner with the employers for insurance, what can we expect to see from business in terms of working with their employees to ensure that they have health coverage?

JP: The biggest thing we’re seeing now is the shift to a new consumerism in health care. Despite some of the mandates on the insurance market, employers are looking to how they can use cost sharing to get their employees the best deals and options for coverage. They’re investing in things like health reimbursement arrangements, flex- ible spending accounts, health savings ac- counts, and different ways employees can get more bang for their buck. We’re going to see more of that as employees are seen as the consumers, rather than recipients, of health care on a much wider scale.

RM: Are employers trying to make it simpler for the employees to make better decisions?

JP: Definitely. Health insurers are focusing on better communications with employees to try to break down what employees are getting for each plan being offered. This is not just the summary of benefits and cov- erage that employers have to provide but really speaking to the employees in terms that make sense: “This is what you had last year. This is what is different this year.” Built into the private exchanges you mentioned is a feature where members can have direct contact with benefit advis- ers who can tell them what they’re get- ting. Of course, a lot of this is done online, and there are strong efforts focused on figuring out what formats are easiest for people to understand, what kind of infor- mation they are looking for, and real-life examples of “if he gets this procedure, it’s going to cost this much.”

Right now, if you’re a doctor and you want to treat your Medicare patient in another state using telemedicine, you have to be licensed in both states. This is a great example of a regulatory barrier that could use additional flexi- bility so we can open up these channels of care.

~Jennifer Pierotti, director of health policy at the U.S. Chamber of Commerce

RM: That last part especially is important to emergency medicine because we fre- quently have patients with high-deductible plans. Our ability to take care of them and then get paid can be a challenge, especially if it’s a complicated patient. The other side of the coin is that high deductible has really generated a large amount of compe- tition for those first dollars in terms of the urgent care clinics and retail clinics. What do you see in that growth of consumerism and the first dollar affecting the growth of new types of businesses in the market?

JP: We’re at an interesting place in the implementation of the Affordable Care Act. There’s this whole new group of low- income people and “young invincibles” who now have access to coverage but still have trouble accessing care. If you’re low income, you can’t always leave work as eas- ily or miss those work hours to go to the physician’s office. As a country, we’re still working through issues of where people are ending up in the access process. It is a learning experience both for the employ- ees and consumers of health care, as well as the providers.

RM: Virtual care and telehealth have been slow in the uptake but are now accelerat- ing. Do you have any insight into that from the business side?

JP: We’ve seen a huge emergence of health information technology, and everybody al- ways assumes that more technology is bet- ter in whatever form.

Of course, we hear a lot from the physi- cian side that electronic health records are really slowing them down. It’s caus- ing dissatisfaction in the workplace for physicians. But we’re seeing more inno- vation in this space to make technology more useful and tailored to physi- cians based on specialty.

On the other hand, telemedicine has shown it is a great way to reach some of these newly-insured populations, espe- cially low-income populations and rural populations that don’t have the same ac- cess to physicians as compared to large cities or high-income areas. As the U.S. Chamber, we’re working toward getting rid of some of the barriers to using this telemedicine as a targeted tool to increase access to care. Right now, if you’re a doctor and you want to treat your Medicare pa- tient in another state using telemedicine, you have to be licensed in both states. This is a great example of a regulatory barrier that could use additional flexibility so we can open up these channels of care.

RM: At hospital-based physicians, a lot of times we find ourselves being very insu- lar or working within our hospital, but it sounds like there’s a need for us to reach out to the business community. From your experience in the health care space, what advice do you have to offer physicians in order to start an effective and meaningful dialogue with business?

JP: The perfect place to start is your local or state chamber. We’ve seen a number of groups develop regional health care collaborations at the local or state level. For example, Nashville, Tennessee, has a health care effort led by the Nashville Area Chamber of Commerce that pulls to- gether all of the health-sector players in that area—hospitals, physician groups, and businesses—and they all figure out the challenges together for the area. They’ve been able to move forward with creating cultures of wellness, making sure that they have adequate hospital and emergency room service and ensuring the business environment is supporting the local health care industry. At the end of the day, if these groups are insulated from the others, they can’t collectively deal with the problems and come to a solution that’s best for that geographic location.
New Guidance on Thoracic Aortic Dissection

ACEP Board of Directors approves clinical policy guiding diagnosis, treatment of TAD

BY ANDREW FREDERICKS, MD, AND DEBORAH DIERCKS, MD, FACEP

In October 2016, the ACEP Board of Directors approved a new clinical policy, developed by ACEP’s Clinical Policies Committee, on the evaluation and management of adult patients with suspected acute nontraumatic thoracic aortic dissection. As is the case with all of ACEP’s clinical policies, it has been published in Annals of Emergency Medicine.1

Acute nontraumatic thoracic aortic dissection is a deadly disease and a can’t-miss diagnosis in the emergency department. Although inpatient mortality from this condition approaches 27 percent, the disease has a very low incidence, and there is little high-quality evidence to guide an approach to diagnosis and management. Considerable medical-legal risk also surrounds its misdiagnosis.

Committee members focused on five critical questions associated with the ED evaluation and management of this condition. A systematic review of the evidence was conducted, and the committee then elucidated a strength of recommendation (A, B, or C) associated with answers to each of the questions (see Table 1). Input was received from ACEP members and individual members of the American Heart Association and the Society for Vascular Surgery during the 60-day open-comment period.

Critical Question 1
In adult patients with suspected acute nontraumatic thoracic aortic dissection, are there clinical decision rules that identify a group of patients at very low risk for the diagnosis of thoracic aortic dissection?

Approximately 8–10 percent of all patients present to the ED with chest pain, and because chest pain is a common complaint in aortic dissection, the treating clinician often considers the diagnosis in patients with this complaint. Therefore, it would be ideal if a clinical decision rule could be used to identify patients at very low risk for having an aortic dissection who do not need to be evaluated for dissection by diagnostic testing. Unfortunately, no such clinical decision rule has been validated in a prospective trial, thus use of clinical decision rules to identify patients at very low risk for acute nontraumatic thoracic aortic dissection was given a Level C recommendation.

Critical Question 2
In adult patients with suspected acute nontraumatic thoracic aortic dissection, is a negative serum D-dimer sufficient to identify a group of patients at very low risk for the diagnosis of thoracic aortic dissection?

Once a clinician decides to evaluate a patient for thoracic aortic dissection, imaging and diagnostic tests must be selected. In recent years, there has been a great deal of literature published on the use of D-dimer in the evaluation of aortic dissection. However, the low quality of these studies resulted in a Level C recommendation for the use of D-dimer to rule out dissection.

Critical Question 3
In adult patients with suspected acute nontraumatic thoracic aortic dissection, is the diagnostic accuracy of a computed tomography angiogram (CTA) at least equivalent to that of transesophageal echocardiogram (TEE) or magnetic resonance angiogram (MRA) to exclude the diagnosis of thoracic aortic dissection?

In the ED, CTA is often used to evaluate patients for suspected thoracic aortic dissection. The Class I, II, and III studies identified in the systematic review of the diagnostic accuracy of CTA reported sensitivities ranging from 93 percent to 100 percent. The evidence demonstrated that the sensitivity of CTA is very similar to that of TEE and MRA, diagnostic modalities that have been suggested as useful for the evaluation of an aortic dissection. CTA is often more readily available in the ED than TEE and MRA, which makes it a practical diagnostic tool. As such, its use received a Level B recommendation.

Critical Question 4
In adult patients with suspected acute nontraumatic thoracic aortic dissection, does an abnormal bedside transthoracic echocardiogram establish the diagnosis of thoracic aortic dissection?

A bedside ultrasound exam such as a transthoracic echocardiogram (TEE) to rule out acute nontraumatic thoracic aortic dissection would be very useful and is becoming a tool in the ED physicians’ diagnostic algorithm as our skills in ultrasound have evolved. However, there are no current studies evaluating ED physician–performed TEE in ruling out thoracic aortic dissection. Thus, no recommendation was provided.

Critical Question 5
In adult patients with acute nontraumatic thoracic aortic dissection, does targeted heart rate and blood pressure lowering reduce mortality or morbidity?

Once a diagnosis is made, treatment is initiated with the aim of reducing heart rate and blood pressure. Existing guidelines generally recommend aiming for targets of 60 beats/minute and systolic blood pressure below 120 mm Hg. However, there are currently no prospective human trials that demonstrate the superiority of a strategy of decreasing heart rate prior to reducing blood pressure. There is insufficient evidence to definitively identify an optimal target in all patients regardless of age and comorbidities. Therefore, no recommendation was made.

The diagnosis and management of acute thoracic aortic dissection in the ED are challenging. For many reasons, this disease is very difficult to study in randomized controlled trials that might elucidate clearer diagnostic or management pathways. This clinical policy reflects the quality of the literature on this topic and therefore the lack of Level A recommendations that can be made on the management of these patients.

Reference

DR. FREDERICKS is an emergency medicine resident physician at the University of Texas Southwestern in Dallas.

DR. DIERCKS is professor of emergency medicine and chair of the department of emergency medicine at the University of Texas Southwestern.

Table 1.

Strength of recommendations regarding each critical question were made by subcommittee members using results from strength-of-evidence grading, expert opinion, and consensus among subcommittee members according to the following guidelines:

LEVEL A RECOMMENDATIONS. Generally accepted principles for patient care that reflect a high degree of clinical certainty (ie, based on evidence from one or more Class of Evidence I or multiple Class of Evidence II studies).

LEVEL B RECOMMENDATIONS. Recommendations for patient care that may identify a particular strategy or range of strategies that reflect moderate clinical certainty (ie, based on evidence from one or more Class of Evidence III studies or, in the absence of any adequate published literature, based on expert consensus). In instances where consensus recommendations are made, “consensus” is placed in parentheses at the end of the recommendation.

LEVEL C RECOMMENDATIONS. Recommendations for patient care that are based on evidence from Class of Evidence III studies or, in the absence of any adequate published literature, based on expert consensus.

Color-enhanced computed axial tomography (CT) image of a human chest, showing a dissection of the descending thoracic aorta (red fish-mouth shaped structure) in which the wall of the artery tears and blood accumulates within the artery wall.
of recognition began on the floor of the AMA House of Delegates. John Wiegnerstein, MD, and others had to fight very, very hard in that venue to persuade a dismissive and unconvinced medical profession that there was a need and a value for the specialty that you and I clearly know there’s a value and a need for. It’s really neat to close that circle. Just for your information—because I know this more clearly than I did before—at the age of 43, I will be the youngest president of the AMA since 1854, and I will be the second youngest of the 170 presidents. The youngest was Dr. Charles Pope in 1854. He was 36 years old. So to paraphrase whoever singer that was—Vanilla Ice?—“can’t touch that,” but it will be pretty cool to be so young in over 160 years of that position.

**KK:** Absolutely, and you’ll be able to instruct us on many, many different areas of medicine and policy, so I will instruct you on hip-hop. That was MC Hammer, my friend.

**SS:** Ah, MC Hammer. I’m sorry. That’s right. That’s my foray into popular culture.

**KK:** As far as scheduling and different responsibilities go, how much different will it be for you after June 9?

**SS:** I’m in a position where, because of the work I’ve done on health information technology and what I’ve done with my interactions with certain facets of the federal government, my schedule right now is at a presidential pace. My life will look something like this: I will average between 50 and 55 clinical hours in the emergency department every month, and I will travel probably more than 180 days for the AMA this calendar year.

I will have innumerable conference calls wedged and peppered during transition points in airports, hotel meeting rooms, office places, or at home. It will be a very, very brisk pace, and I will obviously try very, very hard to build little pockets of time to make sure I remain familiar with my wife and my daughter.

**KK:** Will your position provide some unique opportunities for them travel-wise or being exposed to things that they might not have otherwise experienced?

**SS:** Generally, no—because these trips are so focused on the task or on work, they don’t come with me. Two other reasons: My daughter is a practicing pediatric allergist. She has a full-time practice, and she is the owner of the practice. She and my daughter have very busy lives on their own and can’t just up and come with me on trips. The one exception for that: I will attend the World Medical Association, which meets twice a year. It’s like the United Nations for physicians, and I get to travel around the world and meet with my physician colleagues who represent the other nations of the world. It really is a true conclave of the top leadership of the profession of medicine across the globe. [My wife], Tracie, will go with me on some of those trips because it’s such a novel and once-in-a-lifetime experience.

**KK:** I’m glad that she’ll get to experience some of this with you. Let’s get into some policy issues. Regarding the recent developments with the Sustainable Growth Rate (SGR) repeal, what are your feelings about the current success, and do you think there are any devils in the details, anything in fine print, any concessions that may soften the potential benefit of this repeal for us?

**SS:** On March 26, the House had a historic day whereby, 392 to 37, they passed a bill that would repeal the SGR once and for all. That’s historic because we’ve never gotten this far for a complete repeal of the SGR, and it was a slam dunk. It was overwhelming that the House of Representatives said we’re going to do this. Last year, we did not succeed, but the policy from last year was also historic because it was the first time that both chambers of Congress—the House and the Senate—and both parties—the Democrats and Republicans—and all three committees of jurisdiction within—two in the House and one in the Senate—all voted up policy in support of repealing the SGR.

At that time, the AMA was able to get over 600 physician organizations to join in a sign-on letter supporting that policy. That’s the whole profession of medicine. I’ve never seen a sign-on letter in our profession with that many signatories. This year, we got a sign-on letter with over 700 physician organizations. There apparently were more societies who have come out of the woodwork and signed. When we have over 700 physician organizations signed on to a letter supporting the policy, if you are on the outside of that group, you are clearly the outlier because everybody has joined in supporting that this is the best opportunity we have within the political process to finally eliminate the SGR and achieve meaningful reform.

When you ask about the policy itself, the SGR every year or every six months or every three months, depending on the 17 different patches of varying durations, was like a guillotine over the head of the profession. If these cuts, 20 or 30 percent, were ever to happen, it would be devastating. It would be crippling, and it would be entirely unsustainable. To their detriment, there are a number of folks, physicians included, who have become inured to this and say, “Oh, it’s no big deal. They’ll always patch it.” Well, that’s a risky assumption when you see that Congress has played Russian roulette with the entire nation’s economy through the debt-ceiling debates when they shut the government down. If people just take it as a given that all these patches are going to happen, they have not paid attention to contemporary politics.

In this April 16, 2015, President Barack signs the bill H.R. 2 Medicare Access and CHIP Reauthorization Act of 2015 in the Rose Garden of the White House in Washington.
stream. Hopefully, we can focus on those other programs and make those better, and physicians and their practices will be able to better invest in the future knowing that there is some stability going forward. By any measure you look at it, the proposed policy that the U.S. House of Representatives passed is directionally better, and in some ways substantially so, than where we currently are; however, I have to qualify that and say we haven’t actually won it. There’s always more work to be done, and when this hopefully finally comes to a close by the time you publish this, hopefully we’ll be in a better position with this gone to focus on the other never-ending parade of issues we have to deal with.

KK: If I understand correctly, there’s about a $200 billion price tag on the SGR repeal. How are they paying for it? Is it all in incentives and payment reforms from physicians, or is there some other mechanism?

SS: Well, no. The “price tag” is an artifact of the way of the political process more than the reality. The only way this has not already been part of the federal debt is that we pretend we haven’t spent the money because whatever the price tag is estimated over a 10-year period, which is how the Congressional Budget Office (CBO) does it, whether it’s $150 billion, $140, or $200, you have to remember there are other things included when they quote the total price because there’s not just Medicare. There are extenders for various other payment programs, programs like the Children’s Health Insurance Program (CHIP), Tricare, and other things that are tagalongs to the SGR. What the true cost of the SGR is apart from all of these other things almost doesn’t matter. The only way the federal government doesn’t already have $150 billion more as part of its debt is we pretend we haven’t spent that $150 billion already because the only way we haven’t spent it is if they let a 25 percent cut into play and they take it back from us by not paying us. It’s actually spent money. It’s a debt, and it’s just not recognized on the books. It’s the kind of stuff that probably Enron did, and we all know what happened to Enron. It is funny accounting, and to say that it’s going to add to the debt is a fallacious premise in the first place because it’s already part of the debt. We just pretend it doesn’t exist in the first place. All the politicians say, “We’d never let a cut like that happen with docs because we know it would destroy the health system.” Even the CBO, when it shows projections, has to follow the assumption that the laws of the land will be executed, but it even creates a second series of charts that show, given that the history is they never follow the law of the land, what we really predict to happen. Because we don’t follow the law, there’s more than enough evidence that shows that this is already part of the debt.

As far as how are we going to pay for it, they have a number of different ways where they partially offset it and some where they don’t offset. There’s a new quality paradigm in the bill called MIPS, Merit-Based Incentive Payment System. They are rolling up existing quality programs and integrating them into a more coherent penalty and incentive program. There are still things we’d like to have changed, but politics is a compromise when possible, not about me always getting what I want. We’ll work on that over time, but really is taking things like Meaningful Use, Physician Quality Reporting System, and Value Based Modifier and rolling them up into a more integrated program.

KK: That makes perfect sense and is probably the best explanation I have heard about whether this is actually incurring additional debt. Like you said, it’s money already spent. I am glad we’re down the road, and I suspect from your comments that maybe things aren’t exactly perfect but any way to get the SGR repealed would be of great value to us, despite the fact that there may be small details we’d want to tweak later.
Potential Pitfalls of POLST

New approach to advanced directives brings new challenges

BY FERDINANDO L. MIRARCHI, DO, FAAEM, FACEP

Physician orders for life-sustaining treatment (POLST) is a paradigm moving quickly across the United States and was intended to address deficiencies in the advance directive process. The movement is quickly outpacing quality research, educational standards, and regulatory processes. This POLST movement is becoming an unfunded mandate very similar to the mandate proposed back in 1990 with the passage of the patient’s self-determination act related to living wills and advance directives. POLST is to be utilized in patients who are frail, elderly, and expected to die within six months to one year. However, states and hospital systems are becoming more liberal with utilization. Additionally, payer systems are financially incentivizing institutions to create POLST forms for many different patient populations, especially those discharged to skilled nursing or rehabilitation or admitted to hospitals for a variety of conditions. POLST is a physician order. However, it is often completed by nonmedical personnel and then signed by a physician and in some states by an advanced practice provider. This process, combined with payer incentives, should raise one’s level of concern with the ability of the patient to fully understand the implications and provide informed consent.

Regardless of the aforementioned concerns, POLST has proven useful. In multiple studies, POLST is very effective at minimizing unnecessary resuscitation, predicting location of death, and preventing unwarranted hospital admission.

In multiple studies, POLST is very effective at minimizing unnecessary resuscitation, predicting location of death, and preventing unwarranted hospital admission.

Table 1. ABCDEs of the Living Will, DNR, or POLST

A. Ask patients or surrogates to be clear as to their intentions for their advance directive (living will, DNR order, or POLST form).
B. Be clear as to if this is a terminal condition despite sound medical treatment or persistent vegetative state versus a treatable critical illness.
C. Communicate clearly if you feel the condition is reversible and treatable with a good and poor prognostic outcome.
D. Design a plan and discuss next steps. For example, say, “Your mom is critically ill. We can give her a trial of instituting life-sustaining care for 48 to 72 hours, and if there is no benefit, we can withdraw care and treatment.”
E. Explain that it’s OK to withdraw care and treatment or withdraw care so long as it is in keeping with the patients’ perceived wishes. Also, take a moment to explain the benefits of palliative care and hospice.

The American Bar Association and National POLST Paradigm Task Force regarding reviewing and confirming choices elected on POLST forms.7 The use of a patient-safety checklist would be a conservative approach to individuate patient care and safety. A resuscitation pause or advance directive patient-safety checklist (see Table 1) represents an opportunity to maintain compliance with existing national recommendations and also help ensure the delivery of appropriate care.10,12

References


DR. MIRARCHI is medical director of the department of emergency medicine at UPMC Hamot and chair of the UPMC Hamot Physician Network in Erie, Pennsylvania.

ACEP Advocates for Children by Supporting EMSC Program

BY GORDON B. WHEELEL

Nearly 30 million children receive emergency medical care each year. The federal Emergency Medical Services for Children (EMSC) program, administered by the Health Resources and Services Administration within the U.S. Department of Health and Human Services, helps ensure emergency departments and ambulances have the equipment, supplies, and medications necessary to treat children and helps develop pediatric treatment protocols. The funding that EMSC provides each state goes toward strengthening hospital and pre-hospital services, training first responders, and improving systems to provide more efficient and effective pediatric emergency medical care. Specifically, EMSC funding improves access to care in rural and remote areas, helps improve capacity and transport of pediatric patients, and overall expedites emerging issues for pediatric patients.

For years, ACEP has worked in collaboration with other stakeholders, including the American Academy of Pediatrics, to promote and support appropriate funding for the important research conducted by EMSC. In 2014, our coalition worked with U.S. Representatives Jim Matheson (D-UT) and Peter King (R-NY) and Senators Bob Casey (D-PA) and Orrin Hatch (R-UT) to successfully reauthorize the program before it expired on Sept. 30. Most recently, ACEP and its partners sent a letter to both the House and Senate appropriation committees urging them to fully fund EMSC at $21 million in fiscal year 2016.

To see a list of some of the resources developed by ACEP, go to www.acep.org/Clinical---Practice-Management/EMSC-Resources-Developed-by-ACEP.

MR. WHEELER is ACEP executive director for public affairs.
ACEP proudly recognizes these groups that have all eligible emergency physicians enrolled as members.
Bougienage on a Budget

Use this trick when kids treat their stomachs like piggy banks

by Terrance McGovern, DO, MPH, Justin McNamee, DO, and Julie Sanicola-Johnson, DO

Children, for whatever reason, have a predilection for swallowing coins. Perhaps it’s the taste or that they’re using their stomach as a piggy bank. When these young patients present to the emergency department with a coin lodged in their esophagus, what options do we have? We could call gastroenterology or try to take it out ourselves. One option with few complications is bougienage, where we manually advance the coin into the stomach classically using a Hurst dilator and allow it to pass naturally.

Background

In 2012, there were approximately 93,000 cases of foreign-body ingestions, nearly 4,000 of which were coins.1–3 While the feared button-battery ingestion can cause esophageal necrosis in as little as two hours, impacted coins can also cause perforation, obstruction, or fistulas if left untreated.4,5 The American Society for Gastrointestinal Endoscopy (ASGE) currently recommends an observation period of 24 hours for asymptomatic patients to see if the coin will pass into the stomach without any intervention.6 Up to 56 percent of coins lodged in the distal esophagus and 27 percent in the proximal esophagus will pass into the stomach without any intervention.7 Once in the stomach, most coins will transverse the gastrointestinal tract spontaneously.8–10 If the coin is retained within the stomach for more than three to four weeks, the patient will likely need endoscopic removal. The same is true for any coin that remains stationary for one week past the duodenum; it will need surgical removal.

For coins that do not spontaneously pass into the stomach, endoscopy has shown to be very successful (100 percent), with a small but measurable rate of complications, which are predominantly airway related (2.5 percent).11 An additional method of removal is using the Foley catheter technique. There are variations to the actual procedure, but typically it involves placing a Foley catheter (either orally or nasally) past the foreign body, inflating the Foley balloon, and extracting the foreign body. As you may imagine, the most concerning aspect to this technique is the thought of dragging the foreign body right past the glottis, which is just lying there open and waiting for that coin to drop in as though you are playing the penny slots in Vegas. While the concern is valid, the complication rate is relatively low (0–2 percent), and the success rate is favorable (88–94 percent).12,13 Data on the use of glucagon in impacted esophageal coins is relatively sparse. In 2003, Mehta et al prospectively evaluated the use of glucagon and found it to be ineffective in dislodging impacted esophageal coins.13 While the study was double-blind and placebo-controlled, the enrollment of only 14 patients limits its applicability and influence. Emergency physicians, at this point, cannot endoscopically remove a coin, and most of the published literature surrounding Foley catheter removal is done by other specialties (ie, otolaryngology, gastroenterology, surgery). When the right patient is selected, bougienage is a low-risk, highly successful alternative to the previously mentioned interventions and one we can employ in the emergency department.

Bougienage

Bougienage has been around for decades, but it remains an infrequently used modality for the treatment of retained esophageal coins.14 In the correctly selected patient, as detailed in Table 1, bougienage has a success rate of 83–100 percent in advancing the coin into the patient’s stomach.15–18 Among larger studies with more than 100 patients undergoing bougienage, the success rate is 94–95.4 percent.12,19,20 Rigid adherence to the inclusion criteria maintains bougienage as a reliable modality. However, when not following these criteria, the success rate drops to 75 percent, as Allie et al demonstrated in their 2014 article.11 Perhaps more important, throughout the previous studies, complications directly related to bougienage are nearly unheard of. Arms et al attempted bougienage on 372 patients, two of whom had the complication of intramural abrasions from the bite block used during the procedure.9 Additionally, Allie et al demonstrated a minor complication rate of 16.8 percent in their 137 bougienage attempts.11 The majority of these minor complications resulted from vomiting, gagging, or the need for repeat bougienage, without major complications noted. To the best of our knowledge, there has not been a documented serious or life-threatening complication from attempted bougienage.11–14 In addition to the safety and efficacy of bougienage, there have been numerous reports of the decreased cost and length of stay with bougienage versus endoscopy. The length of stay is decreased 4–20 hours and is associated with a decrease in cost of $1,890–$6,000.15–20 This procedure is not limited to otolaryngology, gastroenterology, or surgery; trained emergency physicians have proven that we, too, can bougienage with the best of them, with success rates of 94–100 percent.15,16,21–23

Bougienage Procedure

Equipment

1. Tape measure
2. Tongue depressors (approximately 5–6) taped together to act as a bite block (Figure 1)
3. Hurst dilator (Figure 2) or alternative as described in the sidebar on pg. 15
4. Topical anesthetic (ie, benzocaine spray)
5. Water-based lubricant

Procedure

1. Confirm that the patient has an esophageal coin with a two-view radiograph and that the patient meets the criteria for bougienage (see Table 1).
2. Measure the distance from the patient’s nares to the epigastrium and mark this distance on the Hurst dilator to approximate how far to insert the dilator.
3. Topically anesthetize the patient with benzocaine spray.
4. Sit the patient upright with a sheet held tightly around the patient and with either an assistant or a parent holding the patient’s head still by the forehead.

Table 1. Inclusion Criteria for Esophageal Bougienage

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Witnessed ingestion</td>
<td></td>
</tr>
<tr>
<td>Foreign body is a coin</td>
<td></td>
</tr>
<tr>
<td>Coin radiographically located in esophagus</td>
<td></td>
</tr>
<tr>
<td>Single coin present</td>
<td></td>
</tr>
<tr>
<td>Coin lodged fewer than 24 hours</td>
<td></td>
</tr>
<tr>
<td>No previous history of esophageal foreign body, disease process, or surgery</td>
<td></td>
</tr>
<tr>
<td>No respiratory compromise on physical exam</td>
<td></td>
</tr>
<tr>
<td>Trained personnel performing procedure</td>
<td></td>
</tr>
</tbody>
</table>

**Figure 1. Tongue depressors taped together to act as a bite block**

**Figure 2. Hurst dilator**
What If I Don’t Have a Hurst Dilator?

Hurst dilators (see Figure 2) are reusable, flexible silicone-based devices that are more commonly used for dilation of benign esophageal sphincters but are also used off-label for bougienage. Most pediatric centers will have access to these through their operating or endoscopy suites. For emergency physicians who do not have easy access to one of these, we offer a potential alternative made of products commonly found in every emergency department across the country.

Figure 4. Equipment needed for the assembly of the alternative to the Hurst dilator and the bougienage.

1. Foley catheter
2. Endotracheal tube
3. 10cc springs with water
4. Tape
5. Tongue depressors (approximately 5–6) taped together to act as a bite block

Assembling an Alternative to the Hurst Dilator

After gathering the equipment (Figure 4), you’ll need to cut the tip of the endotracheal (ET) tube in a perpendicular manner at the distal aspect of the cuff, as shown in Figure 5. Try to avoid forming any sharp corners on the ET tube when making this cut. For the smallest children, likely between 1 and 2 years old, you’ll have to trim the ET tube proximal to the cuff so that the Foley balloon reaches the end of the ET tube. Next, you’ll take the proper-sized Foley and feed it through the ET tube, as in Figure 6. Inflate the balloon to the specified amount (see Table 2) with sterile water and then pull traction on the Foley through the opposite end of the ET tube so that the Foley balloon is held firmly against the distal tip of the ET tube. The operator can either maintain traction on the device throughout the procedure or secure it with tape (see Figure 6). This can now serve as your substitute for a Hurst dilator for the bougienage procedure.

The ET tube is necessary for the production of an alternative to a Hurst dilator because the Foley catheter alone does not provide enough rigidity to manipulate and advance the coin. If you were to use the Foley catheter without the addition of the ET tube, you may be able to reach the esophageal coin using bougienage or endoscopy for esophageal coins in children. A prospective, double-blind, placebo-controlled trial showed that bougienage was as effective as endoscopy for esophageal coin ingestion in children. Please use this alternative device at your own discretion because use of this device has not been studied to support its use for bougienage.

Figure 5. Cut the tip of the endotracheal tube in a perpendicular manner just distal to the cuff.

Table 2. Proper Sizing of Hurst Dilator and Equivalent-Sized Equipment for Facilities Without Access to Hurst Dilators

<table>
<thead>
<tr>
<th>Age</th>
<th>Hurst dilator size</th>
<th>ET tube size</th>
<th>Foley size</th>
<th>Amount to fill Foley balloon</th>
</tr>
</thead>
<tbody>
<tr>
<td>1–2 years</td>
<td>28F</td>
<td>5.0 mm</td>
<td>8F</td>
<td>0.75 mL</td>
</tr>
<tr>
<td>2–3 years</td>
<td>32F</td>
<td>6.0 mm</td>
<td>12F</td>
<td>1.0 mL</td>
</tr>
<tr>
<td>3–4 years</td>
<td>36F</td>
<td>6.0 mm</td>
<td>12F</td>
<td>1.25 mL</td>
</tr>
<tr>
<td>4–5 years</td>
<td>38F</td>
<td>6.0 mm</td>
<td>12F</td>
<td>1.5 mL</td>
</tr>
<tr>
<td>≥5 years</td>
<td>40F</td>
<td>6.0 mm</td>
<td>12F</td>
<td>1.75 mL</td>
</tr>
</tbody>
</table>

Figure 6. Place the Foley catheter through the ET tube completely (Top left). Inflate the Foley catheter to the predetermined volume and place traction on the opposite end to have it flush against the distal tip of the ET tube (Top right). Option to secure the Foley catheter to the ET tube (Bottom).
Extra Retirement Account

Most physicians do have a 401(k), which, in 2015, allows an $18,000 annual employee contribution ($24,000 for those over 50), plus up to $35,000 of employer contributions. However, surprisingly few have access to a cash balance plan.

**Question.** I’ve heard that a cash balance plan can allow me to contribute more toward retirement and save on my current large tax bill. What do I need to know before using one of these?

A. One of the biggest deficits in physicians’ collective “financial fund of knowledge” is a lack of understanding of the various retirement accounts available to them. I have written before about using a health savings account as a “stealth IRA” and about how to contribute to a personal and spousal Roth IRA “through the backdoor.” Another little known, but very useful, retirement account for physicians is a cash balance plan.

In fact, I think the standard retirement options made available to emergency physicians should include both a 401(k) with a profit-sharing component ($53,000 contribution limit for those under age 50, with an extra $6,000 catch-up contribution for those over 50) and a cash balance plan. Most physicians do have a 401(k), which, in 2015, allows an $18,000 annual employee contribution ($24,000 for those over 50), plus up to $35,000 of employer contributions. However, surprisingly few have access to a cash balance plan.

There are two broad categories of retirement plans: defined contribution and defined benefit. A 401(k) is an example of the first type. There is no guaranteed benefit when all is said and done. All that is defined is how much you can put into it as you go along. The amount of money you will have to spend in retirement depends entirely on how much you put into the account and the performance of your selected investments. A defined benefit retirement plan works differently. The classic example is the increasingly rare company pension. You work for a company or government entity for 20 or 30 years, and after you retire, the company pays you a defined benefit for the rest of your life. The company takes all the investment risk. If the investments do well, the company can get away with putting less money into the account. If the investments do poorly, the company must contribute more to the account.

A cash balance plan is technically a type of defined benefit plan, but it can act like a defined contribution plan in two important ways. The first is that, depending on how your plan is designed, you can actually change how much you can contribute each year to the plan. The second is that upon separation from the employer, or when the plan is closed for any reason, you can transfer the money into a 401(k) or IRA, just like most defined contribution plans. For most participants, the cash balance plan is essentially an extra retirement plan allowing for additional tax-deferred retirement contributions above and beyond those allowed in the 401(k).

**How Cash Balance Plans Work.** A cash balance plan seems complicated because, as a defined benefit plan, it must at least resemble a typical pension. That means the participants in the plan cannot select or manage investments in the plan. It also requires complicated actuarial calculations to determine the maximum contributions that can be made into the plan. The contributions also must technically come from the employer, not the employee. Due to these complications, fees on a cash balance plan are generally higher than those in a 401(k). This type of plan is not a do-it-yourself project; you will need to hire an experienced company to design and run the plan.

All contributions into the plan are pooled and invested together by the plan trustee. However, hypothetical individual accounts are tracked and credited with a certain amount of interest each year, depending on the performance of the underlying investments. If the investments perform well, that credited interest rate may be higher up to a certain point, such as 5–7 percent per year. If the investments perform very well, the additional earnings, above and beyond the 5–7 percent limit, are allocated to a surplus account where they can be used to make up for future shortfalls in investment performance or to reduce future required contributions. If the investments perform poorly, the owners of the company may be required to contribute additional money to the plan to make up the losses over a period of a few years. This arrangement of defined contribution plans turns off many physicians (who are generally not only the participants in the plan but also the owners of the company). However, in reality, this mechanism is of significant benefit to the physician. Not only do you get to defer even more money into the plan, the make-up contributions are also deductible. You are essentially forced to buy loss, boosting future market returns. Many emergency physician partnerships have incorporated both a 401(k)/profit-sharing plan and a cash balance plan into their practices. Independent contractors without employees can also use this combination of accounts. An individual 401(k) is relatively easy to set up. A personal defined benefit plan is a little more complicated but still widely available from a number of firms at a fair cost. Because you are both the trustee and the participant, you will have even more control over your investments.

Contribution limits to these plans vary based on a number of actuarial factors, such as the age of the participants. The older the participants, and the fewer years they will be in the plan prior to retirement, the more that can be contributed. Typical maximum contributions for emergency physicians range from $10,000 to more than $100,000 per year, all in addition to your 401(k) and IRA contributions.

Cash balance plans are a type of defined benefit plan that resembles a defined contribution plan. Emergency physicians interested in boosting retirement savings and minimizing their annual tax bill should give strong consideration to adding a cash balance plan on top of their existing 401(k) plan. A cash balance plan is a great option for those who wish to save for retirement and are already maxing out their 401(k)s and backdoor Roth IRAs.
Putting all the tPA-related issues aside for a moment, let’s talk about the next-generation of therapy: endovascular intervention. This is not a new innovation, as clinicians have been exploring this therapy in earnest since the early 2000s. Why are these devices of such great interest given the development of tPA? Because one of the best-kept secrets about tPA, the “clot buster,” is that it doesn’t bust clots. In the largest meta-analysis of angiographically confirmed intracranial occlusions, sustained early recanalization was achieved with tPA only 46.2 percent of the time. Comparing this with the observed 24.1 percent spontaneous recanalization rate, tPA clearly has a maximal ceiling for benefit if only one in five additional patients achieved reperfusion. The aim of endovascular intervention is to overcome this practical limitation to the effectiveness of tPA.

However, the initial foray into such technology produced what might best be described as killing machines. The initial devices, detailed in the Mechanical Embolus Removal in Cerebral Ischemia (MERCI) and Multi-MERCI trial results from 2005 and 2008, had high rates of complications just related to the procedure—arterial perforations and fracture of the stent-retrieval devices. Coupled with high National Institutes of Health Stroke Scale (NIHSS) scores, patients undergoing these procedures had correspondingly high mortality. Over time, however, the devices and techniques improved yet to no avail. The 2013 literature produced a constellation of negative trials: Mechanical Retrieval and Recanalization of Stroke Clots Using Embolectomy (MR RESCUE), Intra-arterial Versus Systemic Thrombolysis for Acute Ischemic Stroke (SYNTHESIS), and Interventional Management of Stroke (IMS) III. Like the earlier trials, these targeted patients with large-vessel anterior circulation occlusions, severe and disabling strokes for which recanalization with tPA is particularly poor. Fewer procedural complications occurred in these trials, but all three failed to show an additive benefit of endovascular intervention over standard therapy.

What a Difference a Year Makes

The end of 2014 brought us the Multicenter Randomized Clinical Trial of Endovascular Treatment for Acute Ischemic Stroke in the Netherlands (MR CLEAN), the first major unambiguously positive trial of endovascular therapy versus usual care. The trial randomized 500 patients with large-vessel anterior occlusions; 32.6 percent of patients achieved functional independence (modified Rankin Scale 0–2) in the endovascular cohort, compared with 19.1 percent with standard care, without any corresponding increase in intracranial hemorrhage or mortality. With a median NIHSS score of 18 and few favorable outcomes with standard care, these were clearly patients for whom alternative treatment options were worth investigating. The generally dismal outcomes of the selected patients almost certainly played a role in finally measuring a meaningful difference in outcomes. The other notable achievement in this trial, specifically, such reservations were not held by the manufacturer of the devices supplied to the ongoing endovascular trials. Upon publication of the MR CLEAN results, three sponsored trials—Endovascular Treatment for Small Core and Proximal Occlusion Ischemic Stroke (ESCAPE), Extending the Time for Thrombolysis in Emergency Neurological Deficits–Intra-Arterial (EXTEND-IA), and Solitaire With the Intention For Thrombectomy as PRIMary Endovascular Treatment (SWIFT PRIME)—used this opportunity to conduct unplanned interim analyses of their trials for efficacy. The results, presented at the International Stroke Conference in February 2015, were universally positive. Indeed, not only were the results positive but the magnitude of favorable outcome differences was even more pronounced than in MR CLEAN. Patients receiving standard care achieved modified Rankin Scale 0–2 at rates ranging from 23 percent to 60 percent, while functional independence was achieved in the endovascular cohorts at rates ranging from 53 percent to 71 percent. Correspondingly, like MR CLEAN, these trials showed endovascular recanalization rates higher than prior trials, ranging from 74 percent to 94 percent.

Of course, as anyone who’s been to Las Vegas knows, it helps to quit while you’re ahead. There are major issues with performing unplanned analyses and early stoppage of trials. Termination of enrollment increases the confidence intervals around the primary outcome and

We can expect to see slow changes to regional stroke triage systems to incorporate the availability of endovascular interventions. Unfortunately, with any such innovation, enthusiasm is almost certain to lead to indication creep beyond the patients selected for recent trials.
Patients were evaluated initially in the old closet, now a proper intake space.

The process and the space accommodated the new changes. After months of planning, construction, and staff training, the PIT process was rolled out in April 2014. Kudos to the leadership team because all too often new processes fail at implementation. Their success suggests that the rollout was impeccable.

Patients were evaluated initially in the old closet, now a proper intake space. Many patients could be dispositioned from this area without ever going to a patient room. The patients with time-critical conditions were seen by a provider and expedited to a room in the main ED. The measurements speak to their wonderful results.

Door-to-provider time 30.5 min. ⇒ 8 min.

The success was immediately noted by the community and patient daily census, which had been stable at 115 patients per day for many years and jumped to 128 patients per day!

Would something like this work in your shop? Take a critical look at your facility. Can you hijack some space in the current footprint that, at minimal cost to the institution, will allow a revamping of your intake process and patient flow? When the Maryview leadership invited the community to “come into the closet,” great things happened.

ENDOVASCULAR JUNGLE

CONTINUED FROM PAGE 17

Dr. Welch is a practicing emergency physician with University Emergency Physicians (UEP) at the Intelligent Health Institute at the Nashville, Tenn. University of Tennessee Health Science Center, and an assistant professor of emergency medicine at the University of Tennessee College of Medicine. He blogs at Emergency Medicine Literature of Note (emlitofnote.com) and can be found on Twitter @emlitofnote.

References

C. Diff & Mono Tests
Two great examples of how kids aren’t just little adults

by LANDON JONES, MD, and RICHARD M. CANTOR, MD, FAAP, FACEP

AS EDUCATORS, we love—and are always humbled by—those moments when we get to say, “I don’t know.” For some of these questions, you may already know the answers. For others, you may never have thought to ask the question. For all, questions, comments, concerns, and critiques are encouraged. Welcome to the Kids Korner.

Spring often means baseball, warmth…diarrhea, and fever. Let’s take a look at some fun topics on these last two.

Question. Are infants’ intestines commonly colonized with Clostridium difficile bacteria, and if so, how should this impact testing decisions?

A n early article by Cooperstock et al prospectively evaluated 107 healthy asymptomatic infants up to a year of age from well-baby clinics. The infants’ ages ranged from 1 to 52 weeks and included a wide range of socioeconomic groups. Evaluating stool samples by ELISA for C. difficile antigens, the authors found that 40 percent (43/107) of infants were asymptomatically colonized with C. difficile. Additionally, there were no significant differences in colonization when these infants were stratified by age (in weeks) or sex. Other older studies have also demonstrated a high incidence of asymptomatic colonization by C. difficile in infants. The overall incidence of asymptomatic colonization in infants is reported to be as high as 60 percent to 70 percent of infants. This incidence of asymptomatic carriage is reported to be as high as 60 percent to 70 percent of infants. These asymptomatic carrier rates probably fall as high as 60 percent (38/65 total children), respectively. In that same study, the asymptomatic carrier incidence was 3.6 percent. A different study in 1989 by Taltus et al prospectively followed 343 asymptomatic healthy clinic infants from birth to 18 months, finding that carriage at 18 months of age (1 percent) was similar to adult incidences.

Summary: Infants are common asymptomatic carriers of C. difficile. This incidence of asymptomatic carriage is reported to be as high as 60 percent to 70 percent of infants. These asymptomatic carrier rates probably fall as high as 60 percent to 70 percent of infants. The incidence of asymptomatic carriage was approximately 6 percent (1/17) in children 24–36 months old, which is similar to reported adult asymptomatic carrier values of C. difficile. A separate cross-sectional study in 1982 by Stark et al demonstrated an asymptomatic carrier incidence of 3 percent (1/37) in children 2 years. In that same study, the asymptomatic adult carrier incidence was 3.6 percent. A different study in 1989 by Taltus et al prospectively followed 343 asymptomatic healthy clinic infants from birth to 18 months, finding that carriage at 18 months of age (1 percent) was similar to adult incidences.

The overall incidence of asymptomatic colonization in infants is reported to be as high as 60 percent to 70 percent.

Q: What is the sensitivity of a Monospot test in children?

T he data are very limited on this topic. Approximately 90 percent of adults develop heterophile antibodies, identified by the Monospot test, following an acute Epstein-Barr virus (EBV) infection. Interestingly, though, only about 50 percent of children develop heterophile antibodies following an acute EBV infection.1

A study by Sumaya and Ench looked specifically at the rate of positive heterophile antibody responses in children with confirmed cases of EBV. The authors evaluated heterophile antibody responses at different ages, stratifying the patients into the following age groups: <2 years, 2–3 years, and ≥4 years. In these age groups, positive heterophile antibody responses were demonstrated in 5.3 percent (1/19), 52 percent (13/25), and 83.6 percent (46/55) of children, respectively. In this single study, the production of heterophile antibodies was near reported adult levels at ≥4 years of age. Overall, children have a relatively poor heterophile antibody response to EBV compared to adults. A study by Linderholm et al evaluated the sensitivity of a Monospot test in both children and adults. The authors arbitrarily broke down the groups into ≤12 years and ≥13 years of age. The sensitivity of the Monospot to detect infectious mononucleosis in the 0–12 age group was 38 percent (3/8) compared to 86 percent in the ≥13 age group. It was a very small sample size, and there were only eight patients included in the sensitivity analysis. Overall, there was a poor sensitivity of the Monospot to detect EBV in children 0–12 years of age.

Summary: Ultimately, the Monospot test shows poor sensitivity in children. The limited data that we have suggest that children don’t make near-adult levels of heterophile antibodies until they are at least 4 years of age, resulting in poor Monospot sensitivity. In regard specifically to the Monospot test, the literature suggests that it is not a good test until they are ≥13 years old. For cases where it is important to diagnostically evaluate the patient, we may need to get the EBV antibody titers additionally or instead.0

References
A Picture’s Worth 1,000 Characters

by JEREMY SAMUEL FAUST, MD, MS, MA

Even within the confines of 160 characters, much can be said. However, one of Twitter’s great features is that it allows pictures in exchange for characters. When it comes to medical education, tweets with images seem to have special potential to go viral. EM educators like Salim Rezaie, MD, FACEP (@srrezaie), a physician in the division of emergency medicine and hospitalist medicine at the University of Texas Health Science Center at San Antonio, and Michelle Lin, MD (@MLim), associate professor of emergency medicine at the University of California, San Francisco, have turned the creation of succinct medical-education images into a form of high art, earning countless views and retweets. Last month, a new account called @EMinfographics popped up and caught my eye. This account is getting in on the act and has already posted a handful of excellent images that anyone can save to their smartphone photo album or desktop with a couple of touches or clicks. I frequently save these images in a “medical images” album on my phone for quick reference during shifts or when teaching. For this month’s column, I’m highlighting some great images that showed up on my feed and that prove a great medical-education picture can be worth 1,000 characters.

@EMinfographics posted this image on shock (see Figure 1). On one slide, they’ve packed in important distinguishing features of the four major types of shock we have to rapidly diagnose and treat. It’s a great image for teaching, and it’s even a good reminder to the seasoned vet.

Speaking of shock, Hilary Fairbrother, MD, MPH, FACEP (@hilaryfair), as- sistant director of undergraduate medical education at the Ronald O. Perelman Department of Emergency Medicine at New York University School of Medicine in New York, tweeted these two images (see Figure 2) from a lecture by Peter Viccellio, MD, FACEP, clinical professor and vice chair of emergency medicine at Stony Brook School of Medicine (who makes a cameo in the images), with the simple title “Epi drips for dummies.” The first image is the recipe for making a 1 mcg/mL epinephrine drip, and the second gives two titration schemes. I’ve already used these images during my shifts.

Davis Gattas, MD (@dgdattas), an intensivist at the University of Sydney, tweeted this image (see Figure 3) from a hot-off-the-press New England Journal of Medicine article that suggests systemic inflammatory response syn- drome (SIRS) may not be as accurate or useful as we previously thought.1 The tweeted image did what all good #FOAMed (free open access medical education) should do: it inspired me to read a new primary literature paper that I otherwise would not have.

One of my own attendings at Mount Sinai Hospital in New York and Twitter newbie Amy Leuthauser, MD (@AmyLeuthauser), has vowed to “win” Twitter. So far, it’s working. Her tweet is a picture that she took in the London Underground of an ad from the United Kingdom’s National Health Service (NHS) designed to decrease unnecessary emergency department visits (see Figure 4), and it sparked quite the #FOAMed debate. The NHS sign discourages patients from using EDs for nonemergencies. The question is: is that a good strategy, or does it put the blame on patients instead of a bloated, out-of-control patient system? That important debate played out on BoringEM, a blog by Brent Thoma, MD, emergency medicine resident at the University of Saskatchewan in Saskatoon, Canada, thanks to an excellent post he wrote on the topic (http://boringem.org/2015/03/26/keep-emergency-for-emergencies/). It garnered many insightful comments by several #FOAMers, including Dr. Seth Trueger (@MDaware), Dr. Damian Roland (@Damian_Roland), EM physician assistant Patrick Bafuma (@EMinFocus), Dr. Nadim Lalani (@ERMentor), medical student Gerhard Dashi (@Gerhard-Dashi), Dr. Rajiv Thavanathan (@rajivthala), me, and others. These top-notch, informed, nuanced, and varying opinions all stemmed from a tweet and a blog.

Finally, in the wake of Leonard Nimoy’s death, medical student and #FOAMed wonderkind, the future doctor Aidan Baron (@aLittleMedic), a student in Sydney, Australia, tweeted this image that should help you re- member the dermatomal distribution of the brachial plexus once and for all (see Figure 5). In his tweet, Mr. Baron thanked whoever anonymously created this inspired image, but in turn, I thank him for bringing it to my Twitter feed. Live long and prosper, my friends, and may your brachial plexi be intact. Ø

Reference

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