



2015
EM Compensation
Report SEE PAGE 10

THEN & NOW
Telemedicine in the '70s
SEE PAGE 11

EM Hits Reality TV
SEE PAGE 16

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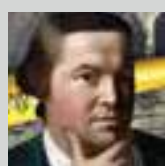
Volume 34 Number 10

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THE BIRTHPLACE
OF MODERN
FORENSICS?**

SEE PAGE 19

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MEDICATIONS IN
KIDS**

SEE PAGE 23



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2015 ACEP ELECTIONS PREVIEW

MEET THE COUNCIL OFFICER CANDIDATES

Each October at ACEP's annual Council meeting, 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 in Emergency Medicine, the Council of Emergency Medicine Residency Directors, the Emergency Medicine Residents' Association, and the Society for Academic Emergency Medicine, will elect the College's President-Elect, four members to the ACEP Board of Directors, the Council Speaker, and the Council Vice Speaker. This month, we'll meet the candidates for Council officer positions.

CONTINUED on page 12

Is Democracy the Gold Standard or Just an Ideal?

Emergency medicine leaders
weigh in for this democracy
roundtable discussion

INTRODUCTION

by KEVIN KLAUER, DO, EJD, FACEP

For decades, the concepts of democracy and democratic group practice have been held as the standard to strive for in emergency medicine. As democracy is akin to motherhood and apple pie, these concepts are accepted today, perhaps, just as they were decades ago. However, with the evolving landscape of health care, is it time to revisit these concepts? Is democracy a group structure or an ideal? Democracy can provide an opportunity to participate in group decisions and control one's own destiny (to a certain extent), but democracy means that, on occasion, you may not get what you want if you are in the minority. Is democracy truly what emergency physicians want, or has fair and equitable treatment become the practical definition of "democracy"? In this three-part series, EM leaders from different walks of life will weigh in on the following questions.

QUESTIONS

1. What is the definition of "democracy"?
a) How do you measure democracy?
2. Is democracy a group structure or an ideal?
3. Do you think there is confusion about what democracy offers in EM?
4. Is this just marketing or substance in emergency medicine?
5. In a democratic group, do physicians get to vote on everything or just certain things?
6. Does democracy have obligations/responsibilities associated with it (eg, financial, covering additional shifts, etc.)?
7. Does a lack of democracy mean you will not be treated fairly? (Is fair treatment confused with democracy?)
8. What are the pros and cons of democratic groups and non-democratic groups?

CONTINUED on page 5



SEE PAGE 14

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A NEW SPIN

To Serve, Protect, and Defend Those Who Protect Us

Tactical emergency medicine providers deserve appropriate protective gear and equipment



A tactical physician works with a police officer during a potentially dangerous encounter.

By RYAN LEWIS, MD, FACEP

A tactical emergency medical services (TEMS) element was on a hostage rescue call-out when things went bad, very bad. The lead TEMS medic at that time was assigned a role on the rescue team as an armed and fully commissioned operator/medic. (The debate of armed versus unarmed is a whole other can of worms for later discussion.) Upon the emergency rescue, due to the suspect shooting the hostage, the rescue team (including the TEMS medic) was fired upon, and the medic was hit in the neck. Fortunately, his body armor stopped the round in his upper collar. If the bullet had hit a mere 1 mm higher or the medic hadn't had body armor with an appropriate level of protection, this would have been a very different story.

With the long-overdue acceptance of TEMS as a component of emergency and out-of-hospital medicine, there has been an evolving discussion and debate about the real danger that TEMS providers face and what level of protection should be required. This debate has primarily hinged on the issue of costs associated with providing expensive protective equipment to TEMS providers and Rescue Task Force (RTF) personnel. While there

is no specific limit to funding issued regarding personal protective equipment, just like with any other entity, the bottom dollar and cost association is often a driving factor in the upstart and/or continuation of the TEMS and RTF units. Included in this debate is the discussion of the threat facing medical providers on active-shooter response teams or RTF teams and the threat to TEMS personnel supporting tactical teams.

First, one must realize that TEMS is a very

different animal than a RTF. Yes, there is overlap between the two. However, they are not one and the same. For example, RTFs have little to do with high-risk warrant service, hostage rescue, or barricaded subjects; they specifically deal in active-shooter response only. These concepts have evolved to minimize delays in immediate lifesaving medical care provided to victims in active-shooter events, particularly those with the top-three causes

CONTINUED on page 4

THE BREAK ROOM

From ACEPNow.com

In response to "AMA President Dr. Steven Stack Talks Physician Shortages and APPs," September 2015]

As a practicing PA, I agree mostly with your response about the use of APPs in the face of physician shortages. Physicians are the most highly trained, and it is improper for a PA or NP to obtain a doctorate and present themselves as a doctor to their patients. With that being said, there is a place for increased (not complete) autonomy, especially at the acute or primary care level. Every good advanced practice provider and primary physician should know their limitations and have a low threshold for referral when needed. The physicians, PAs, NPs, and other advanced practice clinicians need to work harder to put medical politics aside to bring together a cohesive plan of team health care.

—Robert Monzingo

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sis for charting as well as for billing purposes.

As a former nurse, I was taught that a nursing diagnosis must *not* be written as a medical diagnosis (this would be practicing medicine without a license). An example of a nursing diagnosis for a skin laceration would be: actual impaired tissue integrity related to disruption of tissue.

I hope that patients will not become confused when a health care provider with a PhD or a DNP introduces themselves as "doctor."

—David Pecora, PA

both agree and disagree with Dr. Stack's comments concerning advanced practice providers. If he is going to make statements concerning the AMA's stance on this subject, then he should be knowledgeable about the difference in PA's versus NP's (which I think he is, but rather he choose the "easy" response of just grouping several different professions together). The PA profession has never attempted to depart from the physician/PA relationship and the PAEA has stated the terminal degree for the PA profession as a master's degree. Dr. Stack should not have taken the easy road in making a blanket statement about all advanced practice providers and called a spade a spade and stated the AMA's true stance on the NP/DNP movement. As a PA, I am tired of being lumped in with the NP community, not because I don't respect them as providers, but because we come from entirely different aspects of medical training, practice style, future professional goals, etc. ☺

—Dayna Jaynstrin

As a physician assistant in emergency medicine, I agree with Dr. Stack's comments and statements. Since PAs are trained in the medical model, and where physicians take a significant role in our training and supervision, PAs want to continue with the "physician-PA" team model.

The physician is the captain of the ship. We as PAs enjoy an excellent working relationship with our physician supervisors and colleagues.

As far as nursing providers declaring independent practice, they do have a license to practice *nursing*. Where my confusion begins is why nursing personnel use medical diagno-

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A NEW SPIN | CONTINUED FROM PAGE 3

of preventable death in penetrating trauma (hemorrhage, tension pneumothorax, and airway compromise).¹ Conversely, TEMS units are not unique to active-shooter events only, and TEMS personnel may not even be among the first arriving responders in an active-shooter event. (Most events are over prior to SWAT's arrival.)² RTF personnel are composed of traditional EMS and fire personnel escorted by a force protection element of law enforcement personnel. TEMS units, on the other hand, are composed of EMS and fire personnel trained above and beyond the traditional EMT and paramedic curricula and are integrated with tactical teams specifically. While TEMS elements may be included on RTF teams, the teams do not depend on general TEMS personnel/training specifically. Therefore, to assume that TEMS units and RTFs are one and the same, and thus the risk and danger involved in each is the same, is a misunderstanding of the two concepts.

should, argue that this is due to the fact that responders are required to wear appropriate protective equipment and that it is, in fact, doing its job protecting from serious injury or death.⁴ Likewise, how many planes crash at airports every year, yet would anyone even dream of arguing that air-rescue units are too expensive and unneeded statistically and, therefore, we should remove all fire apparatus from commercial airports in order to cut costs?

With a growing number of threats and increasing violence against law enforcement and public safety providers, is this really the time to discuss decreasing the preparedness and protection of our personnel? We certainly cannot bury our heads in the sand and pretend the threat is not increasing and thus it is justifiable to decrease expenditures on appropriate protective equipment for our front-line providers. The simple fact remains that TEMS providers and RTF personnel are entering into dangerous situations when they



Dr. Lewis, right, and colleagues provide training and expert advice to physicians, emergency medical services, law enforcement, and others who may face tactical medical situations.

Now, to address the evolving debate of the appropriate level of protection needed for TEMS units and RTFs. Honestly, this concept is really very simple in my mind. Would you knowingly go into the most dangerous situation anywhere in your city without the maximum level of protection? I know, after 15 years of operational support as a TEMS provider, I personally would never dream of going on an active-shooter event, SWAT call-out, or high-risk warrant service without the maximum level of protection for that mission. Admittedly, I am biased after the above scenario that occurred on my team years ago. However, I believe it remains the standard to provide adequate protection to TEMS providers and RTF personnel.

Is it fair for anyone to say that providers should not be offered the highest level of protection for the job they are performing? Simply because the data show a lack of events occurring in which TEMS providers or RTF personnel are actually hurt or fired upon during their mission does not mean that the risk is non-existent, and it certainly does not mean the lives of TEMS providers are worth less than the protective equipment, which would be purchased.

To compare ideology in services, how many firefighters are seriously hurt in vehicle extractions every year? Thankfully, very few.³ Yet despite the thankfully low incidence, the National Fire Protection Association clearly mandates bunker gear, personal protective equipment, in all extractions. One can, and

respond to these events. To look only at data and attempt to justify cost savings by cutting protective equipment is, at best, irresponsible and, at worst, reckless when compared to a clearly established national standard as recommended by the newly released document published by the Department of Homeland Security with clearly defined position statements regarding personal protective equipment.⁵ At the end of the day, we need to protect those who are protecting us. ☘

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DR. LEWIS is owner and medical director of Special Tactics and Rescue Consulting in Lubbock, Texas.

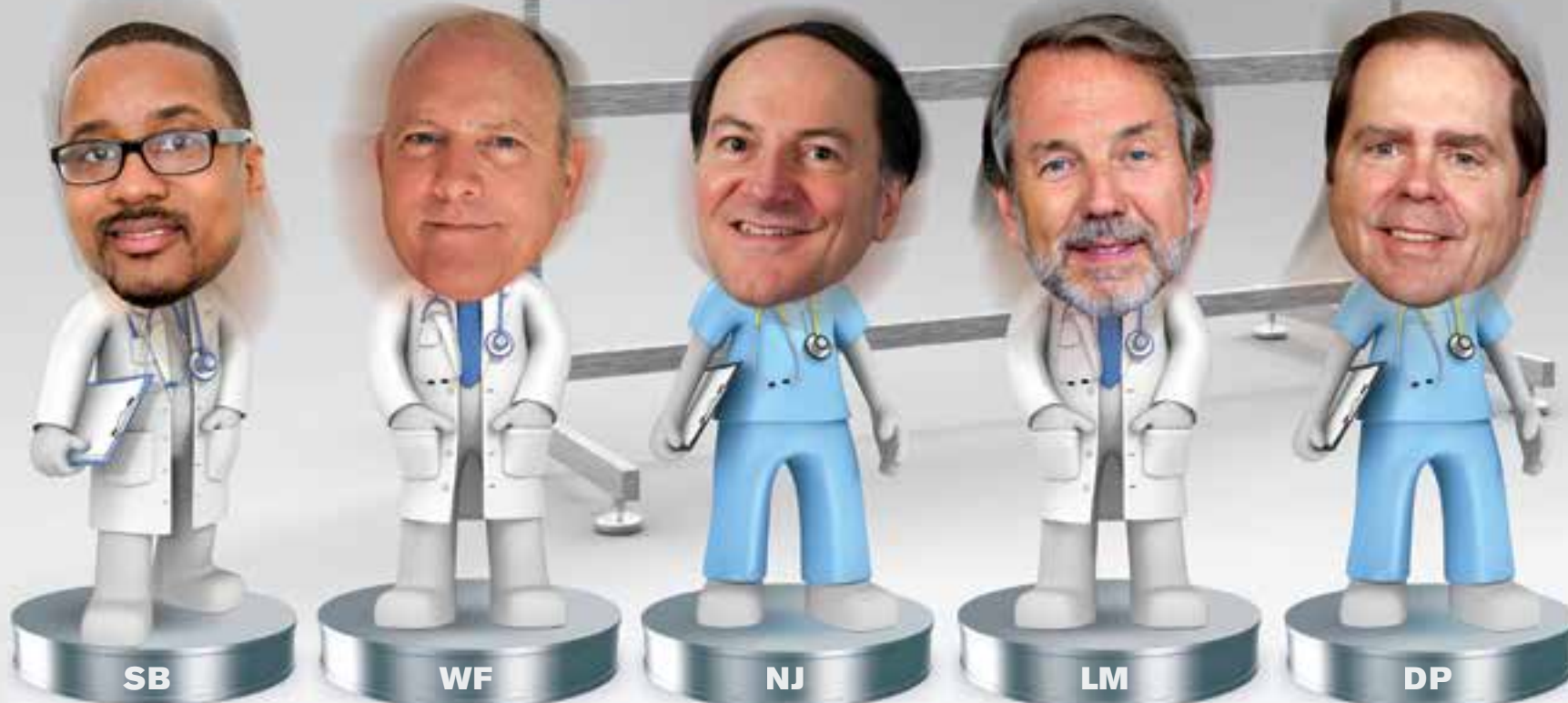
IS DEMOCRACY THE GOLD STANDARD OR JUST AN IDEAL? | CONTINUED FROM PAGE 1

MODERATOR

Ricardo Martinez, MD, FACEP, chief medical officer for North Highland Worldwide Consulting and assistant professor of emergency medicine at Emory University in Atlanta



democracy
noun de·moc·ra·cy \di-ma-kre-se\



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Savoy Brummer, MD, FACEP, vice president of practice development at CEP America in Belleville, Illinois, and chair of the ACEP Democratic Group Section

Wesley Fields, MD, FACEP, past chair and the most senior member of the Board of Directors of CEP America in Emeryville, California

Nicholas J. Jouriles, MD, FACEP, president of General Emergency Medical Specialist Incorporated, a single-hospital group in Akron, Ohio

Lynn Massingale, MD, FACEP, executive chairman of TeamHealth in Knoxville, Tennessee

Dighton C. Packard, MD, FACEP, chief medical officer of EmCare in Dallas

RM: So let me go with our first question: what is the definition of “democracy”?

WF: Well, I think this is very perspective-driven, and I'll start with one that I don't necessarily subscribe to but I think is common with emergency medicine, in particular in a lot of residency programs, and probably supported by the American Academy of Emergency Medicine. Some folks in emergency medicine believe in an ideal or aspiration that's based partly on the idea that emergency medicine can be practiced privately in the same sense you can have a private practice, such as dermatology or something else that's not hospital-based,

and that beyond that, all rights and privileges that can be assigned to other medical specialties need to be attributable and available for emergency physicians as well. I think that some folks believe that to be an attainable goal or a reality in our present world, but all of us have real-life experiences that demonstrate how tough it is to get close to that ideal.

NJ: Definition, I don't know. Go to the dictionary, and 1a you measure with a ruler. I agree completely that everyone has a different perspective, and everyone throws out meanings, and everyone has a different definition. I think the basic concept is,

are you treated fairly? And “fairly” is situational. What's fair in one group is not fair in another. I think as long as each individual member is treated fairly within their own group, that's what should count.

SB: I think that coming from our section's perspective, ACEP was fairly clear in how they defined democratic groups. They had a policy that was adopted back in '08 and reaffirmed in 2014. I believe EM groups are defined by their governing body that is subject to change by fair and transparent elections that embody a one-vote, one-person structure and philosophy or representative vote recognizing equity,

ownership, or seniority within the group. This governing body or electorate will control the finances and the decision making in the group. Again, it's a longer policy, but those are the primary points. How do you measure democracy? I think that is reflective in at least some of the things that our Board of Directors tried to establish. They're not true metrics, but it says that all the members should have a right to petition the governing body for their grievances, access to a fair due-process procedure, freedom to speak within the business confines of the group in a nondisruptive manner that should be exercised without fear, and lastly,

CONTINUED on page 6

an equal and realistic ownership opportunity within their group. Alluding to some of the comments by the last two folks, several of those elements are very much about fairness—due process, how you're treated.

RM: Let's keep going around for other insights in terms of how you might measure that. Lynn, you want to jump in?

LM: I guess to the typical person, I think when you ask what democracy is, it mostly means one person equals one vote on all material things. In reality, most democracy is one person, one vote, but in general, it's one person, one vote on things that come to a vote, not necessarily on all things that matter to that entity or organization or group. I wouldn't even quarrel that the best definition of democracy is one person equals one vote on everything that matters. To me, the question is, is that the best or is that even a common model in emergency medicine today? In addition, I would say it's neither common nor best if that precise definition is actually the definition.

RM: You want to expand on that?

LM: Well, first off, I don't think there are many groups that meet all the criteria that Savoy just recited. I'm not quarreling with them at all. I just don't think there are many groups like that in any specialty and certainly not in emergency medicine. Second, with the pace of change and the challenges that face all of us these days, I just respectfully question whether it's a practical model for "running a railroad," if you will. I think if you take that to its logical extreme, it means that each person has equal responsibility for everything that the organization does, legally, financially, etc. By and large in groups, even the ones that have one person, one vote, my experience has been that the work is never equal and the level of commitment to accountability and responsibility is never equal. There are pretty big differences even within groups that are largely or entirely democratic by even that strict definition.

RM: Great. Who hasn't weighed in here? Dighton?

DP: I think we need to be definitive about what exactly we're trying to define here because Savoy clearly enunciated what ACEP's policy is and that's what a democratic group is. What does "democracy" mean? We may be talking about two different definitions there. I think I would lean

more toward, when you say what does "democracy" mean, what it means to individual physicians. When a doc is working in the emergency department, does he feel or she feel like that she's being treated fair or equitably? Does she have a voice about what goes on in that department? I feel like, more often than not, that's what they would define as "democracy" rather than "I have ownership and I'm responsible for everything that we do." What I'm finding is—and I freely admit that I'm not sure that

to them. I think that's what's happening to hospital-based groups as well. It's becoming very difficult to practice independently. The regulatory, bureaucratic requirements and hospital-based requirements are making it much more difficult to do that. Even if one was to agree that it was ideal, one hospital, one group, purely democratic practice, according to ACEP's definition, I think it's very, very difficult to accomplish that in today's world. Much less, when you deal with systems of hospitals, then it becomes

"Fairly" is situational. What's fair in one group is not fair in another. I think as long as each individual member is treated fairly within their own group, that's what should count.

—Nicholas J. Jouriles, MD, FACEP

Clearly there is confusion, and many times that type of confusion is present because there are groups that are trying to confuse the term for their own purposes. It has been very, very clearly stated, by both AAEM and ACEP, what the tenants of a democratic group are about.

—Savoy Brummer, MD, FACEP

The important question is whether or not the democratic practice model is clearly the best way to deliver care on behalf of populations or if it's really a boutique kind of activity that can only happen in increasingly rare circumstances.

—Wesley Fields, MD, FACEP

I'm the oldest person on the call, but some of us have been around a lot longer than others—that I've seen this change. I know that when we started out, we very much wanted to have our own shop. We wanted an independent practice within the hospital. I think Wes, and to some extent Lynn, has already said that this is becoming intensely difficult to do, just like we've seen many of our fellow independent practitioners outside the hospital coalesce together in large groups for very obvious reasons

even more complicated. Democratic group, well, ACEP has it defined it. I guess I could argue with one or two words, but I think it's more important to me what my doctors feel about it. My doctors feel that they're being treated fairly both by my group and by the hospital. To some extent, I see that as part of my job to make sure that happens.

RM: You raise a good point. Is it really about specific things, or is it really about the definition of "democracy"? I can tell

you, when I ran the National Highway Traffic Safety Administration, I often told my staff that they were confusing our organization with a democracy. Somebody had to be in charge, and we had to have certain roles and responsibilities well-defined in order for us to execute as a team. We're taught in medicine that it's about independence and autonomy, but we see in the landscape a big move toward organizational change that's creating much greater focus on teams. With teams, you have to give a little bit of something to become part of something bigger. That's why this is a good time to help define what the characteristics of democracy are versus our next question: is it something specific, or is it really more of an ideal? I've heard the group talk about having a voice at the table, being able to participate, that sort of thing. So do we think (I'll go to the third question) there's some confusion, bouncing off of Dighton's comment, of exactly what democracy should be about? I've heard it's changing.

SB: As it relates to a democracy, even in our national governance, there are different, obvious forms, and here in the United States, we are the gold standard of a democratic system, but not everyone in our country votes on every issue every time. The ability for an organization, or for a nation, to proceed with effective governance is many times in the form of a representative democracy. There's nowhere in ACEP that describes a democratic organization or even the basis of democracy within a group as a one-site location. When we talk about getting confused, clearly there is confusion, and many times that type of confusion is present because there are groups that are trying to confuse the term for their own purposes. It has been very, very clearly stated, by both AAEM and ACEP, what the tenants of a democratic group are about.

WF: I'm pretty sure ACEP can validate this for me, but I think that most of us that deal with hospitals and hospital-based systems see that there's a pretty strong trend in recent years that there are more emergency physicians directly employed, either by hospitals or related entities, than there are people practicing in democratic groups of any size. It's obviously not what we're talking about, but I think how important this is or how relevant this is depends on how common or prevalent this practice model is. My sense is that it's a little bit of

an endangered species for the reasons that Dighton suggested, and I think folks that read *ACEP Now* probably need to know what the facts are.

SB: We have 15 million visits that are seen in our democratic section. If you take a cross section of the groups that define themselves as democratic practices, which are within that section, 15 million visits is not a small number, and there are plenty out there that are just independent and don't come to the section meetings. So it's a much larger number than one would expect.

WF: I think it raises a question, not from the point of view of practitioners of emergency medicine but from the point of view of payers and executives in hospital systems and other people that are interested in the triple aim. I think that what they want to know is whether or not democratic group structures actually add value to the quality of care on behalf of patients and population. I think that's becoming the market test and also the government challenge coming at us from both employers and payers and people that run the federal programs. The important question is whether or not the democratic practice model is clearly the best way to deliver care on behalf of populations or if it's really a boutique kind of activity that can only happen in increasingly rare circumstances.

LM: I think this will be on point to what Wes just said. My analogy: A friend of mine runs a large, large, large chain of nursing homes. I was talking to him the other day, and he was telling me about how his average length of stay was going down dramatically and how his census was going up and yet his total occupancy was going down. I thought about all three of those data points. Those are metrics that in the past no one would have ever associated with a nursing home except occupancy percentage. No one talked about length of stay in a nursing home in the past. What's happening with payment reform, with demonstration projects, with others putting somebody at risk, somebody who chooses to be at risk, working with an [accountable care organization] or other entity, etc., focusing on the admission and the 90-day post-acute after the admission, the simple fact is that people are trying to get patients in and out of nursing homes quickly, not just parking them there indefinitely. They're aggressively managing the therapy they re-

My doctors feel that they're being treated fairly both by my group and by the hospital. To some extent, I see that as part of my job to make sure that happens.

—Dighton C. Packard, MD, FACEP

ceive. It's an example of an industry that's being absolutely transformed, not willingly but transformed by force, outside forces,

into a whole new set of behaviors that they have no control of. They have no control of the forces that are acting on them. They're

simply reacting to those forces and those forces being the assumption of risk by some entity, like an ACO. Increasingly, I think all of us in emergency medicine, and our colleagues in hospital medicine, are feeling those same pressures. When you think about the IT commitment and the organizational change that has to take place to make the group ready to accept risk, or be part of risk and reward, it's just so hard to do that if you're spending almost all

CONTINUED on page 8



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1. Dolister M, Miller S, Borron S, et al. Intraosseous vascular access is safe, effective and costs less than central venous catheters for patients in the hospital setting. *J Vasc Access* 2013;14(3):216-24. doi:10.5301/jva.5000130. Research sponsored by Teleflex Incorporated and its affiliates.

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4. Internal clinical evidence summary on file.

5. Internal Business Data on File.

6. IMS Data and internal business data on file.

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your work time on clinical care. Somebody has to spend a fair amount of time on the administrative piece and a fair amount of money on the administrative piece. I know when we first started, one of the doctors in my group said, "Look, I appreciate the fact that you want to spend time on the business stuff, but it doesn't really mean a damn thing to me, and I don't think I should have to pay anything for the time you spend administratively." Most groups feel like that. There are big groups, there are democratic

By and large in groups, even the ones that have one person, one vote, my experience has been that the work is never equal and the level of commitment to accountability and responsibility is never equal.

—Lynn Massingale, MD, FACEP

groups that do have people who spend a lot of administrative time, so I'm not saying it's all or none. But it's very hard for a group to do that if, in fact, there's an expectation

that everyone has an equal vote, everyone's going to do equal work, everyone's going to write a check for capital expenditure for IT, etc. It's just gotten so complicated. The good news is everyone on this call spends all day, every day with a group of people who are really, really smart. In my case, most of them are smarter than me, or all of them are smarter than me, but we all spend time around smart people. It's not that doctors in emergency medicine are not capable of doing that. Our experience is more and more they don't want to do that. The ones who want to do that can find a place to do that in any group, either in a small group or midsize group or a big, a democratic group or a group like ours. If you want to do that work, you can find it, but if you don't want to do that work, which is what we find more and more is the case, then you have to figure out where you want to be. And for me, the most important question for a doctor, any doctor, isn't, is it a democratic group or not, but is it a group that's going to win? Is it a group that's going to survive? That's number one. And is it a group that's going to win in a rapidly changing health care environment that requires all of us to be and do things that we were not and could not do yesterday or last week? That to me is the better question. Not is TeamHealth a democratic group or not because we aren't. The question is, are we going to win or not? The question is, is CEP going to win or not? The question is, is the Akron General group going to win or not? And if you are, if that group has the chops and the commitment to win in that changing environment, then I think good doctors can find a great place in any of those organizations.

RM: From my perspective, I often look nationally at different payers, providers, and others, and there are really four major transformations occurring: clinical transformations, redesign; organizational transformation occurring not only to accept risk but also to work in different ways than before; we're seeing digital transformation, I think has been alluded to; and then financial transformation. So the big question is, what is the best structure to survive? Is there a difference? Next month we'll look at the obligations and responsibilities you have with a democratic group in order to succeed, and what opportunities you get from that structure.

Look for part two of this roundtable in the November issue of ACEP Now. ➔

MY VOICE MATTERS

I have a voice in making decisions about the partnership and how that affects my practice.

Bryan Chow, MD / Emergency Medicine Partner



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HOW MUCH DO EMERGENCY PHYSICIANS MAKE?

2015 Compensation Report

BY BARB KATZ

This year's compensation report continues to reflect the total lack of standardization in the specialty, further proving the supply-demand status of the market. Jobs in highly desirable lifestyle areas feature significantly lower incomes because those employers don't need to use dollars as a draw. The following numbers are based on 1,632 clinical hours per year and include incentive bonuses and RVUs where applicable. The annual incomes include a basic benefits package worth \$25K. Sign-on bonuses, loan assistance, and other perks are not included. Rankings are based on state averages, not the sporadic highs. ☉



THE SOUTHEAST leads the country in compensation, with all state income averages near or topping \$200 per hour. Louisiana is back in the top 10 for the first time since Hurricane Katrina!

ALABAMA: Average of \$196 per hr./\$344K annually, high of \$291 per hr./\$500K annually in **Southeast**

ARKANSAS: Average of \$201 per hr./\$352K annually, high of \$225 per hr./\$392K annually

FLORIDA: Average of \$205 per hr./\$359K annually, high of \$291 per hr./\$500K annually in **Southwest Coast**

GEORGIA: Average of \$220 per hr./\$384K annually, high of \$250 per hr./\$432K annually, \$430K+ annually in **Atlanta**

LOUISIANA: Average of \$214 per hr./\$374K annually, high of \$250 per hr./\$432K annually

MISSISSIPPI: Average of \$250 per hr./\$432K annually, high of \$300 per hr./\$515K annually on **Gulf Coast**

NORTH CAROLINA: Average of \$210 per hr./\$367K annually, high of \$225 per hr./\$392K annually

SOUTH CAROLINA: Average of \$200 per hr./\$351K annually, high of \$291 per hr./\$500K annually

TENNESSEE: Average of \$200 per hr./\$351K annually, high of \$260 per hr./\$440K annually



THE MIDWEST is closing in (despite dodgy numbers in closed-mouthed Ohio) due to the boom state of North Dakota and increases throughout the region.

ILLINOIS: Average of \$214 per hr./\$374K annually, high of \$291 per hr./\$500K annually, \$325K annually in **Chicago**

INDIANA: Average of \$197 per hr./\$346K annually, high of \$260 per hr./\$450K annually

IOWA: Average of \$194 per hr./\$340K annually, high of \$272 per hr./\$468K annually

KANSAS: Average of \$200 per hr./\$351K annually, *no significant highs*

KENTUCKY: Average of \$200 per hr./\$351K annually, high of \$230 per hr./\$394K annually

MICHIGAN: Average of \$175 per hr./\$310K annually, high of \$192 per hr./\$338K annually, \$340K annually in **Upper realm**

MINNESOTA: Average of \$175 per hr./\$310K annually, high of \$200 per hr./\$351K annually

MISSOURI: Average of \$210 per hr./\$367K annually, high of \$300 per hr./\$515K annually, \$275 per hr. in **St. Louis**

NEBRASKA: Average of \$200 per hr./\$351K annually, *no significant highs*

NORTH DAKOTA: Average of \$208 per hr./\$365K annually, high of \$291 per hr./\$500K annually

OHIO: Average of \$186 per hr./\$328K annually, *no significant highs*

SOUTH DAKOTA: N/A

WISCONSIN: Average of \$223 per hr./\$390K annually, high of \$300 per hr./\$515K annually, \$300K annually in **Madison/Milwaukee**



Texas, New Mexico, and California drive the high dollars in **THE WESTERN REGION**, with dramatic lows in Colorado, Arizona, and Hawaii.

ARIZONA: Average of \$160 per hr./\$286K annually, high of \$225 per hr./\$392K annually in **Kingman**, \$250K annually in **Phoenix**

CALIFORNIA: Average of \$220 per hr./\$384K, high of \$291 per hr./\$500K annually, \$500K annually in **Los Angeles**

COLORADO: Average of \$150 per hr./\$269K annually, *no significant highs*

HAWAII: Average of \$140 per hr./\$253K annually, *no significant highs*

NEVADA: Average of \$195 per hr./\$343K annually in **Las Vegas**, *no significant highs*

NEW MEXICO: Average of \$224 per hr./\$390K annually, high of \$308 per hr./\$525K annually in **Roswell/Carlsbad** area

OKLAHOMA: Average of \$210 per hr./\$367K annually, high of \$220 per hr./\$367K annually

TEXAS: Average of \$242 per hr./\$419K annually, high of \$300 per hr./\$515K annually, \$450K annually in **Houston** and **Dallas**, \$380K annually in **San Antonio** and **Austin**

UTAH: N/A



THE MIDDLE ATLANTIC states experienced about a 10 percent earnings hike but primarily in Pennsylvania, with other states staying mostly the same.

DELAWARE: Average of \$180 per hr./\$318K annually, *no significant highs*

DISTRICT OF COLUMBIA: Average of \$132 per hr./\$240K annually, *no significant highs*

MARYLAND: Average of \$155 per hr./\$278K annually, high of \$200 per hr./\$351K annually in **Cumberland** region

NEW JERSEY: Average of \$180 per hr./\$318K annually, high of \$200 per hr./\$351K annually

PENNSYLVANIA: Average of \$200 per hr./\$351K annually, high of \$230 per hr./\$400K annually, \$375K annually in **Pittsburgh**, \$300K annually in **Philadelphia**

VIRGINIA: Average of \$194 per hr./\$341K annually, high of \$256 per hr./\$442K annually

WEST VIRGINIA: Average of \$175 per hr./\$310K annually, *no significant highs*



THE NORTHEASTERN states also remain predominately the same, with increases in New Hampshire and New York.

CONNECTICUT: Average of \$175 per hr./\$310K annually, *no significant highs*

MAINE: Average of \$150 per hr./\$271K annually, *no significant highs*

MASSACHUSETTS: Average of \$170 per hr./\$302K annually, high of \$225 per hr./\$392K annually, \$150–\$179 per hr. in **Boston**

NEW HAMPSHIRE: Average of \$180 per hr./\$318K annually, *no significant highs*

NEW YORK: Average of \$168 per hr./\$299K annually, high of \$225 per hr./\$392K annually, \$270K annually in **New York City**

RHODE ISLAND: Average of \$155 per hr./\$278K annually, *no significant highs*

VERMONT: Average of \$180 per hr./\$318K annually, *no significant highs*



Nothing seems to change in **THE PACIFIC NORTHWEST**, land of low incomes and high mountains.

ALASKA: Average of \$140 per hr./\$253K annually, *no significant highs (or jobs for that matter)*

IDAHO: Average of \$135 per hr./\$245K annually, *no significant highs (or jobs for that matter)*

MONTANA: Average of \$175 per hr./\$310K annually, *no significant highs (or jobs for that matter)*

OREGON: Average of \$176 per hr./\$312K annually, *no significant highs (or jobs for that matter)*

WASHINGTON: Average of \$185 per hr./\$296K annually, high of \$250 per hr./\$400K annually

WYOMING: Average of \$185 per hr./\$327K annually, high of \$230 per hr./\$400K annually

TRENDS

- The percentage of jobs open to primary care-boarded physicians is 37 percent, up 6 percent from last year.
- Sign-on bonuses are increasing, with the average at \$25K and the high at \$50K; most do not include relocation. It is difficult to pinpoint the percentage of employers that offer sign-ons, but it is around 75 percent.
- The good news is that emergency physician incomes are up 10 percent across the board from last year.
- The benchmark of \$200 per hour continues to prevail, spreading into the Middle Atlantic but remaining elusive in the Northeast and Pacific Northwest.
- Regional averages show the Southeast still leads in highest average compensation but is followed closely by the Midwest and Western states.

TOP 10 STATES FOR COMPENSATION

- | | |
|----------------|--------------|
| 1. Mississippi | 6. Georgia |
| 2. Texas | 7. Illinois |
| 3. New Mexico | 8. Louisiana |
| 4. Wisconsin | 9. Oklahoma |
| 5. California | 10. Missouri |

BOTTOM 10 STATES FOR COMPENSATION

- | | |
|-------------------------|-------------------|
| 1. District of Columbia | 6. Washington |
| 2. Idaho | 7. Maryland |
| 3. Hawaii | 8. Arizona |
| 4. Colorado | 9. New York |
| 5. Maine | 10. Massachusetts |

THEN & NOW

SCIENTIFIC ASSEMBLY STILL GOING STRONG

This month, emergency physicians will join their colleagues in Boston for education and networking at ACEP15. In 1977, ACEP members were traveling to the opposite side of the country for the Scientific Assembly—but some of the hot topics for discussion haven't changed.



1. JACEP cover from 38 years ago.
2. San Francisco was featured as the fifth ACEP Scientific Assembly location and has continued to be a favorite venue ever since.
3. Telemedicine in the '70s? Amazing how some topics seem to resurface over time. Looking at the title and the era, would you have expected a soup can and a string? Page 440 shows the state-of-the-art telemedicine equipment being used in 1977.

—Compliments of Bruce Walmsley, MD, FACEP

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COUNCIL SPEAKER CANDIDATE



COUNCIL VICE SPEAKER CANDIDATES



2015 ACEP ELECTIONS PREVIEW

MEET THE COUNCIL OFFICER CANDIDATES

CONTINUED FROM PAGE 1



The Council officer candidates responded to the following question:

What one skill do you possess that would be critical to running a successful Council meeting?

COUNCIL SPEAKER

The following is a candidate for ACEP Council Speaker.

James M. Cusick, MD, FACEP (Colorado)

Current Professional Positions: emergency physician, First Choice ER, Thornton, Colorado

Internships and Residency: internal medicine internship, St. Elizabeth's Hospital Medical Center (NEOUCOM), Youngstown, Ohio; ED elective (two months), Lincoln Hospital and Mental Health Center, South Bronx, New York; emergency medicine residency, Kern County Medical Center, Bakersfield, California

Medical Degree: MD, Fifth Pathway: Nassau County Medical Center/SUNY Stony Brook, New York (1983)

✓ Having been your recent Council Vice Speaker for two years, I sincerely believe there is no "one skill" that is critical to running a successful Council meeting. Instead, it requires a multitude of simultaneous technical skills, a solid Council and College knowledge base, and a keen sense of awareness of one's immediate surroundings. Maintaining a good sense of humor, being quick of wit, and possessing a cunning ability

to hear and feel "the collective will of the Council" strongly support success.

Keeping track of time and being respectful of each other as we deliberate on the floor are extremely important to our success in doing the annual business of the Council. This is our tradition; combined with adherence to bylaws, Council standing rules, and honest heartfelt debate of our resolutions, we reap the rewards of improved patient care, support of our membership, and clarity/direction of purpose. I appreciate our process.

Being a good speaker and running a successful meeting involves being a good communicator. Quality communications begin with being a good listener, being open-minded, and understanding the value of different opinions and sometimes seemingly divergent views in a collegial manner while always considering the unintended consequences of all actions.

I have the ability, "skills," and personality of an excellent communicator and will bring the level of communication to new heights. I believe I have the "right stuff" and now the appropriate training to be an excellent Council Speaker and will strive to do so with the help of many College leaders, Councillors and Past Speakers as valued resources.

COUNCIL VICE SPEAKER

The following are candidates for ACEP Council Vice Speaker.

Sabina Braithwaite, MD, MPH, FACEP (Kansas)

Current Professional Positions: associate medical director, Medical Control Board, EMS System for Metropolitan Oklahoma City and Tulsa, Oklahoma (part time); clini-

cal educator, Teleflex; EMS system medical director, Wichita-Sedgwick County EMS System, Kansas; attending emergency physician, Green Country Emergency Physicians, Hillcrest Medical Center, Tulsa, Oklahoma
Internships and Residency: medical internship, Medical College of Virginia, Richmond; emergency medicine residency, Medical College of Hampton Roads, Norfolk
Medical Degree: MD, Medical College of Virginia (1991)

✓ I believe the most critical skill to successfully running a Council meeting is the ability to actively listen. Critically listening to the tenor and content of information shared by the Council will facilitate shaping the will of the Council into specific, achievable guidance for the Board. While other skills I possess are also important, I am confident that these must be rooted first in the ability to listen. I feel strongly that the Speaker's role is not to push forward their own opinion but rather to fully evoke and articulate the voice of the Council—and to keep the meeting productive, on time, and reflective of the diverse and engaging individuals who make up our profession.

Gary R. Katz, MD, MBA, FACEP (Ohio)

Current Professional Positions: system medical officer, The Schumacher Group; vice president, clinical quality and service excellence, Premier Physician Services; facility medical director, Memorial Health, Marysville, Ohio

Internships and Residency: emergency medicine residency, Summa Health System; emergency medicine internship, Summa Health System

Medical Degree: MD, Medical College of Ohio (1998)

✓ Our Council is similar to work in the ED. Many wish to speak, often with competing wants. The effective leader must form order from chaos, help create solutions, and get participants feeling their efforts were time well spent. Helping others to “find their voice” is a skill that I can bring as Vice Speaker.

I have experience as Speaker, having served as Chair of the American Medical Association Young Physicians Section. There, physicians from all specialties represented an array of interests, making collaboration essential. Execution of fair and efficient meetings was critical to achieve success. I served two terms as Ohio Chapter ACEP President, where balancing organizational goals with the governance of a varied board was a necessity. Through these experiences, I have proven my skills for the office of Vice Speaker.

Facilitating fair debate is important. For some, public speaking is a barrier, while others struggle in the other direction. The Speaker must work to uplift those who need support and encourage balance from others.

It has been said, “Everything needs to be said, just not by everybody.” The Speaker should help each person find their voice so all comments add value while strengthening reference committees’ focus on consensus build-

ing. Through this approach, an efficient and vetted consent calendar would free time to debate more controversial topics, removing the rushed pressure to close debate prematurely.

The diversity of our Council can create rich solutions. The Vice Speaker must assure people find their voice so we may enjoy progress and results. I can do that.

Col. (ret.) John McManus, MD, MBA, MCR, FACEP (Georgia)

Current Professional Positions: EMS fellowship director and professor of emergency medicine, Georgia Regents University, Augusta
Internships and Residency: transitional internship, Eisenhower Army Medical Center, Augusta, Georgia; chief resident, emergency medicine, Fort Lewis, Washington

Medical Degree: MD, Medical College of Georgia (1992)

✓ I’ve spent several years working in both medicine and the military for many great leaders, and much to my surprise, the leaders at most of my jobs did not fit commonly espoused theories of leadership. Although several of my previous leaders and mentors were charismatic, possessed a commanding presence, were visionary and educated at elite schools, all of the most successful were servant leaders. Over the past

two decades as I have moved up in the leadership ranks, I have relied on being a servant leader as one of my most prized qualities to build consensus, motivate colleagues and peers, as well as mentor future medical providers off and on the battlefield. A servant leader is one who leads by example and is people-centric. This leader is valued service to others and believes they have a duty of stewardship. I tend to be a humble but passionate operator in my organizations who believes every member should be treated with equal respect and their opinions valued. Servant leaders are felt to be effective because the needs of followers are so looked after that they reach their full potential, hence perform at their best. The strength of this way of looking at leadership is that it forces one away from self-serving, domineering leadership and makes one who is leading think harder about how to respect, value, and motivate people working with them. I look forward to the potential opportunity to serve the Council in this capacity.

Robert C. Solomon, MD, FACEP

Current Professional Positions: attending physician, UPMC St. Margaret, Pittsburgh

Internships and Residency: internal medicine residency, The Western Pennsylvania Hospital Emergency Medicine Residency,

Pittsburgh

Medical Degree: MD, University of Pittsburgh School of Medicine (1982)

✓ Arguably, the key to running a successful meeting is preparation. Ideally, every Councillor comes to the meeting having carefully read and considered all of the resolutions, including background material, ready to engage in illuminating and pithy debate. Much more important, perhaps, is that the presiding officers have a firm grasp of all business that is to come before the Council. Command of parliamentary procedure is valuable, but more valuable still is the ability to keep debate focused on substance, and that requires a clear sense of what each matter under consideration is really all about and what essential issues must be decided. To borrow an analogy from my many years of experience in writing and editing, it matters little if the grammar and punctuation are all correct (although they must be!) if one reads the article and finds oneself saying, perplexed, “Huh?” My six years on the Bylaws Committee (three as Chair) taught me the importance of attention to detail and the even greater necessity of clarity. Strong preparatory work, with that kind of attention to detail and clarity, will enable me to run Council meetings that are focused and productive. ☺

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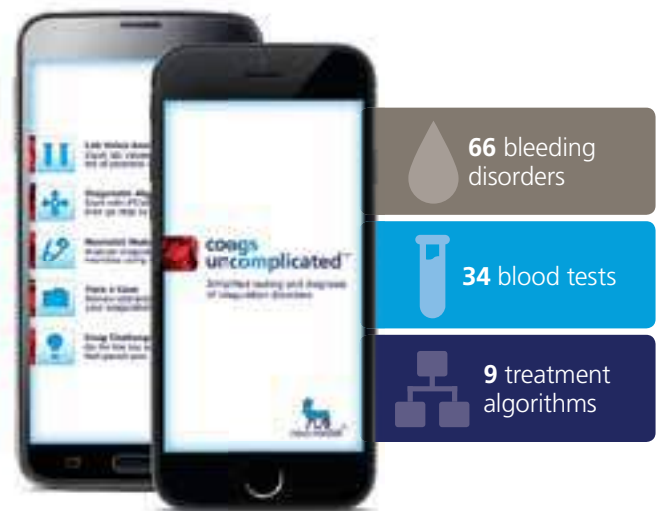
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Emergency physicians man the trenches for the Asterisk Mobile Medical Center in packed Supercross stadiums across the country

BY JAMES R. KENNEDYE, MD, MPH, FACEP | PHOTOGRAPHY BY RENÉE FERNANDES/RENEEMEDIA

Few people would argue whether the specialty of emergency medicine has its own medical jargon that leaves most people scratching their heads. Occasionally, even our patients have been known to say (or ingest) things that may send us running to Google or Urban Dictionary. However, the emergency physicians who work in motorsports also have a language all their own.

A typical exchange at a Supercross event:

DOC: “What happened?”

RIDER: “Doc, I missed the holeshoot. I had it pinned and was pushing through traffic. I was railing off of the berm trying to scrub that first triple when this squid whiskey throttled off of the face of that whoop, got squirrely, and cased the second jump. I totally nailed him and endoed into the ruts. Got roosted on by about five dudes. I think I landed right on his foot peg.”

DOC: “So what hurts?”

RIDER: “Everything!”

DOC: “Let’s get you checked out.”
HUH?!

Dirt bike racing is not in the realm of experience for most emergency docs, but for two emergency physicians, John Bodnar, MD, aka “Doc Bodnar,” and myself, Jim Kennedy, MD, MPH, FACEP, or simply “Doctor Jim,” it is second nature. Both of us are board-certified emergency physicians practicing full-time in EDs out of California and Oklahoma, respectively, and both have been riding and racing dirt bikes since the 1970s, when the sport of professional dirt bike racing, also known as “motocross,” exploded in popularity.

Doc Bodnar is the founding member and serves as medical director of the Asterisk Mobile Medical Center (AMMC). A team of professionals staffs the AMMC and provides medical treatment and stabilization services for the athletes and crews of the Monster Energy Supercross series and the Amer-

ican Motorcyclist Association (AMA) Motocross Nationals across the United States. It is made up of a rotating crew of emergency nurses, orthopedic surgeons, physical therapists, and athletic trainers led by Doc Bodnar and head athletic trainer Eddie Casillas.

MOTORSPORTS 101

“Supercross” is the term for dirt bike racing at its highest level that occurs in major professional football and baseball stadiums across the country. The tracks of Supercross tend to be highly technical and shorter due to space constraints. “Motocross” tends to refer to longer outdoor tracks in more rural areas, which are less technical but come with the risks inherent with more riders and much higher speeds.

The racers at these events are professional athletes in every sense of the word, and top racers regularly demonstrate aerobic fitness on par with that of any athlete across all sports as measured by the VO_2 max. Also, a top racer may have a six- to seven-figure income, and grounding them due to medical injury, a role assumed by the ED docs, is something never taken lightly. As you might expect, concussions, contusions, and various orthopedic trauma are commonplace during practice and racing sessions. However, riders and their crews are often on the road for 30 weeks or more out of the year and have all the typical non-racing-related ailments one might see in the





AS YOU MIGHT EXPECT, CONCUSSIONS, CONTUSIONS, AND VARIOUS ORTHOPEDIC TRAUMA ARE COMMONPLACE DURING PRACTICE AND RACING SESSIONS.

—DR. KENNEDYE

ED on a typical day. If necessary, AMMC physicians are able to function as proxy primary physicians.

Most uninitiated people wonder how hard can it be just riding around a track. I've played most any sport you can think of, and riding motocross bikes on a track environment is the most aerobically demanding thing I've ever done bar none! Every muscle group is firing for 30 to 60 minutes at a time, and you're constantly subject to forces many times the force of gravity while the bike is trying to throw you on your head. The skills of the pro riders are mind-boggling. Yet despite the speeds and heights attained by the racers, severe, life-threatening injuries are quite rare.

ON THE COURSE

During practice or race time, the emergency physicians and other members of the team position themselves trackside, keeping their "heads on a swivel," monitoring for crashes and injuries while protecting their own safety. Coordination with the promoter and race officials is carried out via headset radio. If an accident occurs and the riders are unable to get up on their own and return to the action or to the pit area, Doc Bodnar and I have at our disposal several "medical mules," which are converted four-wheel off-road vehicles. After stabilization and immobilization takes place trackside, they will transport the rider back to the AMMC, which is a large two-story 18-wheel rig that essen-

tially functions as a mobile ED. It is equipped with ultrasound, fluoroscopy, slit lamp, and all of the necessary equipment for treatment of fractures, dislocations, and wounds.

Doc Bodnar and I also organize local emergency medical services crews who are on scene to provide care and transport patients who require a higher level of care to the ED, if necessary. Between events, we provide post-concussion monitoring for the riders, helping guide them back safely to racing status. Additionally, we contribute to safety instruction for racers and provide constant feedback to racing equipment manufacturers that helps with innovation efforts. We've really become ingrained in the culture of professional motocross racing and have earned the respect of the riders, teams, and sanctioning bodies. It really helps to speak the language of medicine and motocross.

Why do we do it? Well, our skills set makes us uniquely qualified to coordinate the mission of the AMMC, and we enjoy the family environment of the teams. However, like all emergency physicians, we are adrenaline junkies and just love the sport. Once the love of riding gets in your blood, it's hard to get it out. This allows us to fuse our love of medicine and motorcycles ... plus, we're terrible at golf. 🏌️

DR. KENNEDYE is a physician at St. Francis Hospital/EMP of Tulsa and serves on the Oklahoma Chapter ACEP Board and as an ACEP Councillor. He recently survived his first Sturgis Motorcycle Rally.

ABOVE:

Dr. Kennedy has been working on the medical staff for the Monster Energy Supercross and AMA National races since 2006. He spends a few weekends each race season traveling primarily the Midwest to be a part of the sport that he loves. Dr. Kennedy has been active in motocross since he was eight years old.

FROM LEFT TO RIGHT:

The Asterisk Mobile Medical Center travels across the country for the Monster Energy Supercross series and the AMA National Motocross series. The unit has four beds and the equipment needed to treat sick or injured riders and support staff. The AMMC has on board fluoroscopy, ultrasound, and cardiac monitoring/advanced cardiac life support equipment as well as supplies for managing fractures, lacerations, and various other medical issues. Routinely, injuries exceed the ability of the AMMC's capabilities and patients are transferred to local hospitals for a higher level of care.

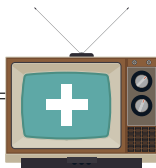
Dr. Kennedy checks a rider in the Asterisk Mobile Medical Center during the Monster Energy Supercross races in Arlington, Texas.

Dr. Kennedy, left, and Dr. Bodnar, right, check a rider in the AAMC.

Dr. Kennedy keeps a very close eye on the action during the Monster Energy Supercross races. Dr. Kennedy stays on the track during the race to watch the riders and says a hard part of his job is watching out for the inherent dangers of being on the track.

Dr. Kennedy keeps an eye on a rider on the back of the Asterisk Medical Mule as he and Dr. Bodnar transport him off the track and back to the medical center for evaluation.





Saying "I Do" to TV

Married to Medicine stars Drs. **Heavenly** and **Damon Kimes** add television to their list of professional accomplishments

Between working shifts, keeping current with medical research, managing life outside of work, and maybe raising a family, most emergency physicians have a lot on their plates. Now imagine adding a grueling filming schedule and the publicity appearances and other responsibilities that come with being a television star to the mix. That's just what emergency physician Damon C. Kimes, MD, and his wife, Heavenly Kimes, DDS, a dentist, decided to do when they joined the cast of the Bravo reality show *Married to Medicine*. The show follows the lives of several Atlanta-based physicians and their spouses as they work to balance careers, family, and friendships.

Dr. Kimes recently spoke with *ACEP Now* Medical Editor-in-Chief Kevin Klauer, DO, EJD, FACEP, about why he and his wife decided to join the show and the challenges of juggling career, family, and TV. Here are some highlights from their conversation.

KK: Where are you located?

DK: We're about 20 minutes outside of Atlanta. I did my training at Grady Memorial Hospital for Emory. I was there from 2001 to 2004.

KK: How long have you two been married?

DK: Almost 20 years. This past August 16 will make 18 years married, but we dated for about three years before that.

KK: You thinking you're going to make it to 20 years? :)

DK: Oh, yeah. If nothing else, everything that's transpired has really made us a lot closer. Probably the opposite of what people might think, just doing something where it's you against the world, it's really brought us really close.

KK: Let me tell you what brought you and I together. So here I am on the elliptical, and Bravo is on the TV, *Married to Medicine*. You two are going out on a date night, and your daughter told your wife, "You are not going out dressed like that!" Then it comes out in the discussion that you're an emergency physician. "Oh, my gosh! It's one of my colleagues," I thought. I got really interested in it at that point. When did you get involved with the show?

DK: Actually, we were involved from the onset. There is a young lady who is on the show, Mariah Huq, who heard about us through mutual friends. Dr. Eugene Harris and Toya Bush-Harris are friends of ours also. I actually helped Dr. Harris get his first ER job. Toya was already on the pilot for the show, and she said, "You know, I think Heavenly Kimes would really fit well." We made it on one of the episodes, a very controversial episode. There was actually a fight between a couple of young ladies.

KK: It wasn't a fight between Heavenly and some other lady?

DK: Oh, no. No, no, no. We were just innocent bystanders. They showed Heavenly and me, and she had a pretty dramatic reaction to the fight. She was actually really shocked and saddened that it had gotten to that level. My wife has owned up to seven dental practices, and I've been sort of her protégé in terms of business because she's really taught me a lot about how to manage a business. We thought, in addition to having some laughs and doing something we could tell our grandkids about, we would maybe inspire somebody who may be pigeonholed into one career and won't really get to try anything else. A lot of emergency

physicians are super-talented folks and are capable of doing many things.

KK: How long is the filming season?

DK: It's several months. It can range anywhere from five to seven months. You do an intense filming where you're filming three to four times a week for about five to six months. Then there are little pickup episodes where they wanted to get a little more information about certain scenes.

KK: How many hours in a day and how many days in a row are they filming?

DK: Usually, you get a couple days off during the week, like Sunday and Monday typically. You end up filming between two and five hours a day.

KK: Damon, you seem like a pretty polished guy. Is there any portion that's scripted?

DK: Honestly, it's completely reality. At first, I was very nervous while being filmed, and I don't really think I was giving a total reality just because I was so aware of the cameras and things going on around me. Then after a while, it becomes second nature because these folks are in your home. After a while, it becomes routine.



Damon and Heavenly Kimes.

INSET: The Kimes children also appear on *Married to Medicine*. Clockwise from right: Alaura, Damon Jr., and Zachary.

KK: How are they always in the right place at the right time?

DK: Well, if you put a couple folks together and they all have strong personalities, you're going to get a good story. It may be that they filmed for a couple of hours, but you only see about 30 seconds.

KK: Have you ever realized that you said or did something that you just wished you hadn't?

DK: Oh, yeah. All the time and also on film as well.

KK: What's your best example of, "I cannot believe that I just said that"?

DK: They didn't actually show this, but I was joking around with my wife about her doing some surgery or something, but it was something that was sensitive to her, so she really got upset. I was so thankful that they didn't show it because I immediately apologized. I didn't realize that it would hit her that hard.

KK: Can you remember feeling, "Oh, no, that did not just happen"?

DK: Well, my wife uses curse words a lot more than I would. Almost every time she says a curse word, I cringe. You can imagine, if you watch the show enough, that I'm cringing almost constantly.

KK: Has this opened up any other doors?

DK: Sure. My wife has opened up a dating app. It's *piq.dating*. That's really gone pretty far. She's been on countless interviews and other television shows that have highlighted what she does and her personality. It's really opened a lot of doors. And, for me, *ACEP Now* is interviewing me, and I think that's pretty awesome.

KK: I'm not pressuring you, but it would be interesting to people to know: Do you get compensated for being on the show?

DK: Yes, we do.

KK: You're giving your time, you're exposing your family, so why not?

DK: Especially for physicians and dentists and other professionals, this is real time that's away from your practice or in addition to your practice. I don't get compensated because it's really my wife who is the main character, but she gets compensated.

KK: Are there other emergency physicians involved?

DK: They've also got Dr. Eugene Harris, Dr. Darren Naugles, and Dr. Aydin Huq.

KK: Well, I really appreciate it, and you have a great day, Damon. ☺

Emergency Medicine Scaling the Triple Aim

ILLUSTRATION/PAUL JUESTRICH; PHOTOS SHUTTERSTOCK.COM



How to succeed in your hospital's quest for value

BY JOHN G. HOLSTEIN AND
ANDREW SAMA, MD, FACEP

Let's set the stage with a couple of industry quotes.

"We're sorry, but we have no idea how we perform on the procedure you are having. We can't tell you if our physicians use the best treatments—the treatments shown in the literature to be the best ... but trust us, we have some great physicians, and we deliver great care. We just can't prove it."

"Putting a single, predictable price tag on a medical procedure allows a hospital to position these services as 'branded products' and to compete on cost and quality. The common element is the necessity to leverage both cost and quality data to craft an evidence-based economic and clinical value story that the organization can share with payers and employers."

The above quotes capture the essence of the hospital C-suite's dilemma today: persistently driving toward greater value while dealing with the pervasive and pressing issue of first defining and then actually measuring quality and cost, the two major components of their value statement.

So what is emergency medicine doing to become the primary driver and answer for today's hospital executives? Whether an em-

ployed, contracted, or an academic practice, emergency medicine can become the epicenter of answers for disruptive innovation and positive change in every hospital.

Before tackling the issue of emergency medicine becoming the answer to this C-suite dilemma, it is first important to note how emergency medicine will not only not become an answer but alternatively can per-

There needs to be a concerted effort by the specialty to tighten up its own house first. According to Kanzaria et al, "over 82 percent of respondents believe too many diagnostic tests are ordered in their own emergency departments."

sist as a center of problems for hospital executives. There needs to be a concerted effort by the specialty to tighten up its own house first. According to Kanzaria et al, "over 82 percent of respondents believe too many diagnostic tests are ordered in their own emergency departments."³ Some degree of intraphysician variability is acceptable. However, it is imperative that we reduce wide variation in patient treatments and diagnostics. W. Richard Bukata, MD, medical director for The Center for Medical Education, Inc., discusses practice variability specifically regarding computed tomography scans and plain X-rays.⁴ Stephen Klasko, MD, MBA, president and CEO of Thomas Jefferson University in Philadelphia, provides valuable perspective here: "Doesn't it stink that Nick Foles has a better idea of whether a screen pass will work in a given situation than I do of knowing whether a cancer drug will work?"⁵ This is prime time for evidence-based medicine.

Can emergency medicine become the epicenter of positive change, innovation, and solutions for today's C-suite? The answer is a resounding yes. This is an incredibly exciting time for the specialty. If yes, then how?

First, the practice needs to be as efficient and financially successful as possible. This requires constant and persistent vigilance over

CONTINUED on page 18

all practice metrics. As reported by *Wall Street Journal* reporter Stephanie Armour, patient volumes continue to rise across the United States.⁶ Additionally, as the Medicaid rollout continues, virtually every practice is seeing a shift in its payer mix. Monitoring the acuity, clinical, and payer mixes of practices is imperative today because very minor shifts can have substantial impacts. There can be subtle shifts today, especially in these days of Medicaid expansion. The former self-pay patient now insured via Medicaid generates new revenue. However, leakage from the former commercial patient mix into Medicaid may cause substantial revenue loss. (See “Role Reversal: Chasing the Insured for Payment” in the July 2015 issue of *ACEP Now* for more on this challenging situation.)

Along with these changes, efficient staffing—meaning the matching of physicians, advanced practice providers, and scribes, where appropriate—becomes increasingly important. The monitoring of the clinical mix will also become more important as ICD-10 rolls out later this year.

Ultimately, the development, refinement, and definition of emergency medicine’s value statement are at stake here. Components of the evolving value statement include:

- The ED as the center for acute undifferentiated care.
- The ED as the rapid, high-quality diagnostic center.
- Asplin et al suggest this may also require changing the approach to intermediate and complex patient conditions.⁷
- The ED as a key hospital center for identification of frequent users, hot spotters, and mental health patients.
- Emergency physicians as master diagnosticians.

The former self-pay patient now insured via Medicaid generates new revenue. However, leakage from the former commercial patient mix into Medicaid may cause substantial revenue loss.

- Emergency physicians as master play-callers in care coordination to subspecialists.
 - Emergency medicine as a major source of hospital admissions.
 - Observation in the ED to reduce unnecessary admissions and readmissions.
 - Benchmarking through the use of already established resources such as the Emergency Department Benchmarking Alliance. It is not necessary to re-create the wheel; these resources are invaluable.
 - Usage of ACEP’s Clinical Emergency Data Registry (CEDR) when available and complete.
 - Usage of such resources as the NNT (www.thennt.com) where applicable. Using evidenced-based protocols and treatments is paramount today. Judd Hollander, MD, FACEP, a deputy editor for the *Annals of Emergency Medicine*, stated, “We don’t need more data, we need more evidence.”⁸ Putera et al note, “The time of [pivotal clinical trials] publication to meaningful uptake of class IA [acute coronary syndrome] therapies into clinical practice took a median of 16 years. This significant time lag indicates systemic barriers to the translation of therapeutics into routine clinical practice.”⁹
 - Mastering patient flow, especially as the clinical mix continues to change.
 - Continual refinement of such indices as:
 - Door-to-doctor times;
 - Door-to-balloon times;
 - ED time after admission decision;
 - ED time before pain medications; and
 - CT scans per provider, which can be monitored via your billing service to ensure intradepartmental consistency.
 - Mastering of patient threshold management, which is measureable.¹⁰ As James J. Augustine, MD, FACEP, vice president of the Emergency Department Benchmarking Alliance, points out, EDs typically stratify into cohorts with thresholds of 20,000 patient visits.
 - Consistently high patient-satisfaction scores.
 - Assessment, evaluation, and decisions on emergency medicine’s contribution to patient care, including the post-ED visit, as well as discharge planning for wellness, post-visit care, and return to the ED if required.
 - Telemedicine’s role in emergency medicine.
- As emergency physician and AIM Specialty Health chief medical officer Susan Nedza, MD, MBA, FACEP, so eloquently stated, “No

one manages uncertainty better than emergency physicians.”¹¹ Emergency medicine’s image is important outside the specialty, namely with hospital administration, payers, and, in some cases, patients. There are challenges and issues to boldly face and solve; it is imperative this be done sooner rather than later, when one or more of these parties will mandate it for the specialty. The time for introspection and reinvention of the breadth of EM services is now. ☛

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The Maryland Global Payment Experiment



Progress at one year

BY WILLIAM JAQUIS, MD, FACEP

In January 2014, Maryland embarked on a unique method of payment reform by asking health systems to be reimbursed by global payments. The history and initial metrics related to that were previously reported in the April 2014 issue of *ACEP Now* (see below). We are now able to see at least one year of results working under the new payment system.

The metrics introduced proposed to accom-

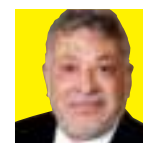
plish two main goals. From a health outcomes perspective, the first goal is to place more responsibility on health systems to manage the health of populations. From that perspective, quality improvement measures, such as hospital-acquired conditions (HACs), needed to see a 30 percent improvement in the initial five-year period. Maryland hospitals were able to achieve a 26 percent improvement in those measures in the first year.

MARYLAND’S NEW PAYMENT MODEL

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

BE A MEDICAL
DETECTIVE—
BONE UP ON YOUR
FORENSIC SKILLS

FORENSICS FACTS



DR. FITZ is clinical faculty at Texas Tech University Health Sciences Center in Lubbock.

The second goal is more directly related to cost. The primary driver for negotiating a new payment system with Medicare was the growing costs to Medicare compared to the rest of the country. The savings target of \$330 million to Medicare, over five years, required a per capita cost increase cap of 3.58 percent per year. Hospitals in the first year were able to keep that cost increase to 1.47 percent. Readmission rates have gone down substantially, but more work needs to be done to meet rates more consistent with national improvements. In addition, hospitals in Maryland have also become more profitable by providing more efficient and effective care.

Instead of being paid by insurers on a case-by-case basis, health systems now get their revenue up front. The global budget they receive is based closely on the revenue they received in the prior year. Health system approaches to patients in the emergency department have required rapid adaptation. Given the change in perspective on decision points such as admission versus observation, more resources have come to ED teams. Case managers and social workers have modified their roles to assist in the decision but also have continued to move more to the front of the ED process. With a global budget, the ability to find resources in the community that will allow patients to be discharged from the ED instead of observed or admitted is paramount.

The savings target of \$330 million to Medicare, over five years, required a per capita cost increase cap of 3.58 percent per year. Hospitals in the first year were able to keep that cost increase to 1.47 percent.

The initial trend toward goals is clearly a positive one for this model of payment. Critics would argue that the first-year accomplishments are simply a result of improving what should already have been more streamlined. Going forward, the adjustments of both the health systems and the payment systems will be more difficult. In addition, by the end of next year, the state must look at planning beyond the initial five years. Hopefully, the systems created and the resources assigned to population health will continue to improve the care delivery system. Thus far, Maryland has saved Medicare \$100 million, far ahead of the five-year schedule. ☘

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

Boston: The Birthplace of Modern Forensics?

by JUAN F. FITZ, MD, FACEP

ACEP welcomes its emergency physicians to Boston, the cradle of America's freedom! As physicians descend upon Boston, it is surprising to know that many physicians were instrumental in America's fight for freedom.

Boston is so full of history that you should make a special effort to spend more time in this city and explore its history. You may be thinking, "History? Boring! I learned it in high school."

Well, for your information, the history we were taught in high school is wrong. Explore the truth in Boston, and you will be surprised what you find.

Here is a little sample of what you may not have known.

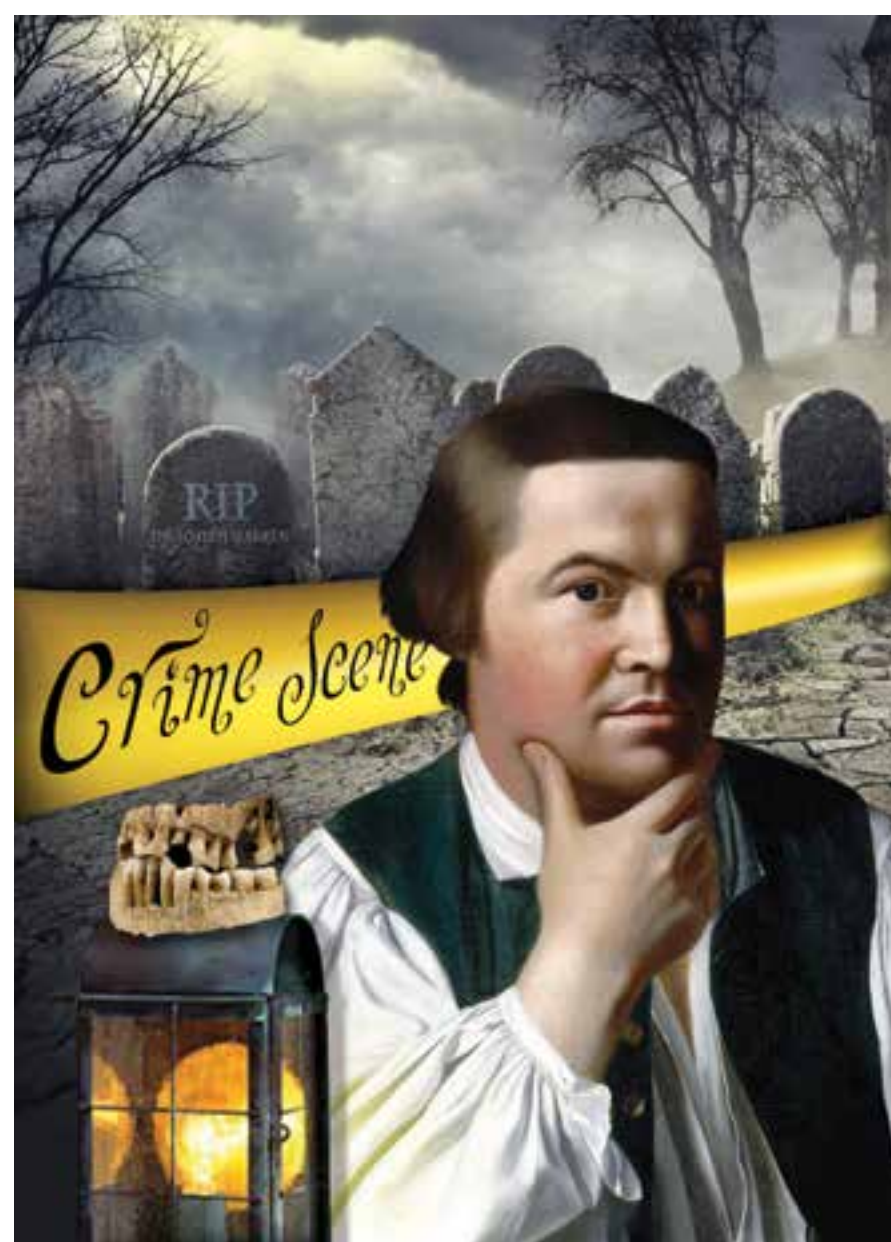
Joseph Warren, a prominent physician in Boston, was actually the one who convinced Paul Revere to do his famous midnight ride, but did you know Revere never finished his ride to Concord? He was captured trying to get there. Samuel Prescott, another physician, rode along with Revere; he finished the ride, not Revere. There was a third rider, but I will leave that for you to investigate. Dr. Prescott just happened to run into the two riders. He was out on a date that night.

Did you know the only reason we know about Revere and his ride is due to a poet by the name of Henry Wadsworth Longfellow who wrote a poem about it on the eve of the Civil War in order to help keep the country together?

Also, did you know Revere's father was originally from France and that his real name was Apollos Rivoire, which was later changed to Paul Revere? Thus, the famous rider was a junior. His father was also a silversmith, just like his son. However, it's a little known fact that Paul Jr. also practiced dentistry. He made teeth and dental bridges. As a matter of fact, and an important one, Dr. Warren was one of Revere's patients.

Dr. Warren continued to contribute to medicine after his death. For those interested in forensics, Dr. Warren was killed during the Battle of Bunker Hill, but exactly how he died has been controversial.

The British buried Dr. Warren, along with other patriots, in a mass grave. Dr. Warren wanted to be buried in the family cemetery, but how do you identify a body two years after death? In addition, it has been reported that Dr. Warren's body was mutilated by the British by order of a particular officer, a piece of history beyond the



Dr. Warren continued to contribute to medicine after his death. For those interested in forensics, Dr. Warren was killed during the Battle of Bunker Hill, but exactly how he died has been controversial.

scope of this article.

This was the birth of modern-day forensics. Dr. Warren was identified by his dental work. Who did that dental work? None other than Paul Revere, a close friend.

The story doesn't end there. Now, back to the controversy of how Dr. Warren died. His skull was later photographed when the body was moved again. The photo showed a small entry wound under the left eye and an exit wound on the right side of the skull. British soldiers used large caliber bullets,

while officers used handguns, not rifles. The rifles used by the patriots were of a smaller caliber than those of the typical British soldier. Evidence shows he was shot at close range. So who shot him? Was it friendly fire or perhaps a British officer with a reason to kill him at close range?

Forensics is all about a deep dive into the facts and applied science to light the darkness.

While in Boston, don't miss the opportunity to explore the history of medicine in this wonderful city. ☘



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A Highly Sensitive Subject

Is the one-hour acute myocardial infarction rule-out ready for prime time?

by KEN MILNE, MD

CASE: A 57-year-old woman presents with left-sided chest pain that started 90 minutes ago. The pain radiates to her right arm, and she has nausea without vomiting. The pain began while she was doing some yard work. The initial electrocardiogram (ECG) is unremarkable.

QUESTION: Can emergency physicians rule in or out an acute myocardial infarction (AMI) in one hour using a high-sensitivity troponin and ECG?

BACKGROUND: About 5 percent of all patients presenting to the ED with acute chest pain will have a ST elevated myocardial infarction (STEMI).¹ This leaves the other 95 percent

of chest pain patients. Our job in the ED is to figure out whom we will rule in versus rule out for AMI.

Many cardiac biomarkers have been used over the last 60 years to try to identify patients with AMI. A limitation of current troponin assays is that they can take three to four hours to rise. This means the diagnosis of non-STEMI can take many hours of continued monitoring with serial blood sampling.

High-sensitivity troponin assays are now being used in many emergency departments. They offer very high sensitivity but are less specific than prior troponin assays.

RELEVANT ARTICLE: Reichlin T, Twerenbold R, Wildi K, et al. Prospective validation

of a 1-hour algorithm to rule-out and rule-in acute myocardial infarction using a high-sensitivity cardiac troponin T assay. *CMAJ*. 2015;187(8):E243-E252.

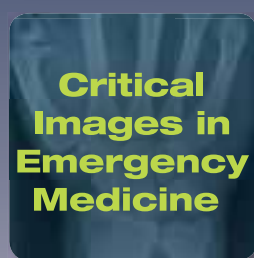
- **Population:** Patients presenting to the ED within 12 hours of onset of nontraumatic chest pain or symptoms suggestive of AMI.
- **Intervention:** High-sensitivity troponin T at time 0 and 1 hour with ECG
- **Comparison:** Two independent cardiologists.
- **Outcome:** AMI.

AUTHORS' CONCLUSIONS: "This rapid strategy incorporating high-sensitivity cardiac troponin T baseline values and absolute

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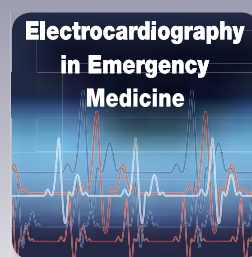
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changes within the first hour substantially accelerated the management of suspected AMI by allowing safe rule-out as well as accurate rule-in of AMI in three out of four patients.”

KEY RESULTS: There were 1,320 patients who presented to the ED within 12 hours of onset of nontraumatic chest pain or other symptoms suggestive of AMI. AMI was the final diagnosis in 17 percent of those patients.

The researchers divided patients into three different categories: rule-out AMI (60 percent), rule-in AMI (16 percent), and observation zone (24 percent). The one-hour algorithm test characteristics for the 60 percent who were ruled out were:

- Area under the curve 0.96 (95 percent confidence interval [CI], 0.95–0.97)
- Sensitivity of 99.6 percent (95 percent CI, 97.6–99.9 percent) and specificity of 95.7 percent (95 percent CI, 94.3–96.8 percent)
- Negative predictive value 99.9 percent (95 percent CI, 99.3–100 percent) and positive predictive value 78.2 percent (95 percent CI, 72.1–83.6 percent)
- Positive likelihood ratio of 23 and negative likelihood ratio of 0.004

EBM COMMENTARY: This was an attempt to investigate whether a one-hour algorithm can rule out and rule in acute myocardial infarction using a high-sensitivity troponin as a biomarker. There were a number of concerns with this manuscript.

1) Bias: The challenge of conducting high-sensitivity troponin studies is that the diagnosis of non-STEMI is a disease entity based on a test without an independent reference standard. This can lead to a number of biases that can distort the results.²

- **Incorporation bias:** This occurs when results of the test under study are actually used to make the final diagnosis. This makes the test appear more powerful by falsely raising the sensitivity and specificity.
- **Partial verification bias:** This happens when only a certain set of patients who under go the index test are verified by the reference standard. This would increase sensitivity but decrease specificity. Patients who were deemed to be low risk did not always proceed to six-hour troponin.
- **Spectrum bias:** Sensitivity depends on the spectrum of disease, while specificity depends on the spectrum of nondisease. You can falsely raise sensitivity if the clinical practice has lots of very sick people. Specificity can look great if you have no sick patients in the cohort. The researchers included only patients who presented to a cardiac research hospital within 12 hours of pain. These patients potentially could have been more ill.

2) Risk of over-testing: Another concern with this protocol and others based on high-sensitivity troponin assays is the lack of specificity. The initial high-sensitivity troponin was only 48.4 percent specific, with more false positives than true positives. If there were inappropriate use of this test in ultra-low-risk patients, there may be a paradoxical rise in the number of patients being evaluated for chest pain in the emergency department.

There were 1,320 patients who presented to the ED within 12 hours of onset of nontraumatic chest pain or other symptoms suggestive of AMI. AMI was the final diagnosis in 17 percent of those patients.

3) Imprecision of the assay: The change in high-sensitivity troponin was within the allowable imprecision of the assay. This is really the keystone because if the change is within the assay’s coefficient of variation, all other issues are moot.³

BOTTOM LINE: A one-hour protocol utilizing high-sensitivity troponin T cannot be recommended at this time. External validation of this protocol along with a more explicit discussion of how the diagnosis of AMI is arrived at might allow for a rapid rule-out in the future.

CASE RESOLUTION: Shared decision making was done with the patient, and she agreed to stay in the ED for six hours. Her troponin at 0 and 6 hours was negative, serial ECGs showed no ischemic changes, and her pain completely resolved. She was discharged to her home with close follow-up with her primary care provider and strict precautions to return if necessary.

Thank you to Daniel McCollum, assistant residency director at Georgia Regents University in Augusta, Georgia, and Andrew Worster, faculty member at McMaster University and part of the Best Evidence in Emergency Medicine group, for their help with this review.^{4,5}

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

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Don't Let Your House Crush You Financially!

Tips on buying your home the right way

by JAMES M. DAHLE, MD, FACEP

Q. *My spouse and I are interested in buying a home. However, we're terrified to spend so much on one single item. What should we know before taking the plunge?*

A. I am continually fascinated by the burning desire among graduating medical students and even residents, and particularly their spouses, to purchase a home as soon as is humanly possible despite having a net worth of a negative \$200,000 or \$300,000. For many people, owning their home is a signal to themselves and others that they have finally "made it." Combine that signal with heavy marketing from the realty and mortgage industries, and we see far too many doctors purchasing the wrong house at the wrong time and at the wrong price. Although it is certainly possible to get lucky, there are several important financial principles doctors should understand in order to buy their home properly.

There are lots of great reasons to own your own home, including the fact that you can have as many pets as you like, you can paint the walls whatever color you prefer, and the landlord can never throw you out on the street. Financially speaking, there are many significant benefits of owning a home. You avoid paying rent, you get to keep any price appreciation, and mortgage interest and taxes are usually fully deductible. Most mortgage payments are fixed, so as the years go by, the mortgage actually gets cheaper and cheaper on an after-inflation basis rather than increasing with inflation as rent generally does. For most people, a paid-off home reduces required minimum monthly income dramatically, which further reduces the need for disability insurance, life insurance, and a larger portfolio nest egg.

However, there are time periods in life when owning your home is a not such a great financial move. As a general rule, it does not make sense to purchase a home if you will not be in it for at least five years. However, during a housing boom, you may break even in less time, but in a housing bust, it may take two or three times that for your home to return to its purchase price, much less break even on the deal. Rookie home buyers nearly always underestimate the non-mortgage expenses of owning a home. These include the transaction costs of buying and selling (expect a round-trip cost of 15 percent of the value of the home), maintenance costs (1 percent to 4 percent of the value of the home each year), insurance, taxes, upgrades, furnishings, landscaping, lawn care, snow removal, and homeowner's association fees.

Is a Home a Good Deal for You?

Too often, prospective first-time home buyers believe real estate agents who advise buying because "the mortgage is less than your rent" or "you don't want to keep throwing money away, do you?" What rookie buyers don't know, however, is well-known by real estate investors. The mortgage is supposed to not only be lower than the rent but dramatically lower. That's because the landlord has to pay all those other expenses. A real estate investor expects about 45 percent of gross rent to go toward non-mortgage expenses. In order to compare apples to apples, multiply your prospective principal and interest payment on a 30-year mortgage by 1.8. If renting a comparable home is much less than that figure, there is a very good chance you will be better off renting unless you are in the home for a very long time.

Given these and other economic realities, it generally does not make sense for an EM resident to purchase a home. If you think you are an exception, run the numbers using *The New York Times'* "Is It Better to Rent or Buy?"

Even when purchasing a home makes sense, it is critical to realize that a home purchase is mostly a consumption item, not an investment.

calculator found at www.nytimes.com and see just how much appreciation you will have to realize just to break even, much less come out ahead. In fact, most attendings would do far better renting for six to 12 months out of residency. This allows physicians to stabilize their finances, make sure the job is working out,

and provide a much more thoughtful and deliberate housing search, all enabling a much stronger negotiating position.

Be a Savvy Home Buyer

Rookie home buyers usually don't realize how good their negotiating position is. There are usually dozens of similar homes on the market at any given time, but home sellers are lucky if they can get even two interested buyers simultaneously. While there are occasional seller's markets, home buyers should understand that 95 percent of the time it's a buyer's market. If you can avoid falling in love with a house, you may be surprised just how good of a deal you can get on a perfectly acceptable house.

Even when purchasing a home makes sense, it is critical to realize that a home purchase is mostly a consumption item, not an investment. Larger homes require more money to heat, cool, maintain, furnish, landscape, insure, upgrade, and clean. Try to buy a home closer to what you truly need rather than everything you could possibly want. Although a mortgage lender may approve you for a home costing four to five times your gross salary, you would do well to make sure your mortgage is less than two times your gross income. So if you make \$250,000, the general rule is that your loan amount should be less than \$500,000.

In recent years, many lenders have started offering "physician mortgage loans." These are loans that banks will give to a physician that allow them to avoid private mortgage insurance (PMI). PMI protects the lender against you defaulting without your putting down a standard 20 percent payment. These loans usually also offer special underwriting that will allow you to close with just a contract rather than proven earnings and may take your student loans into special consideration. It is important to realize that these lenders aren't doing you a favor out of the goodness of their hearts. These loans have slightly higher fees and interest rates than comparable conventional mortgages. The banks are also well aware that your risk of default is very low and hope you will then use their bank for your banking, investment, and insurance needs. A physician loan can make sense but only if you are using the money you would have used for a down payment for a better financial purpose, such as paying off high-interest student loans or making retirement account contributions. If you aren't already using 15–25 percent of your attending gross salary to build wealth (ie, saving or paying off debt), then purchasing a home, with or without a physician mortgage loan, probably isn't a great idea until you get your financial house in order. ☺



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Intranasal Medications in Kids?

Why not? Everything else goes up there!

by ANNALISE SORRENTINO, MD, FAAP, FACEP

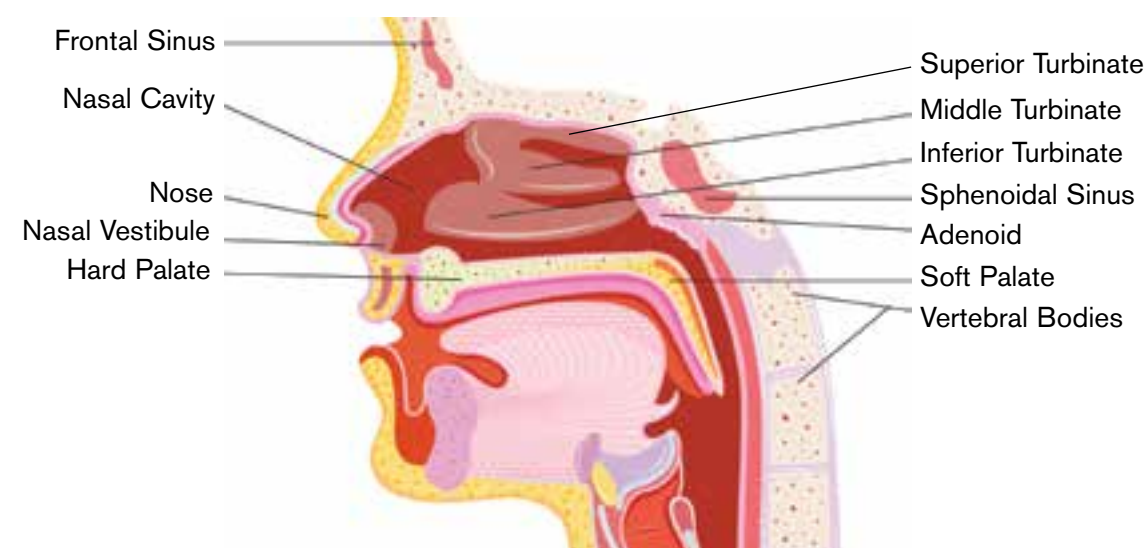
My last shift started with a 3-year-old with a dog bite to the face, a 10-year-old with a forearm injury, and an anxious 16-year-old who needed a lumbar puncture. When working with children and young adults, we are constantly looking for ways to make the emergency department visit more tolerable for all involved. There are two things that have helped me come closer to that goal. The first is having child life specialists. The second is intranasal medication delivery.

Initially created for local nasal effects, intranasal medications have become a desired route for certain drugs when seeking a systemic effect. Some immunizations have found success using the intranasal method, and several other medications have followed suit, namely those used for sedation and analgesia. There are several benefits to using the intranasal route, including:

- High vascularization of the nasal mucosa
- Wide absorption area
- Avoidance of first-pass metabolism by the gastrointestinal or hepatic pathways
- Avoidance of IV placement
- High patient tolerance of the drug administration
- Quick onset of action¹

The nasal fossa is divided into three parts: the vestibule, the cavity, and the turbinates (see Figure 1). The turbinates are classified into the inferior, middle, and superior. The main site for systemic drug entry is around the inferior turbinate due to its high surface area and vascularization.

Figure 1. Nasal anatomy



There are several factors that may play into the effectiveness of intranasal drug delivery, including volume administered, particle diameter, spray administration, factors influencing the site of absorption (eg, other drugs such as phenylephrine), nasal blood flow, and mucociliary clearance and medical conditions that affect it, and these things should be taken into account when administering intranasal medications.² The best absorbed medications have low molecular weights, are highly lipophilic, and have no net charge at physiologic pH.³

Intranasal delivery has been used for several different purposes including vaccinations; treatment of certain conditions such as rhinosinusitis, seizures, migraines, and dia-

betes insipidus; antipsychotic medications; and sedation and analgesia.⁴ For purposes of this article, we will focus on sedation and analgesia. Historically, two main classes of drugs have been used in intranasal administration: opioids and benzodiazepines (see Table 1 for dosing guidelines). More recently, other drugs, such as ketamine and dexmedetomidine, have also been studied.

Medications to Use

Midazolam is a useful drug in pediatrics for situations where you need anxiolysis and amnesia. It can be given in a variety of ways, and intranasal use has been widely studied. Doses ranging from 0.2 mg/kg to 0.5 mg/kg have

been evaluated. Overall, it has been shown to have a rapid onset of action and achieve adequate sedation, and it is associated with high parent satisfaction. One consistently found drawback is that intranasal was more irritating than other routes of administration.³ One study evaluated using intranasal lidocaine as a premedication and found that its use helped prevent the burning that is often associated with the use of intranasal midazolam.⁵ Further prospective studies have been done, and preliminary data (ahead of publication) show similar results. Intranasal midazolam is a great choice when you need something to take the edge off but analgesia

CONTINUED on page 24

Figure 2. Mucosal atomization device



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Table 1. Dr. Sorrentino's Cheat Sheet for Intranasal Drug Dosing

DRUG	DOSE	MAX	ANALGESIA	ANXIOLYSIS	AMNESIA
Fentanyl	1 mcg/kg/dose	100 mcg	+	-	-
Midazolam	0.25 mg/kg/dose	10 mg	-	+	+
Lidocaine 4%	0.5 mL		For use with intranasal midazolam		
Ketamine	Dosing ranges from 1 mg/kg to 9 mg/kg; most studies use 3 mg/kg, but one study found best results with 9 mg/kg; no routine recommendations exist currently ⁶		+	+	+
Dexmedetomidine	1-2 µg/kg ⁹		+	+	-

Table 2. When to Consider Using Intranasal Analgesia and Sedation

Laceration repair (works best in conjunction with local anesthesia)	Injuries due to animal bites (typically associated with a high level of anxiety)
To facilitate getting adequate imaging quickly (eg, deformities or suspected fractures)	As a pre-medication for a regional block
Lumbar punctures	Procedures in younger children or those with developmental issues
Prepubertal genital exams	Abscess incision and drainage
Joint dislocations	Burn debridement or dressing
Patients who are NPO	Simple casting if any cast molding is needed
CT or MRI imaging	Foreign-body removal
Status epilepticus	

is not your main focus. I find that it works best in situations where my analgesia is managed by other means, typically topical anesthetics and/or regional blocks. Its mild amnestic properties are also helpful when it comes to potential follow-up.

Fentanyl is the ideal intranasal medication, highly lipophilic and low molecular weight. It has been shown to be more effective than intravenous morphine for pain reduction in long bone fractures.³ It is very well tolerated overall and produces adequate analgesia. It has recently been compared with

The most basic is the drip method, but this does require a compliant child to achieve success. Probably the most widely used device is the mucosal atomizer.

intranasal ketamine and found to be equally analgesic but have fewer side effects (mainly dizziness), although they were mild overall.⁶ This is a great choice when you need analge-

sia quickly and you don't know if you'll need an IV or if they need to be NPO. I use this routinely before getting imaging in my orthopedic patients.

Other agents for sedation and analgesia have also been assessed. Intranasal ketamine has been evaluated in the emergency department as well as in the pre-hospital setting. Doses ranging from 0.5 mg/kg to 9 mg/kg have been used with adequate sedation.³ Further studies need to be done to establish the ideal dose in the pediatric patient. Intranasal dexmedetomidine was evaluated in an observational study and showed good sedation and image quality when it was used for sedation for computed tomography scans in children.⁷

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Delivery

Delivering intranasal medications can be done in a few different ways. The most basic is the drip method, but this does require a compliant child to achieve success. Probably the most widely used device is the mucosal atomizer. It screws on to the top of your medication syringe, and when you spray it into the nares, it rapidly distributes the particles after breaking them down into smaller ones that are more easily absorbed (see Figure 2).³

Intranasal medication delivery can be a useful tool when dealing with children (see

Table 2 for suggestions on when to consider intranasal delivery). Some tips that will allow for greater success include:

- Consider suctioning prior to administration if there is a lot of mucus present.
- Use small volumes .
- Use the highest concentration of medication available and do not dilute.

Use both nares to increase surface area
Intranasal medications are a quick, safe, and relatively painless way to deliver analgesia and anxiolysis to pediatric patients. They are a great resource to have in your tool kit! ➔

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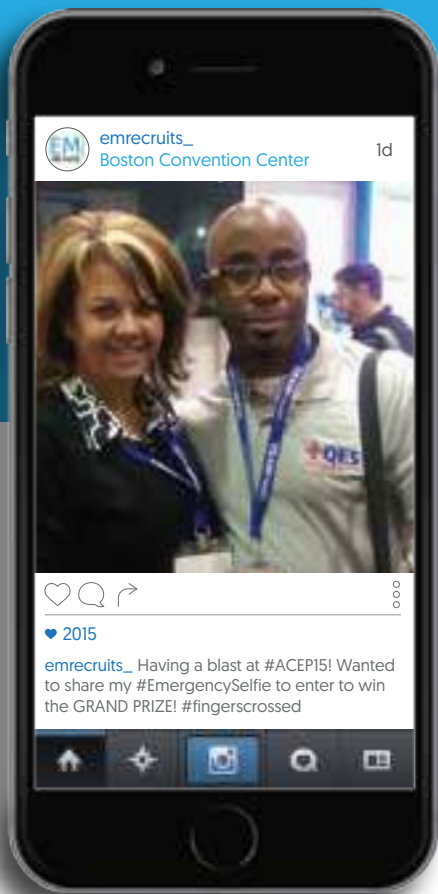
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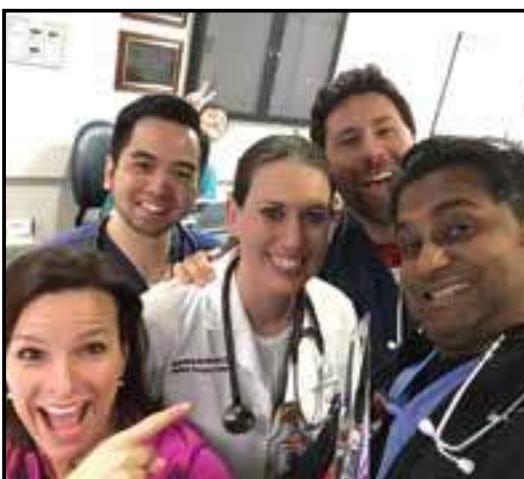
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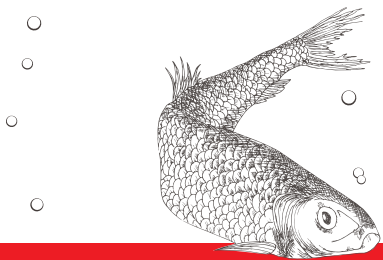
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