What is fear? These are the opening words of the podcast “The Undifferentiated Sick Infant,” which can be found in the Pediatric Emergency Playbook developed by Tim Horeczko, MD, MSCR, FACEP, the mastermind behind a fantastic new pediatric emergency medicine (PEM) resource.

No stranger to emergency medicine, even prior to medical school, Dr. Horeczko worked his way through school as a clerk and EMT in a local emergency department. This is where his interest in medicine was born, and after achieving his bachelor’s degree at the University of California (UC) at Berkeley, he attended UC Davis for medical school. He did his residency in emergency medicine, fellowship in PEM, and graduate studies at Harbor–UCLA, where he is now faculty.

Quick-thinking emergency physician becomes a fan’s health care safety net during a cardiac emergency at a hockey game

Continued on page 14

You never know when the person sitting a few rows from you might save your life.

Bill Streb, a 71-year-old retired Xerox Corporation executive, certainly didn’t expect to encounter a life-or-death situation when he decided to accompany his son to watch the Los Angeles Kings play the Anaheim Ducks in a preseason hockey game at the Staples Center. Mr. Streb, who describes himself as “the most healthy person in my family,” experienced a cardiopulmonary arrest during the third period of the game.

Continued on page 16

New treatment trends for uncomplicated diverticulitis

Continued on page 18
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Mixed Feelings on Code Black TV Series

I have a lot of admiration for Dr. Ryan McGarry and believe his film, Code Black, was the best documentary of 2014. But his suggestion in your recent article “Code Black Moves to the Small Screen” that the subsequent TV series of the same name is “unnecessarily committed to authenticity” is a highly dubious stretch of the truth.

I work at a community hospital but am pretty sure even my cutting-edge academic colleagues have not recently “killed their patients to save them” by replacing their entire blood volume with ice-cold saline to induce metabolic hibernation. This lifesaving intervention was featured prominently early on in the show’s pilot along with an equally eyebrow-raising interaction:

When an elderly patient (Mr. Cleary) with CVA [cerebrovascular accident] symptoms and total expressive aphasia presents to the ED, the attending physician, with his junior resident, and the patient, with his family, have this exchange:

Attending: “Young squire, I heard you mention tPA. Is that what you’re thinking?”

Resident: “Yes. The symptom profile suggests MCA distribution.”

Attending: “I think so, too. Mr. and Mrs. Cleary, tPA is a kind of miracle drug that has the potential to bust the clot up and reverse the stroke...”

After a CT shows no intracranial bleed, the team moves forward with tPA...

Attending: “Come on, baby. Show us the magic, Mr. Cleary, I want you to try and speak.”

Mr. Cleary: (to wife) “I love you.”

Attending: “Yes! AbraCABRAtha. That’s why we are here, young squire. Never forget that.”

I would love to think of myself and my colleagues as miracle workers and magicians. Obviously, the reality is not what will be portrayed in a TV prime-time series. As much as I admire that shows like Code Black feature the hard work of emergency physicians and nurses, we must remain mindful that, similar to direct-to-consumer pharmaceutical ads, these shows may lead to significant false expectations.

Andrew Fenton, MD, FACEP
Napa, California

Dr. McGarry Responds

When Maureen Dowd’s New York Times editorial “A Stroke of Fate” irresponsibly questioned the role of the emergency physician in acute stroke management, I felt it was timely to showcase an overt clinical success in our pilot episode’s stroke case. The script is clear about tPA’s rate of efficacy versus its complication rate versus its more likely outcome of no benefit. I agree the therapy on-set is ramped up for television. I agree that tPA remains a controversial treatment. More than anything, I agree that the American public should have the ultimate trust in its emergency physicians for neurologic emergencies.

The reviewer is correct in that the cold fusion technique featured is certainly not in use in community EM, but it is, in fact, real and under IRB-approved study in humans at the University of Pittsburgh School of Medicine and the Shock Trauma Center of the University of Maryland. In the show, the patient is only brought to the OR; we don’t suggest he’s had a meaningful survival.

I am frequently disappointed by physicians’ and physician organizations’ leveraged media. It is commonly anemic and, at worst, self-serving. The real achievement of Code Black is that we constantly show our specialty as always open, always willing, and never discriminating with regard to patient financial status. What’s more, we do it at 10 p.m. on national television without a dark anteroom, gratuitous sex, or violence. Not an easy sell in these times.

–Ryan McGarry, MD
New York City

Democracy, Yeah, Yeah, Yeah...

I cringed when I saw the title “Pros and Cons: Does Size Matter?” and I kept the November 2015 ACEP Now issue hidden under the cover of other journals until I could force myself to read about democracy in emergency medicine. It was not as painful as I expected. Unfortunately, but not surprisingly, it did not answer the primary questions of the article, “What is the definition of democracy?” and “How do you measure democracy?” I still don’t know from the article if size matters (for ED groups).

I finished residency in 1985, before we knew what democracy was. But we learned that something did not have it. I worked with a few groups and learned that each would portray the air of democracy. It did not take me long to decide what democracy meant to me. I wanted to be given respect for my medical decision making (when deserved) and treated as a financial partner. For most ED providers, the financial part of the equation dwarfs the clinical stuff. If the ED group had financial risk, I was OK being at risk. But the clinical aspect is really the most important. Find a job where you can work with docs who care about what they are doing, care about their patients, and care about their partners and you. Everything will follow after that. To be successful in this endeavor takes asking questions, being lucky, and taking time to see how your partners operate.

But that was not really the focus of the article. Here are my answers to the other questions about democracy. Does size matter? Probably not a lot, but it can. With both big and small groups, fairness is a trait that comes from top down, but it can be permutated into a mirage anywhere along the path without too much difficulty. Big groups have more paths from the top to you. Beware of smoke and mirrors from the top or along the way.

What is the definition of democracy?” I have to say beauty is in the eye of the beholder. We are a democratic group” sounds like the battle cry for the emergency physician employers of the past and future. The common nonmedical definition of democracy portends that it is a system of government controlled by its members, usually by voting. If there is equitable pay, scheduling, and open communication to and from members of the group, I don’t really need to have a vote. To me, a democratic ED group is a group of emergency providers united to care for a common group of patients in an organization that allows open communication, open books, equitable pay, fair scheduling, and equity if equity is earned.

How do you measure democracy? If you cannot measure it, you’re probably not in a democratic group! There is no need to quantify the measurement; we have too much of that already. You just have to feel it for yourself. You can decide if size matters.

DR. BAKER is in the department of emergency medicine at Pali Momi Medical Center in Hawaii.
PMEDSoft/EBSCO Award for Pediatric Emergency Medicine Goes to Dr. Gausche-Hill

The winner of the 2016 ACEP and PMEDSoft/EBSCO Achievement Award is Marianne Gausche-Hill, MD, FACEP.

Dr. Gausche-Hill is medical director of the Los Angeles County Emergency Medical Services (EMS) Agency and professor of clinical medicine and pediatrics at the David Geffen School of Medicine at UCLA. “I am honored to receive the ACEP and PMEDSoft/EBSCO Achievement Award for evidence-based pediatric emergency medicine,” Dr. Gausche-Hill said. “I feel fortunate to have worked with so many bright minds to build the evidence that assists us in providing the best care possible.”

The award is an annual honor given to an emergency physician or pediatric emergency physician who has contributed significantly to evidence-based pediatric emergency medicine. Nominees for the award need to have contributed first-author publications and/or contributed to practice-changing innovations in electronic publication or technology that have meaningfully enhanced emergency care of children. PMEDSoft/EBSCO has sponsored the award since its inception.

“PMEDSoft is used internationally as a comprehensive archive of evidence-based pediatric practice, and EBSCO funded the award to both recognize an academic leader and also to encourage other investigators to engage in scientific work,” said Ron Dieckmann, MD, FACEP, longtime ACEP member and chief medical officer for PMEDSoft. “Marianne is a perfect recipient of the award and has distinguished herself in every category of academic leadership in pediatric emergency medicine and evidence-based practice.”

The award will be presented at the Advanced Pediatric Emergency Medicine Assembly in Orlando, Florida, March 8-10, 2016. The Advanced Pediatric Emergency Medicine Assembly, cosponsored by ACEP and the American Academy of Pediatrics, serves as the premier annual educational meeting for pediatric emergency medicine.

It is the only national award that specifically honors scientific endeavors in pediatric emergency medicine. “I am thrilled that Dr. Gausche-Hill has won this award,” said Sean Fox, MD, FACEP, Advanced Pediatric Emergency Medicine Assembly program chairman. “Without question, Dr. Gausche-Hill epitomizes what it means to be an academic pediatric emergency physician who strives to ensure that children receive the best possible care wherever they are managed. Not only is she a giant in our field, she is a wonderful humanitarian, and I am honored to consider myself a colleague of hers.”

Dr. Gausche-Hill will join a distinguished group of winners who include David Jaffe, MD, Kathleen Brown, MD, FACEP, and Nathan Kuppermann, MD, FACEP, all of whom have contributed substantially to a wide range of practice-changing articles in pediatric emergency medicine.

“I went into pediatric emergency medicine because of a desire to learn as much as I could so that I could care for our most vulnerable patients,” Dr. Gausche-Hill said. “The pursuit of knowledge through scientific inquiry drives change in medicine, which ultimately impacts the care of the patient.”

Dr. Gausche-Hill is nationally known for her work as an EMS researcher and educator as well as for her leadership in the field of EMS and pediatric emergency medicine. Dr. Gausche-Hill is perhaps best known for her remarkable study of prehospital airway management for children published in JAMA in 2000 and her work on the National Pediatric Readiness Project published in JAMA Pediatrics in 2015.

Attend the Advanced Pediatric Emergency Medicine Assembly to learn from Dr. Gausche-Hill and her colleagues in person.

ACEP Toxicology Section App Named Top of 2015

An ACEP mobile app that provides emergency physicians with quick toxicology information has been named one of the top medical apps of 2015. The ACEP Toxicology Section’s Antidote app was named one of the best new apps for iPhone and Android by the physician editors at iMedicalApps. The app was deemed “fantastic.” It provides quick access to important information.

And it’s available for free at www.acep.org/toxicologysection.

It couldn’t have come soon enough for Jennifer Hannum, MD, FACEP, assistant professor of emergency medicine and director of toxicology at Wake Forest School of Medicine in Winston-Salem, North Carolina.

Dr. Hannum was chair of ACEP’s Toxicology Section and helped steer the app through to completion in February 2015. More than 60 volunteers worked on the project, and a section grant from ACEP provided funding for a developer to help create the app.

Each antidote summary was written and reviewed by section members, and the app does not require Internet access once it has been downloaded.

Dr. Hannum said the app was designed to help emergency physicians make important bedside decisions.

In a fast-paced emergency department, it is important to have information readily available for use,” she said. “It is not meant to be an all-inclusive source, and it is not a substitute for consulting with the local poison center. However, I feel it is a nice resource built specifically for use in the emergency department.”

Dr. Hannum said the app might be helpful, for example, when a patient arrives at an emergency department acutely ill from calcium channel-blocker poisoning and a physician needs to determine what dose of calcium would be appropriate.

“You don’t see those cases very often,” she said. “You kind of need information pretty quickly.”

Instead of taking the time to go to a computer for research or to call a poison center, a physician can instead get the information quickly from the app.

“My goal was to create a user-friendly resource created by toxicologists that provides quick access to the indications and dosing of various antidotes that could be used in emergency medicine,” Dr. Hannum said. “The pitfall of many medical apps, and other resources for that matter, is that they are a bit cumbersome to use when you are in need of information quickly.”

“The response has been positive from the thousands of people who have already used the app,” she said. “Folks seem to enjoy using the app. They like that it’s built for the emergency physician and for quick use.”

She is thrilled to see it getting outside recognition.

“I really did not anticipate it would be this well-received,” she said. “I really just wanted to create something with the Toxicology Section that we could all work on together that could benefit other members.”

To read iMedicalApps’ report on ACEP’s Toxicology Section Antidote app and other top medical apps for 2015, visit www.imedicalapps.com/2015/12/best-medical-apps-iphone-android.

Turn to page 16 to read about the Pediatric Emergency Medicine, another tech tool that can help you stay up-to-date on critical patient care issues.
Nominations Sought for ACEP's Board of Directors

The ACEP Nominating Committee is accepting individual, chapter, and section recommendations for ACEP Board of Directors candidates.

Nominations must be submitted no later than March 1, 2016, and must be accompanied by a current curriculum vitae. To qualify for a Board position, a candidate must:
- Be highly motivated to serve ACEP and be committed for three years for a Board position.
- Be an ACEP member in good standing with no delinquent dues.
- Be an ACEP member for at least five years.
- Show evidence of ACEP involvement in both national and chapter activities (such as current or past chapter officer, current or past national committee leadership, current or past Council membership, or current or past section leadership).
- Show chapter and/or section support for candidacy.

Nominations may be submitted to jcusick@acep.org, faxed to 972-580-2816, or mailed to James M. Cusick, MD, FACEP, Chair, Nominating Committee, P.O. Box 619911, Dallas, TX 75261-9911.

The Board of Directors will be elected on Saturday, Oct. 15, 2016, during the ACEP Council meeting in Las Vegas.

For more information about the nomination process, contact Sonja Montgomery, CAE, at 800-798-1822, ext. 3202, or by email at smontgomery@acep.org.

ACEP Seeks Nominations for Awards Program

ACEP is accepting nominations through March 1, 2016, for the 2016 ACEP Awards Program, which honors members who distinguish themselves through leadership and excellence in emergency medicine.

All members are eligible to submit nominations in one or more award categories. A nomination form must be completed for each nomination submitted, and each must be accompanied by a current curriculum vitae. Awards information and nomination forms are available at www.acep.org/aboutus.aspx?id=22550. Additional information and forms may also be obtained by contacting Mary Ellen Fletcher at 800-798-1822, ext. 3145.

The following is a list of awards that are available and their criteria:

- **John G. Wigenstein Leadership Award:** Must be an active, life, or honorary member of ACEP and have made a significant contribution to emergency medicine through a variety of avenues, including ACEP committee service. Recipients of this award are ineligible to receive awards in other categories of the Awards Program.

- **Colin G. Rorrie, Jr., PhD Award for Excellence in Health Policy:** Must be a person of distinction who has made an outstanding contribution to medical health policy or the development or support of legislation and/or regulations that enhance access to emergency medicine, shown exemplary performance as an administrator in medicine and health care, or made outstanding contributions to organized medicine.

- **Award for Outstanding Contribution in Research:** Must be a member of ACEP and have made an outstanding contribution to research in emergency medicine as demonstrated in accomplishments such as outstanding research and publication of original research.

- **Award for Outstanding Contribution in EMS:** Must be a physician who has been an ACEP member for at least five years, a nonmember physician with at least 10 years of EMS activity, or a nonphysician with at least 10 years of EMS activity and have made an outstanding contribution in the area of EMS of national significance and/or an outstanding contribution to the development, promotion, maturation, or education of EMS on a state or national level.

- **Council Meritorious Award:** Must be an active, life, or honorary member of ACEP and a past or current Councillor who has served for at least three years and has contributed to the Council through Steering Committee membership, Reference Committee participation, participation on other Council committees, resolution development and debate, longevity as a councillor, or service as a Council officer.

- **Award for Outstanding Contribution in Education:** Must be a member of ACEP and have made an outstanding contribution to academic emergency medicine through areas such as development of teaching tools and resident education.

- **Honorary Membership Award:** Individuals who have made an outstanding contribution to ACEP by significantly helping to achieve one or more of the College’s purposes and objectives or who have served as a role model for ACEP members, with personal attributes such as inspiration, innovation, and consensus building. Candidates for honorary membership cannot be currently eligible for other categories of College membership.

- **John A. Rupke Legacy Award:** Must be a member of ACEP for more than 25 years with sustained contributions either in the local, state, or national emergency medicine communities as a consensus builder, with humanitarianism, and as an advocate for the profession. The member must have also demonstrated exceptional commitment of time and dedication to emergency medicine and to improving the care of emergency patients. Previous recipients of the Wigenstein or Mills awards are not eligible to receive this award.
Despite the success of raising awareness and gaining buy-in for this program, the early data suggest that little impact has been made in curbing utilization in the areas noted in the 70 lists containing approximately 400 recommendations. Emergency medicine is no exception. ACEP was cautious yet agreed to participate and provided a total of 10 recommendations. However, it seems that this simply isn’t enough.

Choosing Wisely and its participating specialty societies have been talking the talk, but now it’s time to walk the walk.

Although garnering widespread support for this program must have had its challenges, it seems the real challenges lie ahead. Just like any practice update, simply knowing what is right is very different from incorporating that information into clinical practice. When you ask physicians to “choose wisely” and those choices include changing the way they practice and interact with their patients, you’ve reached the crossroads of knowing and doing. In other words, knowledge translation is where the rubber hits the road and where Choosing Wisely may have blown a tire.

To him who devotes his life to science, nothing can give more happiness than increasing the number of discoveries, but his cup of joy is full when the results of his studies immediately find practical applications.

—LOUIS PASTEUR

Pasteur’s quote, cited in a 2006 article about knowledge translation, defines exactly what Choosing Wisely aspires to be. The article further defined translation as to “synthesize research findings and convert them into a form applicable to a target population or audience in the context of the conditions in which its members live and interact.”

In 2012, the American Board of Internal Medicine (ABIM) Foundation and Consumer Reports formally launched the Choosing Wisely campaign in order to reduce the utilization of diagnostic tests and treatments that provide no meaningful benefit to patients. After widespread acceptance in the house of medicine and many consumer groups and with expansion of the program internationally, the question remains, is this just a “feel-good program,” or will this program have any true impact on utilization?

Choosing Wisely in Action—or Not

In a study published in October 2015, 25 million members of Anthem-affiliated BlueCross and BlueShield plans were assessed over a two- to three-year period through 2013. Medical and pharmacy claims were assessed for the following seven Choosing Wisely recommendations:

1. Imaging tests for uncomplicated headache
2. Cardiac imaging without history of cardiac conditions
3. Low back pain imaging without red-flag conditions
4. Preoperative chest X-rays with unremarkable history and physical examination results
5. Human papillomavirus (HPV) testing for women younger than 30 years
6. Use of antibiotics for acute sinusitis
7. Use of prescription nonsteroidal anti-inflammatory drugs (NSAIDs) for members with hypertension, heart failure, or chronic kidney disease

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The first two, imaging for headache and cardiac imaging, showed a small decline from 14.9 percent to 13.4 percent and 10.8 percent to 9.7 percent, respectively. Two recommendations, prescribing NSAIDs for certain conditions and HPV testing for women younger than 30 years, showed increased utilization. Antibiotics for sinusitis remained stable, while preoperative chest X-rays and imaging for low back pain remained high without a statistically significant change. The data cannot confirm a cause-and-effect relationship, and with such a large sample size, the small changes noted could simply be due to chance. However, it certainly suggests that more work is needed to ensure that providers are actively engaged with this campaign. Although two of these recommendations, antibiotics for sinusitis and imaging for low back pain, have also been submitted by ACEP, much of the data sample precedes ACEP’s involvement. Even if we evaluated utilization following ACEP’s submissions, should we expect different results? I don’t think so. It has been difficult for all involved to move the knowledge translation needle for Choosing Wisely.

Brandon Maughan, MD, recently published data from a survey of emergency department chairs and division chiefs at institutions with allopathic emergency medicine training programs. Of the 134 programs invited, 78 percent participated in the survey. Of those, 64 percent had heard of the Choosing Wisely campaign, while only 45 percent of the academic chairs had discussed this directly with patients, and approximately 50 percent could recall any of the ACEP recommendations.

**Put Choosing Wisely Into Practice**

It’s time to make this campaign relevant by taking it to the bedside, benefiting both patients and providers. Avoiding unnecessary tests and treatments makes the emergency physician’s job easier while providing value-added service for the patient. However, patients may not recognize that “less is more” without education. To that end, shared decision making is an excellent tool that empowers the physician, through bedside education, to align patients’ desires for quality care with the payers’ interest in reducing cost and physicians’ interest in efficiency, achieving everyone’s goal for cost-effective care.

Many physicians struggle with how to introduce these recommendations into clinical practice. However, ACEP and the ABIM Foundation have developed resources to assist. ACEP has committed to translating the ideas of Choosing Wisely into action on several fronts. The recently launched ACEP Clinical Emergency Department Registry includes the development of five quality measures that enable emergency clinicians to report on the quality of imaging decisions to the Centers for Medicare and Medicaid Services for the Physician Quality Reporting System. ACEP was recently awarded a Transforming Clinical Practice Initiative grant from the Centers for Medicare and Medicaid Innovation to launch a national learning collaborative supporting emergency departments and individual clinicians in implementing these Choosing Wisely recommendations. Under this grant, ACEP will also be offering new eCME modules and partnering with the American Board of Emergency Medicine to integrate more Choosing Wisely topics into the Lifelong Learning and Self-Assessment and Maintenance of Certification practice improvement activities list.

Below are several steps that may be useful to incorporate Choosing Wisely into your practice. Let’s take ACEP’s Choosing Wisely recommendation #9 (below), prescribing antibiotics for uncomplicated sinusitis, for example. (It is available online at www.choosingwisely.org/clinician-lists/acep-antibiotics-in-the-ed-for-sinusitis.) Many patients expect to receive antibiotics for “sinusitis.” We have to educate them about their lack of efficacy and give them a reason to not want antibiotics.

**Step 1:** Plant the seed of your recommendations: “You know, you may not need antibiotics, and they could be harmful to you.”

**Step 2:** Develop your 30-second monologue explaining Choosing Wisely. For example: “The campaign is designed to provide only valuable treatments for patients based on the current evidence from research. This also helps to avoid injury to patients from treatments they don’t need.”

**Step 3:** Select one of the seven supporting citations accompanying #9 to support your treatment recommendation. For example: Ahovuo-Saloranta A, Rautakorpi UM, Borisenko OV, et al. Antibiotics for acute maxillary sinusitis in adults. Cochrane Database Syst Rev. 2014;2:CD000243.

**Step 4:** Take one or two quotes from the article that suggest a lack of efficacy. For example, “There is moderate evidence that antibiotics provide a small benefit for clinical outcomes in immunocompetent primary care patients with uncomplicated acute sinusitis. However, about 80 percent of participants treated without antibiotics improved moderate evidence.”

**Step 5:** Continue within two weeks.

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**Avoid prescribing antibiotics in the emergency department for uncomplicated sinuses.**

Sinusitis is a common reason for patients to visit the emergency department. Most patients with acute sinusitis do not require antibiotic treatment, because approximately 85% of acute sinusitis cases are caused by a viral infection and resolve in 10-14 days without treatment. For some patients with acute sinusitis, antibiotics might be appropriate, such as those patients taking drugs that reduce the effectiveness of the immune system, those with prolonged, severe symptoms, or those with worsening symptoms. Antibiotics can cause many side effects, and have potentially serious complications, and these risks usually outweigh the benefits of their use for sinusitis. In addition, inappropriate antibiotic use for sinusitis can contribute to the development of antibiotic-resistant infections and contribute to unneeded healthcare costs.

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**Step 3:** Select one of the seven supporting citations accompanying #9 to support your treatment recommendation. For example: Ahovuo-Saloranta A, Rautakorpi UM, Borisenko OV, et al. Antibiotics for acute maxillary sinusitis in adults. Cochrane Database Syst Rev. 2014;2:CD000243.

**Step 4:** Take one or two quotes from the article that suggest a lack of efficacy. For example, “There is moderate evidence that antibiotics provide a small benefit for clinical outcomes in immunocompetent primary care patients with uncomplicated acute sinusitis. However, about 80 percent of participants treated without antibiotics improved moderate evidence.”

**Step 5:** Continue within two weeks.

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**Avoid prescribing antibiotics in the emergency department for uncomplicated sinuses.**

Sinusitis is a common reason for patients to visit the emergency department. Most patients with acute sinusitis do not require antibiotic treatment, because approximately 85% of acute sinusitis cases are caused by a viral infection and resolve in 10-14 days without treatment. For some patients with acute sinusitis, antibiotics might be appropriate, such as those patients taking drugs that reduce the effectiveness of the immune system, those with prolonged, severe symptoms, or those with worsening symptoms. Antibiotics can cause many side effects, and have potentially serious complications, and these risks usually outweigh the benefits of their use for sinusitis. In addition, inappropriate antibiotic use for sinusitis can contribute to the development of antibiotic-resistant infections and contribute to unneeded healthcare costs.

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**Step 3:** Plant the seed of your recommendations: “You know, you may not need antibiotics, and they could be harmful to you.”

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Navigating the CHOPPY WATERS OF M&A

Highlights from the ACEP15 Council Town Hall Meeting: Part 2

Editor’s Note: The ACEP Council hosted a Town Hall meeting on mergers and acquisitions on Oct. 24, 2015, in Boston. Here is Part 2 of our edited transcript of the discussion.

INTRODUCTION

This is our Town Hall meeting and should represent a topic that is really important to the practice of emergency medicine, our specialty, and beyond: mergers and acquisitions. Many of us may not know a lot about this process and how it could impact us, but I think it’s time we discussed it so that we are all more informed about mergers and acquisitions in medicine. That’s why I titled this “Mergers and Acquisitions: The Medical Shark Tank.” I tried to get Mark Cuban; he still hasn’t responded to the request. I’ve asked Ricardo Martinez, who has a wealth of broad health care knowledge, to moderate this session.


MODERATOR

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

PARTICIPANTS

Brent Asplin, MD, MPH, FACEP, chief clinical officer for Mercy Health in Ohio

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

Ray Iannaccone, MD, FACEP, president of EmCare

Jay Kaplan, MD, FACEP, President of ACEP, director of the patient experience for CEP America in Emeryville, California; and a practicing clinician in the emergency department at Marin General Hospital in Greenbrae, California
RM: How are (emergency group) mergers funded?

RI: If your group is acquired, they’ll give you, in return for the group and the revenue stream that comes off of that, cash—which I think is the most common—stock, or both. For the company that’s buying it, they have cash they’re ready to pay you, or they borrow money from an institution to pay you, or in the case of stock, they’ll give you stock.

RM: They would have the money to invest as part of that company and then take the revenues as they come down the road.

RI: Right. Some people will want to sell part of the group. The classic private equity deal would be that the private equity firm would give you some of what might be 40 percent or 60 percent, and then in another three to five years, they decide whether they sell to somebody else or do an [initial public offering]. Doing that would be another opportunity for the owners of the group to get more money.

JK: I have a little bit of a bias here. I majored in social studies in college, and so I studied economics, history, and government. I personally would rather have health care dollars stay in the hands of those in health care. My personal preference, if I had a choice, would be to have an acquisition happen with an organization that has funds available and you don’t have to go to a venture capital partner to get the funds. I think when you do that, you run the risk of losing control. In my experience, it’s much better to merge than it is to be acquired. Let me be clear that acquisitions can either be voluntary or involuntary. You can be told you must join that group, or you can do it on your own. I think if you do it voluntarily, you’re in a much better position to negotiate and to get more than if you’re told you can’t continue the way you are and you have to be acquired by that group.

RI: I want to clarify for some folks that I think the situation Jay’s talking about is who’s telling you, “You have to be acquired.” It may be your health system, which will come to you and say, “Listen, we can’t do this with 21 different groups.”

SB: To follow up on what Jay had said, I think that all groups are at risk of being acquired. Whether your group is a single, independent practice or a large publicly held entity, you’re all at risk for being acquired by someone under some unforeseen circumstance. There are certain differences in how funding occurs. I know that most democratic groups are not looking at going to private equity markets to fund acquisitions. In fact, for the majority of my constituents and especially for my organization, we look at acquisitions as a needless activity, to some extent. Why would we invest $100–$200 million to acquire a group when we can do so organically and with same-store growth? Our philosophical approach has been that we don’t necessarily have to purchase the market to obtain a piece of that market. That’s a very different view of our growth strategy.

BA: Two basic questions from the hospital side are, is there an equity holder of the asset that is being acquired? Yes or no. The second is, is there a conversion of tax status? If the answer to either of those is yes, then you have to find a mechanism to purchase the equity from the entity that owns the asset. There is a community benefit typically that needs to be paid back going from a non-profit to a for-profit tax status conversion. Nonprofit to nonprofit, which is the type of acquisition that we would be most engaged in at Mercy Health, is simply a member subscription with some commitment to that community for capital investment.

JK: The issue comes back to physician control. It’s how much do we have to give up control over our own practice environment. I understand Brent’s perspective on decrease in variation. I think, with regard to joint ventures, the real issue is, if you’re going to joint venture with someone, how much control do you retain over your practice environment?

RI: We have a very large joint venture with HCA, and it’s healthy. We have a couple of other smaller ones. I don’t know if it’s going to take the country by storm, but I don’t think it’s going away.

RM: One of the questions that comes up is, when these consolidations are done, do we see that, overall, physicians are harmed or benefited? I think there’s a lot of fear out there, which is why the question was asked.

SB: If you’re getting a huge windfall, you’re a single owner of a practice, and the lifespan of your clinical practice doesn’t extend outside of this windfall, then it could be largely beneficial. We’ve all had conversations as to what is the perceived value of your practice after you engage in some of these transactions. Many times, if you’re going to get a huge windfall up front, that means your clinical hourly is going to go down. Those are the rules of doing business.

RI: If you’re looking at consolidating or merging, or whether you should be very careful with the partner that you pick. The point that Savoy made is important to keep in mind; there are physician-owned groups of all different kinds. As the former chair of the Democratic Group Practice Section, which Savoy is now the chair of, we should be a lot more even internally, trying to define what a democratic physician group was. There is a large variety. Emergency Medical Associates, like CEP, is a very broadly owned group. There are other groups that are owned by one person. The impact of the sale of each of those groups is very different from the others. In EMA, we always had to take whatever number that somebody would be willing to offer and divide it by our number of partners. Years ago, when this thing was in the group, I think it was split by 60. A few years ago, when we talked about it, it was 200. This year, when we finally did it, I think it was 250. The payment looks big, but when you divide it by 250, nobody’s retiring. It’s not that kind of money. The reasons we did it has something more to do with that change. There was an equation that was always done, and it was never enough money to make it worthwhile for us to do it just for the money. This time, we decided to join EmCare, and this is of available and talked about strategically that we felt were more important. If you’re one or two people and you own a contract with four or five hospitals, you’ll be offered a lot of money.

JK: Can I make two comments, Ricardo? Number one, it can benefit you if you have had a cantankerous relationship with your hospitalists and, all of a sudden, you and your hospitalists are part of the same group. We found that it really helped to facilitate communications and patient flow when you have the same ethos and culture among the emergency physicians and the hospitalists. The second is a little bit more conceptual. Do you want the doctors that you work with to feel like owners or do you want them to feel like renters? There is a difference between an owner and a renter and between being a winner and a whiner. Whiners only complain about things; they come in, they do their hours, and then they leave. Winners take responsibility for issues. If a problem comes up, they’re going to fix it; they’re not going to run off and let somebody else fix it. However you accomplish this, whether you’re part of a large group or whether you’re part of a small group, we want our doctors to feel like owners. When many of us first went into practice, the model was that emergency physicians felt like cowboys. As cowboys, we come in, do our hours, and the rest of the time you spend on the beach, spend in the mountains treking, or whatever else you’d like to do. That’s changed. Now, if we’re going to be successful as emergency physicians, we really have to become integral parts of the social fabric of our hospitals. The only way to do that is to make people feel like we’re owners in whatever model. If becoming a

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BA: I think these are great comments. I love the theme of ownership. There are large systems that are clearly just on a scale-and-leverage play. It’s just grow, grow, grow, and we can get another ounce of cost reduction out of our fixed infrastructure by adding the revenue of additional organizations. It is just about balance sheet finances and operating infrastructure scale and leverage. I don’t think they’re ultimately going to win because if you stretch that out between states and think they’re ultimately going to win because of infrastructure scale and leverage. I don’t think they’re ultimately going to win because if you stretch that out between states and become these giant organizations on the hospital side, it’s really going to be difficult without engaging physicians as operators in clinical redesign. That is where the next huge treasure trove of cost reduction is in hospital operations in this country, and it’s going to result in much better outcomes. You can’t get that without engagement and ownership of physicians and their leadership, whether they’re part of your system from an employment standpoint or contractual relationship. That’s what we’re striving for. It’s a journey; we’re not there yet, but that is the model that will beat consolidation and growth for scale and leverage at all cost.

RM: I like that a lot. Culture eats strategy for lunch, so I’m really interested in this theme. You talked about engagement. What are some of the big ways to address making it work, and what are some of the big pitfalls in implementing mergers and acquisitions?

SB: I would tend to agree with Jay. I think mergers and acquisitions are actually two separate types of categories. Philosophically, an acquisition is much more of a transactional arrangement. I think when you talk about a merger, it’s much more about a partner. It’s more about who fits your philosophical approach to your organization, whether they’re going to bring value to you, and whether you’re going to bring value to them. Especially with democratic groups, they come frequently to CEP America, and they ask about our structure and our approach. Sometimes it works out, and sometimes it doesn’t, but the time and energy it takes is much more than a profit-loss margin type of discussion and, instead, more of a cultural empowerment professional type of discussion.

RM: I do want to make a comment on that. Do you remember Daimler and Chrysler merging years ago? The joke was, “How do you pronounce Daimler-Chrysler? The Chrysler’s silent” That thing fell apart because of culture.

RI: That’s the conventional wisdom, and it’s my experience also that mergers or acquisitions fail because of different cultures. I don’t think it matters whether it’s a merger or an acquisition. I don’t think it matters whether you’re the acquired or the acquirer. It’s about going into it with the willingness to have your culture change. Because no matter how similar you are, there are differences. There can’t be a need or an expectation that everything’s going to stay the same after the transaction.

Council Town Hall highlights will continue in the March issue.

The Next President
What will this year’s election mean for the future of health care in the United States?

BY L. ANTHONY CIRILLO, MD, FACEP

As of Feb. 1, we were officially 202 days away from the next presidential election on Nov. 8. Also on Feb. 1, we heralded the beginning of “primary season,” with the first caucus being held in Iowa. Over the past few months, we have watched the Democratic and a historically unprecedented crowded Republican fields begin to deplete, with more “thinning of the herd” likely by March 1. (Let’s hope so.) Although only two or maybe three candidates (maybe an Independent) will make it to Election Day, it’s worth getting a preliminary understanding of the current major candidates and their health care policy platforms.

Let’s start with the Republicans. The one common theme here is pretty consistent: according to the Republican candidates, Obamacare is a “disaster” and must be “repealed and replaced” (R&R). The big question, of course, is replaced with what? Starting at the top of current polling lists and working our way down, we begin with “The Donald.” On his website, Donald Trump doesn’t even have health care listed under his “Issues” tab, and he has not issued any type of comprehensive plan. In debates, Trump has called for repealing Obamacare and cited rising insurance premiums and high deductibles as problems with the program. In a “free market” vein, Trump has been supportive of allowing insurance plans to be offered across state lines and is supportive of health savings accounts.

Next up is U.S. Sen. Ted Cruz, who, although he also doesn’t have health care listed on his “Issues” tab, did sponsor the “Health Care Choice Act” in March 2015 (with co-sponsor U.S. Sen. Marco Rubio), which would allow for insurance plans to be sold across state lines and, of course, repeal key sections of Obamacare. Cruz, as a federal employee, insured his family through a private plan rather than going through the federal health care exchange after his wife took a leave of absence from her private sector job, and her employer-based insurance, to join his campaign.

Through a measure added to the Affordable Care Act, members of Congress are no longer eligible for federal (employer-based) health insurance but can receive subsidies to offset the costs of obtaining private insurance (which are not available to all other Americans); Cruz has said he will not accept the subsidies. Hooray! Finally a Republican candidate with health care as an issue on his website. Rubio, in addition to being a part of the R&R gang, lays out the following three building blocks for health care reform: provide a refundable tax credit that can be used to purchase insurance, ensure access by expanding access to consumer-centered health plans with insurance regulation reform, and create a Medicaid block-grant program for states to manage. Rubio also has been critical of “profiteering” by pharmaceutical companies, which has become another rallying cry for both Republican and Democratic candidates.

Last on my major Republican candidate list is Dr. Ben Carson. Dr. Carson is the renowned pediatric neurosurgeon and one of two Republican physician candidates. (Did you know that Rand Paul was a practicing opthalmologist for 18 years?) Carson is on the R&R bus and has his own unique plan for health care reform. Touting the failures of Medicaid and Medicare to deliver equitable health care, Carson has proposed the creation of health empowerment accounts (HEAs). These accounts would provide Medicaid and Medicare beneficiaries the freedom to purchase health insurance in the private market. Carson would gradually raise the Medicare eligibility age to 70 and provide block grants to states for Medicaid, which would then fund the HEAs for individual beneficiaries.

For the remaining GOP candidates—Chris Christie, Jeb Bush, John Kasich, Carly Fiorina, Mike Huckabee, Rick Santorum, and Paul—anything is possible, but none of them has really distinguished themselves on health care. [Editor’s Note: Shortly CONTINUED on page 12]
Antarctica is the Earth’s coldest, highest, and driest continent. You don’t believe that’s true? Antarctica’s average elevation is 8,200 feet (2500 m); its precipitation is as low as 0.8 inches (20 mm) per year; and the lowest temperature ever recorded on Earth, -128.6°F (-89.2°C), was at Russia’s Vostok Station in 1983.

So how should I prepare to spend the next seven months on “The Ice,” as it is known? For simplicity, I divided it into clothing, personal necessities, work, and entertainment and electronics.

• Clothing: The program I’m traveling with provides the extreme cold weather (ECW) gear you need, including the massive hooded coat, “Big Red,” that you may have seen in any movie depicting the continent. It also issues a heavy black pair of wind-protective coveralls, gloves, heavy boots, and a neck gaiter. The last is possibly the most important piece of clothing since it protects the area between your balaclava (ski mask) and chest from any stray wind and blowing ice.

Aside from normal indoor wear, I bring several pairs of medium- and heavyweight long underwear, my own heavy socks and gloves, jackets, sweatshirts, and various shirts for layering. For the cold, I also bring a ColdAvenger balaclava and face mask that I found to be lifesaving on my last sojourn on The Ice.

• Personal Necessities: Personal hygiene products and indoor shoes are a must. Also, so I found out, is a humidifier. Experience proves that, while I may not need a lot of cash, I’ll need a debit card that functions in the southernmost ATM machine in the world, located in McMurdo Station’s main building. Finally, since I’m in the Medicare age range, I have daily prescription medications, and that leads to the problem of New Zealand’s unusual customs regulations. They only permit travelers to carry three months’ worth of medications, so I had to get prescriptions for four additional months’ worth of medications and send them to myself at McMurdo. I also sent the humidifier and some other personal items ahead via US Mail (the only acceptable method) so that my luggage would meet the stringent weight restrictions for U.S. Air Force C-17 travel from Christchurch, New Zealand, to McMurdo. I hope they arrive!

• Work: Since the medical clinic is well-equipped, I only need my stethoscope, some penlights, and some electronic medical resources, including my book, Improvised Medicine: Providing Care in Extreme Environments, which proved to be very useful last time I was there.

CONTINUED on page 12
• Entertainment and Electronics: Months of long nights mean that, in addition to community activities and other social gatherings, personal entertainment will be necessary. For some I have gathered sufficient audiovisual media and electronic books to keep me happy. The one hitch is that, being a U.S. government facility run by the National Science Foundation and extremely concerned about both bandwidth limitations and security, there is no streaming, no Skype, and no WiFi using Android or Apple operating systems. My cellphone will be only for medical apps, and my Internet will be through my Windows 7 laptop. I will communicate to the world the “old-fashioned way,” via email and a hardwired telephone.

Now that I’ve prepared to go, I will spend a couple of weeks at the University of Texas Medical Branch in Galveston, getting oriented to various aspects of the medical operation. Then it’s off to Christchurch to get on the C-17. Why New Zealand? While the tip of Antarctica’s peninsula (which we call “the Tropics” for its relatively balmy weather) is closest to South America’s tip at Cape Horn, the United States has only the small Palmer Station there. Those working there travel by ship through the Southern Ocean’s often brutish Drake Passage. Those of us working at the McMurdo (77°50’S, 166°36’E) and Amundsen-Scott South Pole (90°S, 0°W) stations don’t take that route. McMurdo Station, by far the largest of the three stations, is located directly south of New Zealand.

Christchurch is where the US Antarctic Program has its base of operations and, most important, distributes the ECW gear. A lesson learned last time: make very certain that every piece fits properly; you won’t have an opportunity to swap it out when you get there.

Once in Christchurch, you arise every morning at about 4 a.m. to see if the weather has cleared sufficiently for the C-17 to attempt the five-hour trip. Often, you get up, get dressed, go into the lobby, and eventually discover that you should just go back to bed and wait another day. That, however, is far better than the experience that many folks have of almost getting to McMurdo or actually flying overhead and then having the plane return to Christchurch because the weather is too bad to land. This time we made it, and the winter adventure in Antarctica begins.

A lesson learned last time: make very certain that every piece fits properly; you won’t have an opportunity to swap it out when you get there.
2016 Coding Changes

The Centers for Medicare & Medicaid Services (CMS) released the Medicare Physician Fee Schedule (PFS) Final Rule on Oct. 30, 2015. It addresses changes to the physician fee schedule as well as other important Medicare Part B payment policies. The rule became effective Jan. 1, 2016, and was published in the Nov. 16, 2015, Federal Register. Last month, we reviewed changes to Medicare payments and incentive programs. This month, we’ll look at some coding changes for 2016.

Proposal to Eliminate the Global Surgical Package for Procedures

CMS has previously proposed to eliminate the 10-day global and 90-day global packages for many procedures. The relative value units (RVUs) and payments for affected procedures would be lowered substantially because the procedures would not include any bundled follow-up care as part of the payment for the initial procedure. CMS originally proposed to make this transition for procedures that have a 10-day global period in 2017 and for procedures that have a 90-day global period in 2018. The methodology for recalculating the RVUs associated with broad, sweeping changes to the global surgical packages has proven to be complicated, and CMS has softened the exact timeline. If the global surgical package were phased out, ED providers would continue to bill for procedures, such as incision and drainage, joint reductions, etc., but the RVUs would be significantly reduced. However, if a patient returns to the ED for additional care, the opportunity might exist to report a 9928x E/M level for associated follow-up visits.

The Fee Schedule included the following statement about next steps in evaluating global surgical packages: “We appreciate the extensive comments we received from the public regarding the global surgical package. We have noted the positive feedback from commenters about holding potential open forums or town hall meetings to discuss this process. We will consider these comments regarding the best means to develop and implement the process to gather information needed to value surgical services as we develop proposals for inclusion in next year’s [2017] PFS proposed rule.”

—MPSS Final Rule 114/135B

2016 CPT Coding Changes

The Current Procedural Terminology (CPT) book is published annually, and for 2016, there are 92 deletions, 134 revisions, and 140 CPT code additions, totaling 366 changes. The code changes impacting emergency medicine are listed below.

The Following Code Has Been Added for 2016

69209 Removal impacted cerumen using irrigation/lavage, unilateral

Significant specific direction is also provided:
- For removal of impacted cerumen requiring instrumentation, use 69210.
- For cerumen removal that is not impacted, use an E/M service code.
- Do not report 69209 in conjunction with 69210 when performed on the same ear.
- For bilateral procedure, report 69209 with modifier 50.

Significant Changes to Pelvic and Hip X-Ray Codes

Deleted: 73500 Radiological examination, hip, unilateral; 1 view

New Codes

73501 Radiological examination, hip, unilateral, with pelvis when performed; 1 view
73502 Radiological examination, hip, unilateral, with pelvis when performed; 2–3 views
73503 Radiological examination, hip, unilateral, with pelvis when performed; minimum of 4 views

ICD-10 update

On Oct. 1, 2015, there was scheduled to be only limited code updates to the ICD-10 code set to capture new technologies and diagnoses as required by section 503(a)(i) of Pub. L. 108-173. There will be no updates to ICD-9-CM since it will no longer be used for reporting. On Oct. 1, 2016 (one year after implementation of ICD-10), regular updates to ICD-10 will begin. The ICD Coordination and Maintenance Committee will continue to meet twice a year during this partial freeze. At these meetings, requests for new diagnosis or procedure codes will be driven by the criteria of the need to capture a new technology or disease. Any code requests that do not meet the criteria will be evaluated for implementation within ICD-10 on and after Oct. 1, 2016, once the partial freeze has ended.

Other Resources

Resources for these and other topics can be found on the reimbursement section of the ACEP website. Mr. McKenzie is also available to field your questions at 800-708-1822, ext. 3233. Finally, ACEP offers well-attended and highly recommended coding and reimbursement educational conferences annually, with an offering each January.

DR. GRANOVSKY is president of LogixHealth, an ED coding and billing company, and currently serves as the course director of ACEP’s coding and reimbursement courses as well as the Chairman of ACEP’s National Reimbursement Committee.

MR. MCKENZIE is reimbursement director for ACEP.
Fortunately for Mr. Streb, emergency physician Sujal Mandavia, MD, FACEP, group vice president at TeamHealth Emergency Medicine’s West Group in Glendale, California, and a faculty member at the University of Southern California in Los Angeles, was also attending the game. Dr. Mandavia noticed Mr. Streb’s cardiac distress and leapt into action, providing immediate medical attention and ensuring that Mr. Streb made it to the emergency department to receive lifesaving care.

Dr. Mandavia and Mr. Streb recently sat down with ACEP Now Medical Editor-in-Chief Kevin Klauer, DO, ERII, FACEP, to talk about the events of the game and how the experience has affected their lives.

KK: Where were you sitting, Bill?
BS: I was sitting in the lower section, about 15 rows up from the ice. My son and his wife have season tickets. His wife was a bit under the weather, and they gave me a call and asked if I’d like to go instead.

KK: Sujal, where were you sitting in relation to Bill?
SM: I was behind Bill and over a few seats.

KK: Distance-wise?
SM: Probably six or seven feet.

KK: Getting right to the point, Bill, you suffered a cardiopulmonary arrest. You said you would be regarded as the healthiest sibling in your family. How did you feel prior to this event? Did you have any suspicion?
BS: We had gone to Ventura, which is about 50 miles north of us, had a seafood lunch in which I ate things I usually don’t eat—New England–style clam chowder and fish and chips—and then had a normal dinner before going to the game. During the day, I did not feel anything. Somewhere in the beginning of the first period, I started getting what I thought was indigestion, though the indigestion was rather different than before because it was a lot stronger. In the break between the second and third period, I believe, I even went to the first-aid station and got some Tums for my stomach.

KK: Did you tell them that you had some indigestion and you needed Tums?
BS: Yes, I told them that I needed Tums before I signed something that said I received the Tums.

KK: So you’re receiving Tums, and in no way did you or anyone else feel like you had a heart condition that day?
BS: No way at all. I did speak with my oldest son, Michael, who was there with me, and I told him it was really stronger than I’ve ever experienced and a little bit higher. It was above the breast plate on the top part of the plate, and it went from one side all the way to the other. My normal heartburn would be mostly on the right side only. About nine years ago, I’d actually had enough of it that I went in and had a stress test. The stress test showed nothing at all.

KK: Bill, it’s human nature to explain away important symptoms because we don’t want anything bad to be happening. What led you to the point of saying, “Despite the fact that this is entirely different than anything I’ve experienced before, I’m going to decide that this is indigestion”?
BS: I actually never entertained that it was a heart issue at all. I’m sure if I had been home with my wife and told her what I had, she would have mentioned it. Every time I got indigestion, she said, “Are you sure it’s not your heart?” and I’d say, “Yeah, it’s the same as I always have. I’ll go take some medicine, and it’ll be done.”

KK: Did you just wake up at the hospital, or did your condition get worse and did you have other symptoms?
BS: I was watching the game. I was feeling my chest, and it was hurting. I was thinking that I was ready to go home, but let’s see how much time is left in the game. I looked up to the scoreboard, and I think it was 5:41. Almost immediately after noticing that, I began getting really lightheaded and dizzy. The next thing I knew, I woke up in the emergency room, and somebody was jamming something down my throat.

KK: Tell me, Sujal, how were you aware of this? Did you have to move the hot dog and popcorn vendors out of the way? How did this play out?
SM: I was at the game with my wife, Kelly. I looked over, and Bill just didn’t look right. At the time, he wasn’t unconscious, but I noticed that Bill’s son was speaking with him, and he wasn’t really responding. I don’t know if Michael noticed right away because he was still watching the game. Then, about three to four seconds later, I looked back to Bill, and I saw him take an unusual agonal breath, and that’s when I knew what was going on there. I jumped over the seats, and Michael and I got Bill down into the row, which was not easy. I probably have never given somebody bystander CPR, or CPR in a clinical setting, as quickly. We were in the right place at the right time, and there was recognition pre-arrest. You probably had CPR started within literally five to seven seconds of having your cardiac arrest.

KK: Did you do one rescue of CPR?
SM: I did one rescue of CPR. I’ll be honest; I probably went past 30 cycles before mouth-to-mouth was initiated because I knew that was not what was going to save Bill’s life at the time. There was a lot of attention,
Bill just didn’t look right. At the time, he wasn’t unconscious, but I noticed that Bill’s son was speaking with him, and he wasn’t really responding. ... Then, about three to four seconds later, I looked back to Bill, and I saw him take an unusual agonal breath, and that’s when I knew what was going on there.

— Sujal Mandavia, MD, FACEP

BS: You are correct with that.

KK: How much care was delivered right there by the seats?

SM: We were working in between the seats and in between the rows where the popcorn falls.

KK: Was there an intubation attempt there, IV started, or medications? What else transpired right there at the facility?

SM: Bill was not intubated because he was actually breathing spontaneously; he had supplemental oxygen. An IV was started, but he didn’t actually require any medications because he did have a pulse at that time. I know that there is a paramedic unit within the stadium at every game, but that’s actually for the players. We had to wait for the emergency medical services [EMS] system to bring a paramedic unit that would transport and take care of Bill.

KK: Did the players stop?

SM: Play didn’t stop. Part of it was there wasn’t awareness, and unless there is an event on the ice, they won’t stop play.

KK: Sujal, did you go to the hospital with Bill?

SM: No, I didn’t. As you’ve been in these situations before, there were a lot of folks who got involved; there was a cardiologist and everyone else coming out of the woodwork. I knew that by that time, my work was done, and I felt comfortable with how Bill was going to be handed off to the EMS system.

KK: Sujal, how has this changed your life, if it did in any way?

SM: It has given me a whole different level of appreciation for the simple things we can do in cardiac arrest. The other piece of it is it truly humanized that experience in a way that I do not think I’ve had the opportunity to see before. Sometimes I’ve been able to follow up with patients, but I’ve never shared the connection with a patient in the way I have with Bill.

KK: Bill, what are a couple of ways that this has changed your outlook on things?

BS: There are a couple of things. One, my other sons are going to get some tests done with a little more urgency than they were before to make sure that they do not have similar problems. Prior to my event, the only person in the family who had anything was my grandfather who, at 63, passed away from a heart attack. There is no other person with heart disease on either side of my family. I now look at every day as a gift because I had the v-fib once at the Staples Center and twice more in the emergency room, so I had it three times in total. My middle son says, “That makes you a zombie because you died three times.” My youngest son is actually a radiologist, and he says, “No, you didn’t die because death is brain death, and you didn’t come anywhere near that.” Now we look at every day with a little more appreciation.

KK: Some people talk about seeing lights, some say it’s physiologic, and some say it’s more spiritual. Did you have any of that experience?

BS: No. My sister asked if I had seen the light, and no, I did not see anything.

KK: Did you just have one stent, or did you have multiple stents?

BS: There were three places that were blocked. The stent was actually in the back side of the heart, and it was 100 percent occluded. I had one at 70 percent and another at 30 percent. We’ll see my cardiologist a week from Tuesday, and we are supposed to be scheduling a nuclear stress test to see if we need to do anything else with those other arteries.

KK: Did they stent the 70 percent lesion or not?

BS: No, just the 100 percent. Then they put me on high dosages of Lipitor, 80 mg, to see if we could drive it down and have the actual plaque dissolve.

KK: Sujal, when did you follow up with Bill?

SM: I had known where Bill was going to be transported because of the STEMI [ST elevation myocardial infarction] network that we have here in Los Angeles. I provided my contact number to one of the hospital administrators, who was able to pass it on to probably the nurse manager in the ICU, who then got it to Bill. Bill called me two or three days later.

KK: We [emergency medicine] are the safety net of the health care system. Sujal was your personal safety net.

BS: I need to know where he sits from now on when I go to the games.
Launched in September 2015, Pediatric Emergency Playbook is a monthly podcast addressing some of the current issues in PEM, including use of intranasal medications, the undifferentiated sick child, and status epilepticus. When compared with some other educational tools, the podcast has the advantage of being available on the go. “The beauty of a podcast is that I can be with you in the car or at the gym or out for a run,” said Dr. Horeczko.

Even though it is relatively new to the scene, Pediatric Emergency Playbook has enjoyed numerous successes already. There are listeners in more than 60 countries, and it was named to the Top 10 Podcasts for medicine in iTunes’ “New and noteworthy” section. Dr. Horeczko’s goal with this endeavor is to help provide physicians caring for sick children with not only the evidence and practice styles but also some experience. “My goal is to demystify pediatric care and add value to our specialty,” he said. “I try to serve the audience by not just talking about the absolutes in medicine, the ‘yesses’ and the ‘nos,’” including the ‘maybes’ and also the ‘whys.’ It’s about getting at the subtleties and the nuances of what we do. Using the three levels of knowledge—the theoretical, the technical, and the practical—we are able to use our experiences to help teach others.

Dr. Horeczko gets the inspiration for his podcasts from the problems those physicians caring for sick and injured children face and struggle with every day. He uses his format of presenting a vignette, discussing the evidence behind the problem, putting his own experience to use with some treatment options, and fleshing out some of the controversies involved to help listeners work their way through a common clinical problem.

We have all been there: evaluating the child that presents to our department and is sick—really sick. It may be the 7-day-old with breathing problems or the 5-year-old with vomiting and fever, with every patient bringing their own broad differential and varying approach. In that instant when we start our resuscitation or evaluation, we often remember the words or advice given to us by a mentor or colleague, helping us learn and treat based on their experiences—sometimes successes and sometimes not. That is Dr. Horeczko’s goal with the Playbook: to give pearls and advice on some common (and not so common) pediatric presentations that he has gleaned along the way in an effort to help others.

He starts with Adam, the 7-day-old with breathing problems. The differential diagnosis for the sick infant: “THE MIS-FITS.”

- T = Tone
- I = Interactiveness
- C = Consolability
- L = Look/gaze
- S = Speech/cry

The Playbook also refers to the Pediatric Assessment Triangle (PAT), a global assessment tool that takes into account what is done in the first 20–30 seconds that you are in a patient’s room (see Figure 1). It helps to distinguish the difference between potential respiratory, cardiovascular, and metabolic etiologies of disease.

The Playbook then discusses a differential diagnosis for the sick infant: “THE MIS-FITS.”

- T = Trauma
- H = Heart disease or Hypovolemia
- E = Endocrine emergencies
- M = Metabolic
- I = Inborn errors of metabolism
- S = Seizures
- F = Formula problems
- I = Intestinal disasters
- T = Toxins
- S = Sepsis

The Playbook takes special time to review a specific subset of patients who will present in this age group, and those are the ones whose ductus arteriosus is closing. These patients will often present in cardiopulmonary failure, pending arrest. As the ductus closes, patients with cardiac lesions, dependent upon that route for supplemental blood flow, will decompensate. Examples of these lesions include critical coarctation of the aorta, truncus arteriosus, transposition of the great arteries, tricuspid atresia, tetralogy of Fallot, and total anomalous pulmonary venous return. To help with the diagnosis, the hyperoxia test can be performed. Place the child on a non-rebreather mask and, after several minutes, perform an arterial blood gas (ABG) test. Ideally, you obtain a preductal ABG in the right upper extremity and compare that with one on the lower extremity, but this may not be practical. In a normal circulatory system, the pO2 should be high, in the hundreds, and certainly over 250 torr. This effectively excludes congenital heart disease as an etiology. If the pO2 on supplemental oxygen is less than 100, then this is extremely predictive of hemodynamically significant congenital heart disease.

If you are giving this child 100 percent FiO2 and he doesn’t improve 100 percent—that is, his pO2 on ABG is not at least 100 torr—then he has congenital heart disease until proven otherwise. The lifesaving intervention necessary is the initiation of prostaglandins to help keep the ductus open, preserving that flow of blood. The most common side effects of prostaglandins include apnea and hypotension, so you should be prepared to address both of those conditions. See Figure 2 for a neonatal shock algorithm that incorporates these assessment tools.

“We all learned from someone who learned from someone else. We have experience spanning decades and thousands of patients,” said Dr. Horeczko. “This provides a platform for building a community together and sharing collective knowledge. I am able to provide the audience with not only the pearls and the rapid-fire information that we all crave but also with the thought process behind it. It helps to get at some of the intangibles of the practice of medicine.”

I congratulate Tim on his new endeavor and thank him for making it available to the masses. I have listened to his podcasts in the car or in the office and have taken away some very useful nuggets of information that I have already utilized. I look forward to his next installment. Give it a listen—I think you will enjoy it, too.

Dr. Sorrentino is professor of pediatrics in the division of emergency medicine at the University of Alabama at Birmingham.
Should I Buy Insurance From My Professional Society?

The pros and cons of purchasing association and other group policies

by JAMES M. DAHLE, MD, FACEP

Q. Every month, I get mail from the American Medical Association, ACEP, and other organizations trying to get me to buy life or disability insurance through them. Why do I get these, and are these the best policies for me?

A. Professional associations, such as ACEP, offer benefits such as insurance policies to their members for various reasons. First, they understand that these are important financial products for their members to purchase. When physicians become disabled without disability insurance, especially early in their careers, a financial catastrophe often occurs. Life insurance is similar. If you die prior to reaching financial independence, those who depend on you financially will very much appreciate your making up the difference between your portfolio size and what it would take to be financially independent with a solid life insurance policy or two. Your association wants to make it easy for you to do the right thing.

Second, some doctors have a difficult time obtaining disability or life insurance on the open market due to health problems or dangerous habits. Association policies often ask fewer health questions; do not generally require a physical; and rarely ask about dangerous hobbies, such as rock climbing, scuba diving, flying, or skydiving. For these doctors, the association policy may be their only opportunity to get the coverage they need or want at a reasonable price. People in these situations see these offerings as important benefits of the association and are more likely to join if these benefits are offered.

However, what cynics would point out is that the insurance agent or company selling these policies is generally sharing revenue with the association. Unfortunately, that conflict of interest ensures the association may not give you unbiased advice on these topics. While it is possible an association group policy is your best option, you need to shop carefully prior to actually purchasing it. You will often find an association policy is neither the best nor the least expensive option.

Association group disability insurance policies generally have three significant flaws. The first is that their definition of disability is usually weaker than that available through a good individual policy. This means it is less likely to pay you in the event that you actually become disabled. The second flaw is that the payout is also often decreased by factors you might not expect, such as Social Security disability payments. The third flaw is that the policy can be changed by the association at any time and usually can’t be taken with you if you decide to leave the association. Emergency physicians should also be aware of other limitations, such as a requirement in the ACEP-sponsored disability insurance plan that you be working at least 30 hours per week. Consider that 15 eight-hour shifts per month, generally considered full-time among emergency physicians, when divided over 31 days is only 28 hours per week. If you are working any less than that, you may not qualify at all for such a policy. In return for accepting these weaknesses, association disability insurance policies are generally less expensive, sometimes much less expensive, than a good individual disability policy.

On the other hand, association life insurance policies are often more expensive than a comparable term life policy for a healthy, nonadventurous physician. For example, I recently received in the mail a pitch for term life insurance from The Hartford insurance company as part of the ACEP insurance program. It offered me, as a healthy, nonsmoking 40-year-old, a $500,000, five-year level term life insurance policy for $57.60 per month, or $691.20 per year. Just for fun, I went to one of the sites on the Internet that will provide you an instant quote for term life insurance and discovered that similar policies could be purchased on the open market at prices ranging from $243 to $920 per year. A healthy woman would have even better rates. Obviously, paying more than twice as much for a policy isn’t a very sound financial decision for most people.

However, there are a few exceptions. If you do not want to do a paramedic physical examination (usually just vitals, routine blood work, drug screens, and a urinalysis) for convenience purposes or because you are afraid it will reveal a medical condition, you may be interested in this policy because it does not require the examination. Also, if you engage in dangerous hobbies, you may also find this policy useful since it asks no medical questions on the application.

A bigger problem for many physicians is that association and other group life insurance policies simply don’t offer large enough benefit amounts. Typical young physicians with a family depending on them should be purchasing a life insurance policy with a benefit of $1 to $5 million, far more than the $500,000 maximum offered on the ACEP-sponsored policy. It would be a hassle, if it is even possible, to piece together multiple group policies from various associations and employers to provide the needed coverage. Group policies can also be cancelled or changed at any time by the association or employer. For these reasons, group life insurance policies are generally, at best, only a supplement to your main life insurance policy.

Despite their flaws, there are situations where both group disability and group life insurance plans are appropriate. But prior to purchasing one, be sure to do your homework and shop around rather than blindly assuming that your association or employer has done that for you.
There is a bit of an axiom that circulates in medical school: “Half of what you’re learning is wrong, but we don’t yet know which half.” This has borne out observationally simply by examining the frequency of reversed medical practices in the major medical journals.1 There is also an entire school of academic inquiry into the likelihood of research arriving at erroneous conclusions, and it can be statistically demonstrated that most published findings are false.2

The treatment of diverticulitis seems poised to be the next domino to fall in reversal of dogmatic medical practice. Some patients with diverticulitis progress to perforation, abscess, sepsis, and death, and the advent of antibiotic therapy substantially reduced morbidity and mortality associated with diverticulitis. The classic teaching, then, has required hospitalization and intravenous antibiotic therapy while monitoring for deterioration. However, with better understanding of the disease process, it was proposed that diverticulitis is primarily an inflammatory rather than an infectious state, and only those with a complicated disease course may benefit from antibiotic therapy.3

Given the increasing challenges of antimicrobial resistance paired with the rise of disabling *Clostridium difficile* infection, such a hypothesis did not go unnoticed. The first bits of evidence testing the disutility of antibiotics in acute, uncomplicated diverticulitis have been trickling out over the past three years. The first, the AVOD randomized trial, was an open, multicenter study in Sweden published in 2012.4 In this study, 669 patients with a CT-confirmed diagnosis of acute, uncomplicated diverticulitis were hospitalized and randomized to either intravenous fluids only or intravenous fluids and intravenous antibiotics in combination with fluids. Patients were evaluated daily while hospitalized, then followed for up to six months following enrollment. The quick results summary: no difference. Patients in each group had nearly identical hospital courses, with similar rates of resolution of pain and fever, and median in-hospital length of stay of fewer than three days. The number of patients progressing to complicated disease was in the single digits in both cohorts. Ten patients randomized to no antibiotics were started on antibiotics due to suspicion of clinical worsening, while three patients on antibiotics terminated therapy due to allergic side effects. Recurrent episodes of diverticulitis during follow-up were likewise identical at six months.

The second, the DIABOLO randomized trial, was performed in a multicenter Dutch...
population, and the results were presented in 2014. Similar to AVOD, this trial hospitalized most uncomplicated cases of diverticulitis and randomized them to either intravenous fluids or intravenous antibiotics. This trial enrolled 528 patients, and again, outcomes were not different between cohorts. Patients in the no-antibiotics arm were treated more frequently as outpatients, had fewer in-hospital days, and ultimately had a crossover rate to antibiotics of 5 percent. Most important, similar to AVOD, no patients in the no-antibiotics arm suffered serious complications, either short-term due to progression of disease or in their six-month long-term follow-up window.

The final bit of evidence comes from the same group conducting the AVOD clinical trial. Based on their findings, these authors initiated practice change at two of the hospitals involved in the prior research and began treating qualifying diverticulitis patients without antibiotics as outpatients. To qualify, patients needed to have clinical symptoms and a CT-confirmed diagnosis of uncomplicated diverticulitis. Patients were then excluded based on being immunocompromised, pregnant, experiencing severe pain or vomiting, or at risk of poor compliance. These authors tracked 155 patients treated in accordance with this strategy, and there were a mere four treatment failures requiring hospitalization and antibiotic therapy. This failure rate, 2.6 percent, was no different than the expected rate of failure with antibiotics of approximately 2 percent. Of the failures, one had progression of a small abscess missed by the radiologist at initial presentation. Conversely, there were two patients whose initial CTs showed a missed perforation. Neither of these patients developed complications secondary to observation without antibiotics.

These data, taken cumulatively, are quite fascinating. However, these data are also quite weak—the GRADE classification of the quality of this evidence is “low.” The AVOD study accrued 528 patients, and the JAMA study analyzed 155 patients. In both cases, patients were chosen based on having uncomplicated diverticulitis. Determining the relative improvement of even a single, small, negative crossover to antibiotics in the AVOD study could have been the result of statistical chance. The JAMA study’s small sample size makes the chance of a Type II error (a false-negative error) extremely high. Neither study has the power to detect differences in small absolute numbers, given the low expected rate of failure with antibiotics. These trials were designed to show that diverticulitis patients treated without antibiotics were no worse off than those given antibiotics. Despite this, patients treated without antibiotics were less likely to develop complications and had shorter hospital stays. This is similar to the finding of a recent meta-analysis of randomized trials comparing antibiotic therapy vs. observation in patients with uncomplicated diverticulitis. This meta-analysis included four trials and showed that patients treated with antibiotics were 2.6 percent more likely to develop serious complications (relative risk, 1.026; 95% CI, 1.004–1.048) and had a 2.9 percent higher rate of antimicrobial resistance.

The American Gastroenterological Association published new guidance in December 2015, indicating a “selective” antibiotic strategy for acute, uncomplicated diverticulitis is reasonable.
trial suffers from substantial risk of bias, while the DIABOLO trial has been presented only in oral abstract form. The observational evidence is important but also suffers from bias and lack of a control cohort. All this said, however, these data have not gone unnoticed, and many guidelines have changed.

The American Gastroenterological Association (AGA) published new guidance in December 2015, indicating a “selective” antimicrobial strategy for acute, uncomplicated diverticulitis is reasonable. While this might seem premature to many, given the strength of the evidence, the AGA is actually rather late to the party; the Danish Surgical Society, a Dutch guidelines working group, an Italian consensus conference, and a German society of gastroenterology have all gone on record endorsing similar limitations in the use of antibiotics.13-15 More evidence is certainly needed to strengthen these recommendations, and our lessons regarding medical practice reversal must yet be heeded with any practice change. However, given the benefits associated with avoidance of unnecessary antibiotic use, the growing evidence makes a selective antibiotic strategy appealing.

With these guidelines in place, appropriately treated patients with uncomplicated diverticulitis may be considered for an observation-only strategy. The limitations of the evidence should be discussed with patients, and appropriate follow-up should be available or arranged. An initial liquid diet seems to be the most appropriate starting point, with progression as tolerated. Patients should expect to have continued, slow resolution of their symptoms over, in general, a week’s duration.

The limitations of the evidence should be discussed with patients, and appropriate follow-up should be available or arranged. An initial liquid diet seems to be the most appropriate starting point, with progression as tolerated. Patients should expect to have continued, slow resolution of their symptoms over, in general, a week’s duration.

References

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Step 6: The safety zone: make a statement open to antibiotic use in the future but con-
firming you won’t be prescribing any today. For example: "Today it looks like you have a vi-
rus, which won’t respond to antibiotics. If you don’t get better, we can always use antibiotics at a later time, when it might be possible that you have a bacterial infection."

Step 7: Confirm the patient is on board with the plan and document that in your medical record. If they’re still not on board, you may consider writing them a “wait-and-see pre-
scription” (not to be filled unless their symp-
toms don’t improve by a certain date).

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provements. ☞

References

How can schools of public health move as forward? Public Health Rep 2006;121(1):97-103


DR. KLAUER is the chief medical officer-emergency medicine and chief risk officer for TeamHealth as well as the executive director of the TeamHealth Patient Safety Organization. He is an assistant clinical professor at Michigan State University College of Osteopathic Medicine and medical editor-in-chief of ACEP Now.
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