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The Official Voice of Emergency Medicine

AUGUST 2019 Volume 38 Number 8 FACEBOOK/ACEPFAN TWITTER/ACEPNOW ACEPNOW.COM

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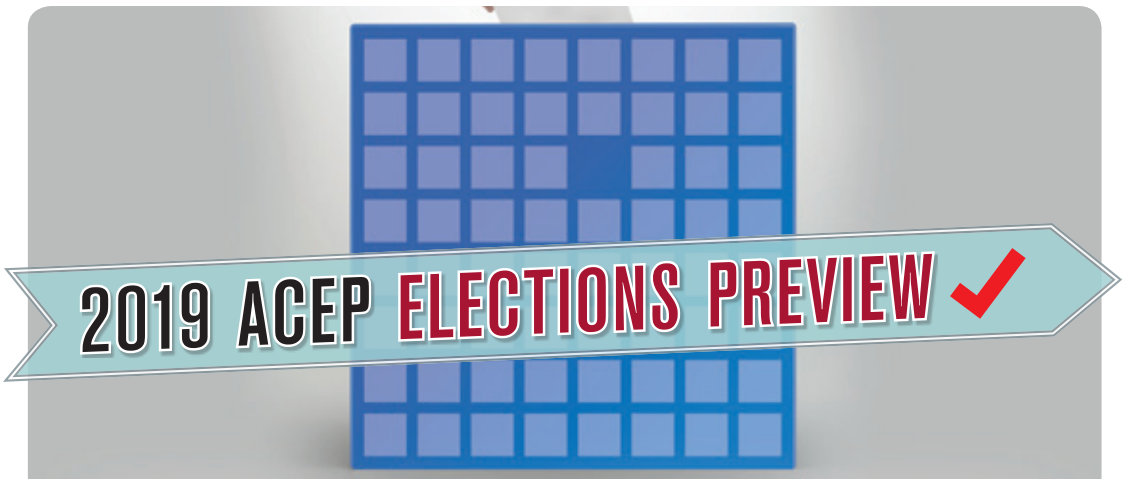

2019 ACEP ELECTIONS PREVIEW

MEET THE ACEP BOARD OF DIRECTORS CANDIDATES

The candidates discuss major issues facing emergency medicine

Each year, ACEP's Council elects new leaders for the College at its meeting. The Council, which represents all 53 chapters, 39 sections of membership, the Association of Academic Chairs of Emergency Medicine (AACEM), the Council of Emergency Medicine Residency Directors, the Emergency Medicine Residents' Association (EMRA), and the Society for Academic Emergency Medicine, will elect the College's President-Elect, Council Speaker and Vice Speaker, and four members to the ACEP Board of Directors when it meets in October. This month, we'll meet the Board of Directors candidates.

CONTINUED *on page 8*

PHILLY HOSPITAL TO SHUT ITS DOORS

Hahnemann's unexpected closure leaves Drexel University residents, community scrambling

by KELLY APRIL TYRRELL

After months of speculation, residents at Drexel University/Hahnemann University Hospital learned in July that, as of July 29, 2019, they have to finish their residencies elsewhere.

On June 26, 2019, the California-based investment firm that owned the Philadelphia hospital filed for bankruptcy and abruptly announced the hospital would close. The question was, when?

Matt Abrishamian, MD

Liz Calhoun, MD

In the weeks after notice of the impending closure, residents were left with no shortage of uncertainty. In mid-July, Matt Abrishamian, MD, didn't know whether he would need to move by the end of the month. Or maybe it would be early September. He didn't know for certain whether, or when, the funding he had as a resident would travel with him as he sought out a new program to complete his third and final year. He didn't know if he would be licensed in time to train in a new state. Dr. Abrishamian was looking into transferring to an emergency medicine program at the University of California, Irvine.

"This is uncharted territory, and there is a lot of uncertainty," said Dr. Abrisha-

CONTINUED *on page 17*

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NEW COLUMN:
RESIDENT VOICE

POWER *of* ADVOCACY

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NEWS FROM THE COLLEGE

UPDATES AND ALERTS FROM ACEP

End-of-Year Report

ACEP making progress in its mission

by DEAN WILKERSON, JD, MBA, CAE, ACEP EXECUTIVE DIRECTOR

At the end of our fiscal year, I traditionally present a year-end recap of the new projects and initiatives that are helping us advance ACEP's mission during the June Board of Directors meeting. Here is a quick summary, and you can read the full report at www.acepnow.org.

50th Anniversary

Our anniversary celebration reached its crescendo at ACEP18 in San Diego, which had nearly 8,000 registrants. It was a beautiful celebration in which we honored long-time veterans of our specialty, heard panels and "Titan" talks, displayed a clever museum of dozens of panels depicting our history through the decades, released the *Bring 'Em All* book of dramatic photos and essays that was honored with an award, and much more.


Dean Wilkerson, JD, MBA, CAE

Advocacy

This was a very strong year for our federal advocacy efforts. We saw enacted into law two opioid bills spearheaded by ACEP, the **Alternatives to Opioids (ALTO) in the Emergency Department Act** and the **Preventing Overdoses While in Emergency Rooms,** or POWER Act, as part of the large omnibus opioid legislation.

We also developed and introduced the **Improving Mental Health Access from the Emergency Department Act** in time for our Leadership & Advocacy Conference (LAC) in May. ACEP and our chapters are also working with the Coalition on Psychiatric Emergencies to advocate for state-based solutions on mental health.

There has not been a time in the past 15 years when ACEP has been directly in the middle of an important advocacy issue in Congress like we have been with the out-of-network issue, also known as "surprise billing." Our staff and leadership have aggressively lobbied the Senate and House, and we've closely collaborated with the American Medical Association and other specialties. We have strongly supported the **Protecting People from Surprise Medical Bills Act,** and we will keep working to change or oppose proposals that are not to our liking. It's unrealistic to expect to get 100 percent of what we want out of Congress, but we'll continue to try.

LAC was a huge success. We made 551 visits on Capitol Hill to discuss surprise billing legislation and access to mental health care. We filed suit against Anthem in Georgia for violating the prudent layperson standard embodied in the law, and we expect a ruling from the judge soon. We are working with our chapters in several other states where insurers are retroactively denying claims and coverage for patients.

Quality

Our Quality Line of Service continues to hit on all cylinders. ACEP's **Clinical Emergency Department Registry (CEDR)** has continued to grow in every major metric we track. It has exceeded our goals in the number of patient visits, number of hospital emergency departments, and number of clinicians, plus has seen continued growth in revenue. We continue to gain large hospital systems and billing companies as customers.

We began developing a **Quality Measure Consortium.** Development of quality measures is expensive, so we have invited other organizations with registries to jointly develop measures with us and share the cost.

With more than 1,200 emergency departments in 46 states and more than 40,000 clinicians participating, the **Emergency Quality (E-QUAL) Network** is growing and helping improve patient care for sepsis and chest pain as well as promote avoidance of unnecessary imaging and treatment of opioid use disorder.

We held an **ACEP/EMF Data Summit** earlier this year to begin developing a plan to build a data analytics platform to enable research with CEDR data for more than 50 million patient visits.

In July, we held a **Health Information Technology Summit,** bringing together around 100 electronic health record (EHR) vendors, payers, government agencies, and thought leaders. We know your administrative burden is constantly growing; we want to help make EHR systems more efficient and less burdensome for you.

Clinical

We pushed back on an inappropriate policy for sedation promulgated by the American Society of Anesthesiologists, instead producing our own **Unscheduled Sedation Policy** specific to our specialty. We're going through the same process for sepsis because the Society of Critical Care Medicine released a sepsis protocol that does not consider the unique nature of emergency medicine.

We got the Occupational Safety and Health Administration and The Joint Commission to clarify that our members are allowed to have food and drink at their ED workstations, and we developed a members-only toolkit to help you educate your administrators about this clarification.

We launched a new members-only **emergency medicine Point of Care (emPOC)** app (read more about this new member benefit on p. 14).

We produced many opioid-related resources (www.acep.org/opioids), including the ALTO boot camp and the first EM-specific Medication Assisted Treatment (MAT) waiver training. We're doing state MAT waiver trainings with our chapters pursuant to a grant.

Publications

We are developing a **second journal** that will be open-access and online only and selected Henry E. Wang, MD, MS, to be its new Editor in Chief. The first issue is planned for February 2020.

We hired a new medical Editor in Chief for ***ACEP Now,*** Jeremy Faust, MD, MS, MA, after former medical Editor in Chief Kevin Klauer, DO, EJD, FACEP, accepted a new role as CEO of the American Osteopathic Association.

Workforce Studies

ACEP is taking on two important and complex situations affecting emergency medicine. The **Nurse Practitioner/Physician Assistant Utilization Task Force** will help us provide leadership on the scope of practice and appropriate protocols for use of nurse practitioners and physician assistants in the emergency department. The delivery of health care is changing with freestanding emergency departments, the growth of urgent care centers, telemedicine, and the consolidation and employment of emergency physicians. The **Emergency Medicine Workforce Task Force** will help us better understand the current ED workforce environment and predict future needs.

Workplace Violence Initiative

ACEP is launching a new **Campaign to End Workplace Violence in the ED** with the Emergency Nurses Association (ENA) this fall. This will be a robust collaboration with different resources and deliverables examining all sides of this problem. We're already working with ENA on the federal Workplace Violence Prevention for Health Care and Social Service Workers Act and are encouraging our chapters to collaborate at the state level.

Accreditation Programs

The **Geriatric ED Accreditation Program** is growing. More than 60 hospitals are accredited, including one in Spain, and we have more than 100 in the pipeline. We've agreed to accredit 20 VA hospitals next year to help improve care of our veterans.

Our new **Emergency Department Pain and Addiction Management Accreditation Program** strives to provide better care for patients suffering from opioid use disorder and pain. We will be rolling it out by the first of the year.

ACEP is setting the standards for **accreditation of freestanding emergency departments.** Another organization, the Center for Improvement in Healthcare Quality, will do the accrediting, but accreditation will be based on standards developed by ACEP.

International

ACEP is upping its efforts to grow internationally in a cost-effective way. We will have a **Global Village** at ACEP19 and are inviting international societies to attend, we're hosting an **International Summit** to bring together EM leaders to discuss successes and challenges to support the growth of emergency medicine worldwide, and we established an **International Committee** focused on how we can grow our role in worldwide emergency medicine. We are developing a close relationship with the European Society for Emergency Medicine. I believe if we do this the right way, our whole membership will benefit by expanding our international reach and collaborations. We'll be able to share our expertise and help others while gaining fresh perspective from other countries.

Public Engagement

Our **Until Help Arrives** program launched at LAC. Until Help Arrives training is similar to Stop the Bleed, but it's a shorter course and its curriculum includes hands-only CPR. We're excited to give our members this opportunity to make a positive impact in their communities by teaching bystanders these lifesaving skills.

Reimbursement

We've spent a huge amount of time and effort battling the out-of-network issue to prevent insurance companies from significantly reducing reimbursement to our specialty. At the same time, we're working on other initiatives to prepare for our future reimbursement. We developed the **Acute Unscheduled Care Model** as a proposed alternative payment model (APM). This was a difficult and expensive project, and we're proud that our APM is one of the few that has made it through the Physician-Focused Payment Model Technical Advisory Committee process and is sitting on the Secretary of Health and Human Services' desk, waiting for approval. We plan to develop a toolkit, best practices, and other resources to help our members and their ED groups implement this APM. This model, or some variation of it, could be a significant payment methodology in the future, so we think it's important ACEP continue to provide leadership and guidance on how it is used in our specialty.

We also launched the **Reimbursement Leadership Development Program,** a highly coveted opportunity for members interested in increasing their knowledge of reimbursement issues and serving ACEP in various ways. We had 72 applicants, and we selected some unbelievable people who are being groomed through this program.

Management Services

We just signed a new five-year shared services agreement with the **Emergency Medicine Residents' Association,** an organization that continues to grow by leaps and bounds. We're continuing to provide administrative support for the **Council of Emergency Medicine Residency Directors** and the **Society of Emergency Medicine Physician Assistants,** both of which had record-breaking years in terms of attendance at their meetings and their financial performance. We've been asked to provide management services and administration for the large, growing **FemInEM** conference.

ACEP is blessed to have a very engaged Board of Directors and talented, dedicated staff. We have active and productive chapters, committees, task forces, and sections. Through collaboration and teamwork, we have helped ACEP make significant progress in achieving our mission.

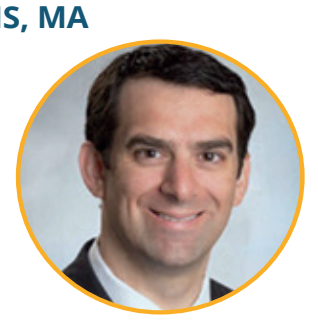
June Board Meeting Recap

The ACEP Board of Directors convened June 26–27, approving ACEP's FY2019–20 budget and discussing several topics related to policy and practice. To read a full recap of the actions taken during the meeting, including several new and revised policy statements, visit www.acep.org/leadershipreport.

New Editor in Chief for *ACEP Now*

With our sincere gratitude, and on behalf of the entire emergency medicine community, we would like to thank Dr. Kevin Klauer, outgoing Editor in Chief of *ACEP Now*, for his dedication to the publication and for the many hours and positive influence he has had on it throughout his six year tenure.

Newly Appointed Editor in Chief
Jeremy Samuel Faust, MD, MS, MA



We are very pleased to welcome our newly appointed Editor in Chief, Jeremy Samuel Faust, MD, MS, MA, who will be an energetic and active new leader for *ACEP Now.*

Dr. Faust is well-established in the emergency medicine community, and has a breadth of experience with the publishing process through various roles he has held. We look forward to working with Dr. Faust to continue the success of our publication and fulfill our objective to serve as "the official voice of emergency medicine."

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A Vision for the Future

CARRYING ON THE WORK OF *ACEP NOW*

SUSAN R. SYMONDS FOR MAINFRAME PHOTOGRAPHICS

by JEREMY SAMUEL FAUST, MD, MS

I'm tremendously honored to have been selected as medical Editor in Chief of *ACEP Now*. Thanks to my predecessor Dr. Kevin Klauer's passion and vision, I am fortunate to inherit a thriving publication that already lives up to its motto and mission statement to be the "official voice of emergency medicine."

This publication needs no reboot. You can expect many things to stay the same: evidence-based clinical updates, expert how-to's, advocacy reports, information on ACEP resources, and financial and career advice—coverage of critical issues by and for emergency physicians.

But every editor has a vision, and I'd like to share mine with you and use this opportunity to introduce you to some new features we will roll out in the coming months.

My three major goals for the magazine will build on our current efforts that are already under way:

1. *ACEP Now* will reflect the increasing diversity of our membership. As our field diversifies, the stories we cover and the authors we publish must reflect this. This will give our readers a more accurate representation of what is actually happening and where we are headed.
2. We will use this space to more aggressively highlight what ACEP as an organization—both members like you and its professional staff—is doing to advance the common interests of our field. Many of us, myself included, are not fully aware of the efforts of both our volunteer leaders and paid professionals. They're on Capitol Hill keeping us afloat financially. They're writing position statements so that we are medical and moral leaders in health care. They're interfacing with mainstream media to represent us. And our passionate members are changing ACEP from the inside, often through inglorious committee work that truly deserves to be highlighted. "Where are my dues going?" you often ask. We will make sure you know so that you can be proud—and maybe motivated to get involved to make the changes you envision a reality.
3. The magazine will put a spotlight on the major medical and political problems of our time. We cannot close our eyes and stop our ears on issues where we do not enjoy consensus. We may not always have the answers to these problems, but if we do not at least document them, our successors will justly ask, "What were they thinking?" Therefore, this magazine will be a space where you can turn for coverage of major developments in medicine and policy, through the lens of emergency physicians. We're not trying to spawn angry emails (but, yes, we will read them all) but rather to rouse action from diverse corners of our specialty.

I'd like to introduce you to just some of the new features and columns that will appear in the magazine. All of these are in service of the goals above.

1. **FACEPs in the Crowd:** Our members are simply amazing. Many of them are passionate about more than just emergency medicine. We will highlight the nonmedical accomplishments of our multifaceted FACEP members. This month's inaugural installment features three fascinating emergency physicians. Turn to page 16 to learn what they do when they're not treating patients.
2. **Residency Spotlight:** Each month, we will feature one emergency medicine residency program in the United States. You'll get to know programs across this great land through these snapshots and learn about their strengths and, of course, their charming quirks. Our first installment, on page 18, features University of Nebraska Emergency Medicine. I chose this program because it is located the closest to the geographical center of the contiguous United States of any residency. But trust me, that's not their only claim to fame.
3. **The Equity Equation:** The discussion we are (not) having about equity in medicine is long overdue. These columns will be data-driven policy pieces designed to both diagnose and respond to problems we face. Our first column, on p. 22, tackles clinical scheduling during pregnancy. How do we balance the safety of our pregnant colleagues with the clinical needs for our patients who rely on full staffing models?
4. **Resident Voice:** We need to hear from our trainees. What is happening on the ground, both good and bad? This column will focus on issues that can best be described from the resident perspective. On page 23 in this issue, you'll see how residents can advocate for change and succeed.
5. **Injuries, By the Numbers:** The annual mortality statistics from the Centers for Disease Control and Prevention are staggering. Every year, well over 200,000 Americans, often young and otherwise healthy, die unnecessarily. We can't forget these people, and we *should* be angry. For example, we know that increasing the speed limit on interstate highways increases mortality rates. We can and will juxtapose such facts when mass casualty events occur, be it on our highways (such as last month when seven motorcyclists died in a single crash in New Hampshire) or in our schools and houses of worship that are terrorized by guns. See p. 17 for our first dive into the numbers.

And that's just a few of the new features and columns you can expect. Some of these changes are designed to be pure fun, while others are more serious. What works and what does not is something that we will discover together as a community. We won't always get it right, but we will take big swings and not "strike out looking."

To that end, I want to thank you, each and every reader, for joining me on this journey. Together, we will highlight and enhance our collective efforts as emergency physicians and proud members of this vibrant College. I will continue to rely on your expertise, passion, and vision. I anticipate a robust conversation that will elevate more than just this vital publication but also our collective professional success, ultimately improving the safety and health of the cherished communities we serve.

DR. FAUST (@JeremyFaust) is medical Editor in Chief of *ACEP Now*, a clinical instructor at Harvard Medical School, and an attending physician in the department of emergency medicine at Brigham and Women's Hospital in Boston.

SEND YOUR THOUGHTS AND COMMENTS TO ACEPNOW@ACEP.ORG

THE BREAK ROOM

Concern over Pharma Reps

This is to voice a bit of alarm regarding the overtly pro-pharma column entitled "United States Constitution Versus FDA" [June 2019]. It appears to take a pro-industry stance throughout and ends with the provocative suggestion: "So the next time your favorite drug rep comes calling, feel free to discuss off-label uses of their medical products…" This is downright offensive. For one thing, it assumes that the reader *has* a "favorite drug rep," that reps can constitute trusted sources of information regarding other physicians' practices, or that pharma has any credibility whatsoever as a platform for dissemination of information regarding their products outside of strict adherence with FDA regulations. The author appears totally oblivious of the fact that pharma executives are going to jail these days, not for asserting their free speech rights, but for bribes, graft, and other outrageous criminal activities in connection with the opioid debacle. Indeed, justice would probably be served if they went to jail for murder, their products having probably killed more people than the sum total of lives saved as a result of pharma products during the same period. It will be a long, long, long time before the industry regains ethical credibility with respect to the marketing of their wares.

Beyond venting sentiments shared by most of my colleagues, I have two suggestions that might be actionable:

1. Insist on full disclosure of relevant financial associations between the authors of your columns and, particularly the pharmaceutical and medical device industry.
2. Consider adding a letter-to-the editor segment to your publication so that readers are not left on their own to find venues for expressing their opinions, particularly if you elect to publish highly politically sensitive opinion pieces such as the one in question.

Peter Wyer, MD, FACEP
New York, New York

The Author Responds

Thank you for your passionate response to my article. Just as I respect and encourage you to voice your opinion under the protections of our First Amendment, I would ask that you kindly consider re-reading my article with the understanding that the First Amendment also protects those pharmaceutical companies when they elect to discuss truthful off-label usages of their products. I believe that you have read much deeper into this article than I ever intended. I hope that you noticed I am an attorney and a board-certified emergency physician. With these titles I must walk the most delicate ethical balances in every aspect of my life, including any publications that I may author. I thank you again for the opportunity to respond to your concerns.

Kenneth Alan Totz, DO, JD, FACEP

EDITOR'S NOTE: *ACEP Now* does require authors to provide conflict of interest and financial disclosures.

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Gregory L. Henry, MD

- Former CEO of two emergency physician malpractice insurance companies
- Has reviewed in excess of 2,200 malpractice cases over the last 25 years as a risk management consultant
- Serves as a medicolegal consultant for numerous physician groups and hospitals
- Editor of the ACEP book *Emergency Medicine Risk Management: A Comprehensive Review*

W. Richard Bukata, MD

- Edited over 15,000 abstracts and wrote over 200 essays on EM-related topics while editor of *Emergency Medical Abstracts*
- As Medical Director of the Center for Medical Education has been involved with the production of over 600 Emergency Medicine courses since 1985
- Served as the Medical Director of a community hospital in Los Angeles for over 25 years
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Simple Ischemic Stroke: Is There Really Such a Thing?

Stroke is a common presentation, but don't assume you know the cause in a particular patient

by RAYMOND ISENBURG, DO; AND DENIECE BOOTHE, DO

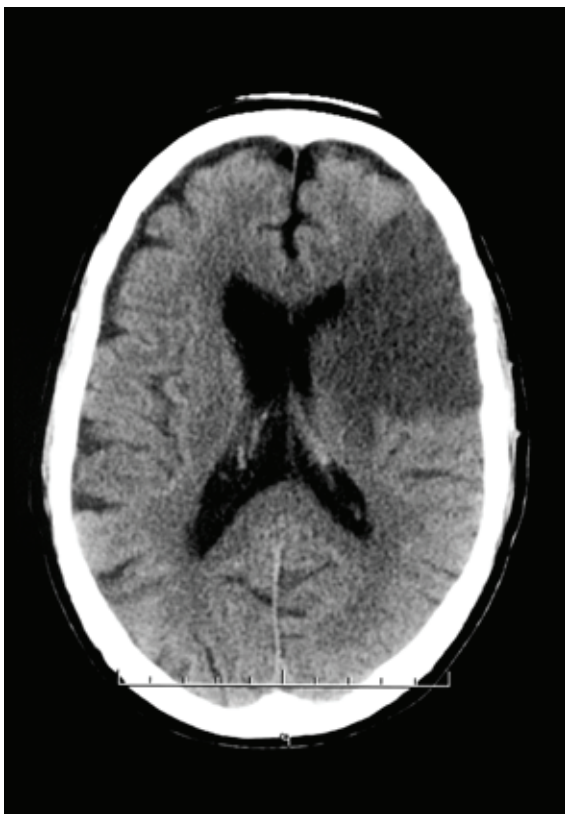
The Case

A 50-year-old male with no known past medical history is brought to the emergency department by EMS after his wife found him down with right-sided flaccidity and aphasia. A prehospital stroke code was called in the field. Upon arrival, the patient is found to have no movement in the right upper or lower extremity, a left sided gaze, and complete aphasia. Computed tomography (CT) without contrast was performed and revealed a large left middle cerebral artery (MCA) thrombosis with infarct and bilateral subarachnoid hemorrhages. Tissue plasminogen activator (tPA) is not given due to subarachnoid hemorrhage. Neurointervention is consulted and brings the patient to the angiography suite to perform an endovascular thrombectomy extending from the terminus of the left internal carotid artery (ICA) to the left MCA. Following thrombectomy, the patient has good blood flow to left ICA and MCA.

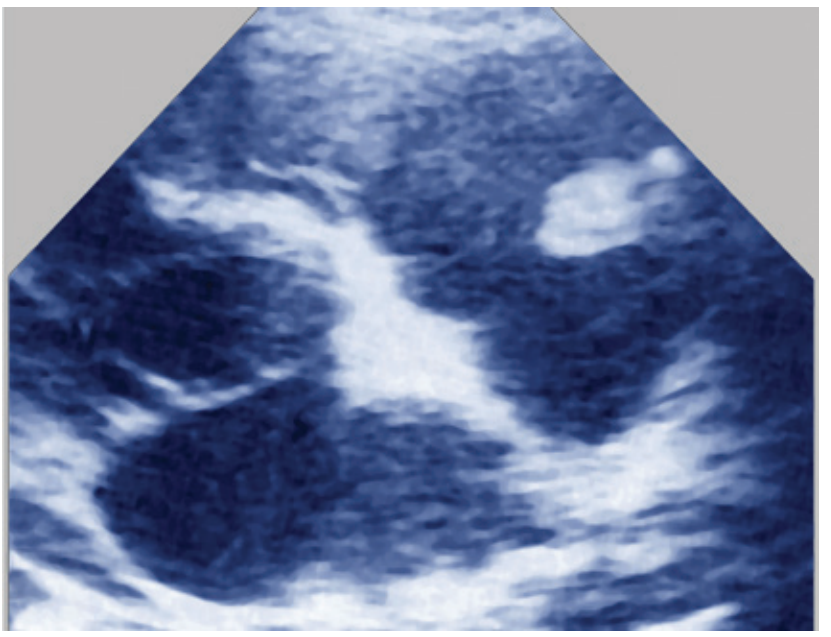
Slam-dunk stroke code with resolution of the cause?

History obtained from the wife shortly after the patient's admission reveals that, over the previous six months, the patient had experienced intermittent fevers, night sweats, and a 25-pound weight loss. She adds that the patient recently emigrated from the Dominican Republic, where he had been evaluated for these symptoms, though he was never given a definitive diagnosis.

The patient subsequently receives a transesophageal echocardiogram, which reveals a bicuspid aortic valve with vegetations and mitral valve abscess. He is started on empiric antibiotics for endocarditis. Blood cultures grow *Streptococcus mitis*. The patient has a complicated recovery requiring percutaneous endoscopic gastrostomy tube placement, physical therapy, and daily intravenous antibiotics. Despite a complicated course over the period of a month, the patient has relative improvement in symptoms, begins to move his right upper and lower extremities, and regains his speech, but with dysphasia. He is discharged to a subacute rehabilitation facility with the diagnosis of a left MCA stroke secondary to septic embolus from infective endocarditis.



MEDICAL BODY SCANS/SCIENCE SOURCE



JAMES CAVALLINI

LEFT: Axial nonenhanced CT of the head shows acute middle cerebral artery infarction.

ABOVE: Cardiac ultrasound of infectious endocarditis. Note the vegetation in the trunk of the pulmonary artery.

Causes of Stroke

Stroke is a common presentation to the emergency department. Most emergency physicians are well versed with the presentation and are trained to think stroke with thrombus means give tPA (controversy aside). However, the presumption of traditional ischemic stroke in all patients with stroke-like symptoms can result in disastrous consequences.

Ischemic strokes can be subdivided:

1. Thrombotic
   a. Local obstruction of an artery that can be due to a variety of causes, most commonly atherosclerosis
   b. Most commonly occur in older patients
2. Embolic
   a. Refers to a stroke that presents after an obstruction from particles or clot that originated in a different part of the body

Clinically, both of these ischemic entities are treated similarly in the emergency department. If there is an occlusion and the patient has no signs of bleeding and falls into the appropriate time frame, tPA should be strongly considered. Depending on your institution, there should also be consultation with neurosurgery and neuro-intervention for potential thrombolysis, but that's not the end of the evaluation.

Embolic stroke has multiple causes and can arise from the heart, aorta, or any large vessel. In this subset, we have the opportunity for further investigation and potential early intervention. Factors that suggest embolic stroke, triggering us to begin thinking of other causes, include:[1]

- Sudden and maximal onset of stroke symptoms
- Decreased level of consciousness
- Large vessel occlusion (anterior, middle, or posterior cerebral arteries, and the carotid, vertebral, or basilar arteries)
- Wernicke or global aphasia without hemiparesis

In a patient where embolic stroke is suspected, additional workup is warranted and may benefit the patient. A full set of vital signs (including a temperature), ECG, laboratory diagnostics, CT angiography of the brain extending from the aortic arch, a bedside echocardiogram or point-of-care ultrasound, and possible early cardiology consultation are essential components of the evaluation. Treatment decisions must be in concert with neurology colleagues.

Common treatable causes of embolic stoke seen in the emergency department include:

- New-onset atrial fibrillation
- Recent myocardial infarction
- Infective endocarditis with septic emboli
- Carotid, vertebral, basilar, or aortic dissection

Along with true cerebrovascular accident, emergency physicians must be aware of the many potential stroke mimics. The list is not exhaustive, but some common mimics include hypoglycemia, Todd's paralysis, migraines, malignancy, factitious disorder/malingering, and many others.[2,3] Prior to heading down a typical stroke treatment algorithm, pause to consider these alternative diagnoses.

Discussion

Cerebrovascular accident is a commonly encountered and severely debilitating disease. As we protocolize early stroke management, diagnostic anchoring to "just" a stroke and lack of investigation into stroke mimics or secondary causes of stroke are real risks. Strokes that are embolic in nature can originate from a variety of causes, which will likely alter the overall approach and management of the patient. It is imperative that emergency physicians identify which patients may have an embolic stroke and investigate for reversible or treatable causes. Although not every stroke patient will have a source identified beyond traditional atherosclerotic disease, consideration of secondary causes has the potential to benefit our patients greatly. In short, all strokes are not created equal.

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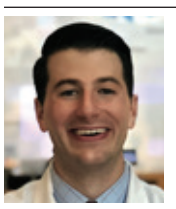
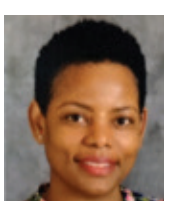


DR. ISENBURG is an emergency medicine resident at St. Joseph's University Medical Center in Paterson, New Jersey.



DR. BOOTHE is an emergency and palliative care physician at St. Joseph's University Medical Center.

RESOURCES FOR FURTHER READING

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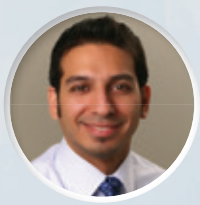

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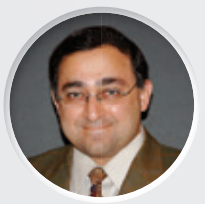

SPEAKER:
Amal Mattu MD, FAAEM
Vice Chair of Academic Affairs
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CONTINUED FROM PAGE 1

MEET THE ACEP BOARD OF DIRECTORS CANDIDATES

PLATFORM STATEMENTS

The following members are candidates for the Board of Directors. They responded to this question:

What do you believe is the single most divisive issue in ACEP at this time, and how would you address it?

Michael Baker, MD, FACEP (Michigan)

Current Professional Positions: director of telehealth, EPMG/Envision; medical director, Munson Healthcare Cadillac Hospital, Cadillac, Michigan; clinical assistant professor, Michigan State University College of Osteopathic Medicine, East Lansing; adjunct clinical instructor, University of Michigan College of Medicine, Ann Arbor; attending physician, St. Joseph Mercy Hospital, Ann Arbor; core faculty, University of Michigan/St. Joseph Mercy Hospital emergency medicine residency
Internships and Residency: emergency medicine residency, University of Michigan
Medical Degree: MD, Ohio State University, Columbus (1993)

Response

What is the value of emergency board certification when physicians without emergency medicine certification and advanced practice providers (APPs) care for emergency patients? In the 1990s, the closure of the practice track to EM board certification created a schism within emergency medicine between boarded and nonboarded emergency physicians. Meanwhile, ACEP promoted the value of EM board certification. Today, the notable use of APPs and nonemergency boarded physicians has reopened the divisive debate on whether emergency board certification is required to independently care for emergency center patients.

A provider who is not boarded in emergency medicine has neither standardized education nor a certification process in the care of emergency patients, yet we are seeing these providers take an independent role in caring for emergency patients. Emergency patients in the United States are seen by a mix of both emergency physicians and nonemergency providers. An *Annals of Emergency Medicine* 2018 study revealed that emergency physicians provide two-thirds of the care delivered in the emergency center. Meanwhile, the remaining 33 percent of care was delivered by nonemergency physicians (family medicine and internal medicine) and by APPs.

It doesn't need to be this way. No other medical provider has the mastery of boarded emergency physicians in the evaluation, diagnosis, and management of acute care issues. ACEP has remained steadfast in its statement that the independent practice of emergency medicine is best performed by a boarded (or board-eligible) emergency physician. Formal residency training and board certification have both been researched and improved over the decades. As a result, emergency medicine residencies and board certification remain integral to ensuring the quality of emergency care delivery. Nevertheless, physician shortages and market pressures have encouraged the use of other care providers in many emergency centers.

To prevent this divisive issue from growing into a schism, ACEP will need insightful leadership to navigate three significant areas. We must narrow the need for providers who are not boarded EM physicians, develop a collaborative environment with such providers, and explore the efficiencies of telemedicine. We can ensure a large, diverse emergency physician workforce by advocating for funding of additional residency training opportunities (especially in underserved areas), supporting board certification improvements, and fighting the causes of burnout that lead to early retirements such as burdensome documentation and the public undervaluing of emergency services by payers.

Second, ACEP needs to review its existing practice policy statements and work with key organizations to ensure policies and practice models that support an evidence-based collaborative care environment with APPs, including training and certification recommendations.

Lastly, ACEP needs to explore the potential for new technologies such as telemedicine and digital health to help emergency physicians efficiently collaborate in the care of an increasingly complex emergency patient population by maximizing the ability to digitally connect emergency patients, APPs, and non-EM physicians with EM boarded physicians.

With insightful ACEP leadership on this divisive issue, we will achieve the ideal of anything, anytime, anyone emergency care provided by a board-certified emergency physician for all emergency patients.

Jeffrey Goodloe, MD, FACEP (Oklahoma)

Current Professional Positions: attending emergency physician, Hillcrest Medical Center Emergency Center, Tulsa, Oklahoma; professor of emergency medicine, EMS section chief, and director, Oklahoma Center for Prehospital & Disaster

CONTINUED *on page 9*

Medicine, University of Oklahoma School of Community Medicine, Tulsa; chief medical officer, medical control board, EMS System for Metropolitan Oklahoma City & Tulsa; medical director, Oklahoma Highway Patrol; medical director, Tulsa Community College EMS Education Programs

Internships and Residency: emergency medicine residency, Methodist Hospital of Indiana/Indiana University School of Medicine, Indianapolis; EMS fellowship, University of Texas Southwestern Medical Center, Dallas

Medical Degree: MD, Medical School at University of Texas Health Science Center at San Antonio (1995)

Response

I am concerned about the potential threat to civility and decorum within our College given we are increasingly exposed to ad hominem thoughts, commentary, and actions occurring in our larger society. Divisiveness itself may become the single most divisive dynamic within ACEP. We may not achieve, or even need, a formal policy on every issue that catches our attention. The manner with which we responsibly navigate our deliberations, respecting one another, being inclusive in more than words, sincerely valuing one another—the future of our College depends upon us doing so.

Firearms injuries. Gun violence. Responsible gun ownership. These phrases bring immediate emotions palpably disparate within society, which are reflected within our College. Disparity can, and often does, foster divisiveness. A trusted colleague advised, "You'll be okay in your Board candidacy as long as you stay away from firearms." Just two weeks later, I was asked a pointed question regarding gun violence. My approach to addressing this and other divisive issues as a candidate for your Board of Directors is clear. I cannot and will not avoid issues that so critically affect our patients and practices, particularly those that engender strong opinions from our members.

As one ACEP member, I certainly am not going to resolve such a complex issue with a few words. Surely, as emergency physicians, we can work to a point of consensus, with due concern about gun-related violence while advocating for evidence-based injury prevention based upon scientifically valid research. As an elected ACEP Board member, I will actively engage in consensus building on this and other polarizing issues affecting our patients, all of us, and society as a whole.

First, for ACEP to pursue formal policy on any issue, the issue must impact the health of our patients or be of legitimate interest to the practice of emergency medicine and emergency physicians. Regardless of facility size or one's practice setting, most emergency physicians manage preventable gunshot wounds. Clearly, violence involving firearms is an issue for us and our patients.

Second, ACEP must utilize nonbiased data when constructing formal ACEP policy. Even casual consumers of media in any of its forms can be inundated with a dizzying volume of statistics regarding firearms—strongly pro, strongly con, and everywhere in between. ACEP leaders must use credible resources to parse related data carefully, exclude biased research, discard vitriolic rhetoric, confirm valid research, and advocate for research in unvetted areas of importance.

Third, ACEP must act transparently when developing formal policy. Lack of transparency begets lack of confidence begets loss of trust.

Using these tenets in drafting policy, the Board of Directors can then act responsibly in representing members.

Whether firearms injury prevention, gender-related pay and opportunities, contract management group impacts, board certification requirements, or any of the other myriad issues where opinions can vary widely, we must always remember we are all emergency physicians. We must genuinely respect one another, listening with an open mind, valuing the commitments each of us makes to our specialty and to humanity.

Rachelle (Shelley) Greenman, MD, FACEP (NJ)

Current Professional Positions: assistant professor of emergency medicine, Cooper Medical School of Rowan University, Camden, New Jersey

Internships and Residency: internal medicine internship, Montefiore Hospital, Bronx, New York; internal medicine residency, Montefiore Hospital; emergency medicine residency, Jacobi Hospital/Bronx Municipal Hospital Center, Albert Einstein College of Medicine, Bronx

Medical Degree: MD, New Jersey Medical School University of Medicine and Dentistry, Newark (1985)

Response

While there are many issues confronting us that are controversial and divisive, there are few that rival the topic of gun control in its ability to create contention and instigate dispute, as evidenced by two articles published in the May 2019 issue of *ACEP Now*.

The front-page article by Dr. Megan Ranney emphasized that, as professionals, firearm injury affects us all, outlining actions already undertaken by ACEP, including education and advocacy efforts to improve public safety. Several pages later, Dr. Marco Coppola's response suggested that the firearm issue is "less about patient safety than about furthering a political agenda." He writes that ACEP "runs the risk of alienating a good number of members" and "should stay out of divisive issues."

A 2018 NBC/*Wall Street Journal* poll found that 80 percent of registered voters believed the country was divided. So, it would come as no surprise that ACEP members are also divided on many issues. As emergency medicine physicians, our obligation is to safeguard and protect our patients and our communities. Patient welfare must always be our top priority even though this may require putting aside partisan leanings and influences.

In a 2018 *WSJ* op-ed, James A. Baker III wrote, "We have become an evenly divided red-state, blue-state nation more intent on waging political battles than finding ways to advance the common good."

One need simply recall the straw polls taken at Council preceding the last few presidential elections and note that we, in ACEP, were split virtually down the middle. Despite this, we seem to be able to put aside our differences and focus on doing the right thing for public health and safety.

If we approach any rift with an "us vs. them" attitude, it is unlikely progress will be made. Reframing the gun control discussion as one aimed at reducing injury and death by addressing firearm safety and gun violence without infringing upon the right to own and use firearms will encourage bipartisan conversation and meaningful compromise.

Fortunately, there is history of reaching common ground that can be used as a template for further progress. A 2018 ACEP member survey found that almost 70 percent of respondents supported the current ACEP policy on firearm safety and prevention, with an additional 21 percent supporting some of the policy.

There will always be issues that we disagree on, but with identification of common ground, calm discussion, mutual respect, education, and sincere effort to understand each other's perspectives, we can work together to effect constructive change. Much can be gained by creating a safe, nonjudgmental environment to express opinions, focusing on big-picture, long-term goals by making small, mutually agreeable compromises. Rather than a "winner take all" mentality, there must be recognition that we are all on the same team working toward a mutual goal. ACEP must work with all concerned to develop a consensus approach incorporating the many different viewpoints in an effort to move forward toward meaningful progress.

Gabor Kellen, MD, FACEP (AACEM)

Current Professional Positions: chair, department of emergency medicine, Johns Hopkins University, Baltimore; physician-in-chief, emergency medicine, Johns Hopkins Medicine; director, Johns Hopkins Office of Critical Event Preparedness and Response; chair, Board of Directors, Johns Hopkins Emergency Medicine Service, LLC; principal staff, Applied Physics Laboratory, Johns Hopkins University; professor of emergency medicine, anesthesiology, and critical care medicine, Johns Hopkins University School of Medicine; professor of health policy and management, Johns Hopkins University School of Public Health

Internships and Residency: internship, University of Toronto, St. Michael's Hospital; residency, University of Toronto, St. Michael's Hospital; emergency medicine residency, Johns Hopkins Hospital

Medical Degree: MD, University of Toronto (1979)

Response

I don't much like focusing on issues that divide us and would rather spend the energy on promoting factors that unite us and keep us as a cohesive body to further the field of emergency medicine for the betterment of patients, physicians, and our allied staff.

That said, there is an issue, perhaps so permeating, that most do not recognize that it is an issue at all—or that it is divisive. Emergency medicine no longer has a unifying defining purpose. There is a multiplicity of purposes, each organization coveting and protective of its uniqueness or niche. There are over 225 EM residencies, and over 75 percent of universities have established autonomous academic departments. Today, EM personalities can dominate an institution. EM has been a primary specialty now for more than 30 years. EM physicians are health system CEOs, state and national surgeon generals, deans of medical schools, entrepreneurs, etc. More and more distinct niche societies allied or stemming from EM wish a strong degree of autonomy and identity.

In its most formative days, pressing the advancement of and seeking recognition as a respected specialty was the clarion call that united virtually all of EM in a singular purpose. In many ways, this was akin to pursuing legitimacy and acceptance, the basis for most social and civil rights movements. This purpose drove the founders and legacy physicians and influenced at least two generations to advance the field. Today, the ascendancy of EM and its rightful place in medicine are not questioned any more than the usual (and unfortunate) disparagement of some specialty members toward another specialty—and sometimes we ourselves give as much as we take.

So, what does this have to do with divisiveness? Since we are not all rowing in the same direction, and don't particularly have unifying purpose for the specialty, many of our members are adrift. Those of us on Council and leaders of ACEP are generally driven by a strong purpose to improve the lives of our patients and members. But a perusal of EM blogs and other social media discourse reveals that many in EM (including many ACEP members) are adrift. Many feel like they are simply a cog in some organization, without voice and without meaning in their work, simply "processing" patients while having to perform to various metrics—many of which have nothing to do with clinical acumen or patient engagement.

Reinvigorating commonality of purpose such that daily lives of emergency physicians have meaning is not a simple task. However, given the enormity of the situation, even if very underrecognized, solutions are worth exploring. We could start by soliciting suggestions from our members and reaching out to other EM-linked societies. One option would be to convene a summit of sorts with leaders and constituents from the various EM entities (big and small) to allow us to take stock, reaffirm commonality, and develop a new shared vision that a strong majority of emergency physicians can back with energized conviction.

Pamela Ross, MD, FACEP (VA)

Current Professional Positions: CEO and sole proprietor, Holistic Medical Consultants, LLC, Troy, Virginia

Internships and Residency: emergency medicine residency, St. Vincent Medical Center, Toledo, Ohio; pediatric emergency medicine fellowship, Inova Fairfax Medical Campus, Falls Church, Virginia; integrative medicine fellowship, University of Arizona Center for Integrative Medicine, Tucson

Medical Degree: MD, Emory University School of Medicine (1991)

Response

ACEP operates democratically by majority vote of ACEP members present and participating in the ACEP Council. The Council is the collective representation of our membership and includes all states, sections, and other similarly aligned EM organizations like EMRA. The Council democratically elects, advises, and instructs the Board of Directors regarding any matter of importance to any ACEP member. The Council accomplishes this through bylaws, resolutions, and any other action the Council deems necessary. Once elected, management and control of the organization is officially vested in the Board of Directors. If there be any confusion or concern for how we have arrived to where we are on any issue in ACEP today, remember that power in ACEP (as it historically and currently stands) is held solidly in the proceedings of the ACEP Council.

Based on the proceedings of the last official meeting of the Council held October 2018 in San Diego, bearing witness to the political nature of debate and the deeply divided Council deliberations, the single most divisive is-

sue in ACEP at this time is our ACEP Policy on Firearm Safety and Injury Prevention, where Council directed this already-existing policy be updated. There were 51 resolutions presented. While there were about seven other resolutions that rose to similar levels of contention, my selection is validated by opposing articles written by Dr. Megan Ranney and Dr. Marco Coppola, published in the May 2019 issue of *ACEP Now*.

We won't get around divisive topics within our organization by carrying on as if they do not exist. We are equally challenged if we try to ignore one side of an issue. We are currently living in deeply divided times and, in the wisdom of Gandhi, world-renowned activist, "Unity, to be real, must stand the severest strain without breaking." It is important to exercise due diligence to identify all the ways we can stand united. My methods as a leader to address issues of deep organizational division in search of organizational unity include but are not limited to:

- Start with me as a leader—poised, open-hearted, collaborative, diplomatic, respectful, strong, and committed to the vision and values of ACEP.
- Conduct well-researched, unbiased, scientifically validated surveys of Council and/or membership.
- Promote *EngagED* member feedback and discussion in our 38,700 ACEP members-only online community, https://engaged.acep.org/home.
- Facilitate town halls or other meeting forums where members can engage through activities like opposing panel presentations, group discussions, round tables, etc.
- Feature opposing articles, research, letters to the editor, etc. in ACEP publications.
- Support and facilitate communication between ACEP Board, committees, task forces, chapters, sections, etc. to assure alignment of referred resolutions with ACEP mission/vision.
- Systematically review and facilitate exploration/development of resolutions that change organizational operations in ways that most effectively meet member needs and bring the largest possible collective member voice to ACEP.
- Continually support and encourage member patience and participation in the process.
- Courageously lead in the direction that Council/membership would have our organization go.

Gillian Schmitz, MD, FACEP (incumbent, Government Services)

Current Professional Positions: associate professor, department of military and emergency medicine, F. Edward Hébert School of Medicine, Uniformed Services University, Bethesda, Maryland; adjunct associate professor, department of emergency medicine, University of Texas Health Science Center at San Antonio

Internships and Residency: emergency medicine, University of North Carolina

Medical Degree: MD, Loyola University Stritch School of Medicine, Chicago (2004)

Response

The single most divisive issue in ACEP is our response, as an organization, to address firearm safety. Many members feel this is an important public health issue that ACEP should take the lead on. Others feel this is a political topic that is outside the scope of the College and any action has the potential to alienate members on both sides. Historically, ACEP members have been split on this issue, which has been reflected in the passion and emotionally charged discussions of our members and debate on 23 prior Council resolutions.

This is not about furthering a political agenda but rather addressing a national public health issue. This does not need to be a partisan clash of ideals. The American College of Surgeons (ACS) recently tackled this by surveying all of its members with a robust survey method to guide their advocacy efforts and found their members agreed on much more than they disagreed on. Having objective data with high response rates will help ACEP have better direction and transparency about the current viewpoints of our members. Heaven forbid—if the surgeons can agree and make decisions without a white blood cell count or pan scan, imagine what we can do!

ACEP is composed of a politically diverse membership. The College aims to support bipartisan advocacy issues that impact emergency medicine, our patients, and our members. We don't take sides or support "red" or "blue" issues unilaterally. We support patients, our colleagues, and our specialty. Sometimes the lines of what falls under the EM umbrella can be blurred with politically charged topics, but I believe public health and patient safety are core elements of emergency medicine, and we can find solutions and common ground if we focus on what is best for patients. That's what we do best.

Rather than fighting over 20 percent of firearm issues where we disagree, we should be spending more time and energy moving

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ANDEXXA has not been shown to be effective for, and is not indicated for, the treatment of bleeding related to any FXa inhibitors other than apixaban or rivaroxaban.

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WARNING: THROMBOEMBOLIC RISKS, ISCHEMIC RISKS, CARDIAC ARREST, AND SUDDEN DEATHS

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Treatment with ANDEXXA has been associated with serious and life-threatening adverse events, including:

- **Arterial and venous thromboembolic events**
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- **Cardiac arrest**
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Monitor for thromboembolic events and initiate anticoagulation when medically appropriate. Monitor for symptoms and signs that precede cardiac arrest and provide treatment as needed.

WARNINGS AND PRECAUTIONS

Thromboembolic and Ischemic Risks

The thromboembolic and ischemic risks were assessed in 185 patients who received the Generation 1 product and in 124 patients who received the Generation 2 product. The median time to first event was six days, and patients were observed for these events for 30 days following the ANDEXXA infusion. Of the 86 patients who received Generation 1 product and were re-anticoagulated prior to a thrombotic event, 11 (12.7%) patients experienced a thromboembolic, ischemic event, cardiac event or death.

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the ball forward on the 80 percent of solutions we all agree on. The focus is not on gun control but rather preventing firearm injury. Whether you own a gun or not, we should all be on the same side here. We are industry leaders in addressing other public health issues including reducing mortality from opioids and car accidents. Investing in research, studying the impact of legislation in several states that enacted extreme risk protection orders (ERPOs), enforcing existing laws on firearm safety, and reviewing the data in the medical, economics, and criminal justice literature are objective ways we can be proactive. Studying and enforcing interventions that improve outcomes for patients is "our lane." We need to work together, collaboratively and respectfully, to understand our differences, find common ground, and advocate for what will enhance our ability to care for our patients.

Ryan Stanton, MD, FACEP (Kentucky)

Current Professional Positions: emergency physician, Central Emergency Physicians, Lexington, Kentucky; EMS medical director, Lexington-Fayette Urban County Government; public safety medical director, Blue Grass Airport, Lexington; Kentucky and Florida medical director, AirMed International

Internships and Residency: surgery internship, James H. Quillen College of Medicine, Johnson City, Tennessee; emergency medicine residency, University of Kentucky

Medical Degree: MD, James H. Quillen College of Medicine (2003)

Response

We have so many challenges with varying degrees of divisiveness and angst among our members and leadership. Several recurring themes include diversity, guns, politics, wellness, staffing, and engaging future emergency physicians. Thankfully, I believe the majority of our members and leadership are working diligently to address many of these issues and find common ground to move forward. Bold discussions and growing diversity within our College are a couple of our greatest strengths and are working to address many of these challenging topics within emergency medicine.

However, I believe the most widespread area of divisiveness across the country specifically related to ACEP and our members is the future direction of health care with regard to politics, structure, and our role in that system. The political environment within the United States is a potential powder keg at every turn. With the history of emergency medicine and its evolution over the last number of years, we are now at a tipping point where change MUST happen. We are currently dealing with legislation regarding out-of-network billing that could cut a quarter to a third of our income and potentially impact future employment and patient access to care. The initial insurance industry–driven bill could have been devastating to our practice, allowing

CONTINUED *on page 12*

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2 min

Rapid reversal of anti-FXa activity within 2 minutes

following bolus administration in older, healthy volunteers on apixaban or rivaroxaban.[1,2]

Expert guidance recommends Andexxa for first-line therapy to reverse apixaban or rivaroxaban in patients with life-threatening or uncontrolled bleeds.[3]

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Thromboembolic and Ischemic Risks (continued)
Monitor patients treated with ANDEXXA for signs and symptoms of arterial and venous thromboembolic events, ischemic events, and cardiac arrest. To reduce thromboembolic risk, resume anticoagulant therapy as soon as medically appropriate following treatment with ANDEXXA.

The safety of ANDEXXA has not been evaluated in patients who experienced thromboembolic events or disseminated intravascular coagulation within two weeks prior to the life-threatening bleeding event requiring treatment with ANDEXXA. Safety of ANDEXXA also has not been evaluated in patients who received prothrombin complex concentrates, recombinant factor VIIa, or whole blood products within seven days prior to the bleeding event.

Re-elevation or Incomplete Reversal of Anti-FXa Activity
The time course of anti-FXa activity following ANDEXXA administration was consistent among the healthy volunteer studies and the ANNEXA-4 study in bleeding patients. Compared to baseline, there was a rapid and substantial decrease in anti-FXa activity corresponding to the ANDEXXA bolus. This decrease was sustained through the end of the ANDEXXA continuous infusion. The anti-FXa activity returned to the placebo levels approximately two hours after completion of a bolus or continuous infusion. Subsequently, the anti-FXa activity decreased at a rate similar to the clearance of the FXa inhibitors.

Thirty-eight patients who received the Generation 1 product were anticoagulated with apixaban and had baseline levels of anti-FXa activity >150 ng/mL. Nineteen of these 38 (50%) patients experienced a > 93% decrease from baseline anti-FXa activity after administration of ANDEXXA. Eleven patients who were anticoagulated with rivaroxaban had baseline anti-FXa activity levels > 300 ng/mL. Five of the 11 patients experienced a > 90% decrease from baseline anti-FXa activity after administration of ANDEXXA. Anti-FXa activity levels for patients who received the Generation 2 product were not available.

ADVERSE REACTIONS

The most common adverse reactions (≥ 5%) in patients receiving ANDEXXA were urinary tract infections and pneumonia.

The most common adverse reactions (≥ 3%) in healthy volunteers treated with ANDEXXA were infusion-related reactions.

Immunogenicity
As with all therapeutic proteins, there is the potential for immunogenicity. Using an electrochemiluminescence (ECL)-based assay, 145 Generation 1 ANDEXXA-treated healthy subjects were tested for antibodies to ANDEXXA as well as antibodies cross-reacting with Factor X (FX) and FXa. Low titers of anti-ANDEXXA antibodies were observed in 26/145 healthy subjects (17%); 6% (9/145) were first observed at Day 30 with 20 subjects (14%) still having titers at the last time point (Days 44 to 48). To date, the pattern of antibody response in patients in the ongoing ANNEXA-4 study who received the Generation 1 product has been similar to that observed in healthy volunteers with 6% (6/98) of the patients having antibodies against ANDEXXA. None of these anti-ANDEXXA antibodies were neutralizing. No antibodies cross-reacting with FX or FXa were detected in healthy subjects (0/145) or in bleeding patients (0/98) to date. There is insufficient data to assess for the presence of anti-ANDEXXA antibodies for subjects who received the Generation 2 product.

To report SUSPECTED ADVERSE REACTIONS, contact Portola Pharmaceuticals, Inc. at 1-866-777-5947 or the FDA at 1-800-FDA-1088 or www.fda.gov/medwatch.

References: 1. ANDEXXA [prescribing information]. South San Francisco, CA: Portola Pharmaceuticals Inc.; 2018. **2.** Siegal DM et al. *N Engl J Med*. 2015;373(25):2413-2424. **3.** American College of Cardiology. Guidance for anticoagulation reversal. https://www.acc.org/~/media/Non-Clinical/Images/Tools and Practice Support/Mobile Resources/ManageAnticoag/B18120_ManageAnticoag_App_Fact_Sheet.pdf. Updated July 2018. Accessed November 15, 2018.

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them to further drive down reimbursement to unsustainable levels. There are many fingers pointing to US as the problem and not the many other hands in the pockets of our patients and practices.

Emergency physicians from around the country have come together to advocate for our specialty and our patients. It is the most united I have seen our profession in quite some time. With my experience in Kentucky and Washington, D.C., during these discussions, I see the need and power of unity in emergency medicine, even if we don't always see eye to eye.

Unfortunately, there are pretty defined lines within the political world based on right and left with special interests at every turn. That is why physicians must evolve from our historically introverted nature to become a larger and more vocal advocacy group for improved access to care, efficiency in practice, and protections allowing focus on evidence based practice. Emergency physicians must be the leaders of the house of medicine, within our departments, within our hospitals, and at all levels of policy development. We have the "best seat in the house" when it comes to the health and condition of our system and the evolving needs of our patients.

One of the greatest gifts of ACEP is the diversity of beliefs, but this also means that the debate on the direction of the health care system can be a very contentious topic. We must work together, with our primary focus, no matter the politics, being our patients and the future of our profession.

Thomas J. Sugarman, MD, FACEP (California)

Current Professional Positions: emergency physician and chair of emergency services, Sutter Delta Medical Center, Antioch, California; senior director of government affairs, Vituity, Emeryville, California; urgent care physician, East Bay Physicians Medical Group, Lafayette, California

Internships and Residency: emergency medicine residency and internship, Harbor-UCLA Medical Center

Medical Degree: MD, University of Illinois at Chicago (1989)

Response

ISSUE: ACEP's most divisive issue is that many members and potential members perceive that partisan interests drive ACEP's agenda. Interestingly, many of the partisanship concerns are contradictory, with some believing ACEP is biased in one direction and some seeing prejudice on the other side. Distress over partisanship manifests as a sense of anger or apathy—"it does not matter, it's out of my control." This limits both member engagement and ACEP membership.

Emergency physicians often have different viewpoints based on practice setting—rural vs. urban, tertiary hospital vs. referral hospital, big group vs. small group, doctor-owned v. non-doctor-owned group, or academic vs. nonacademic. Like all specialists, emergency physicians' divergent views reflect the highly partisan national political environment that engenders political gridlock. I observe some physicians not supporting or joining ACEP because they disagree with ACEP's position/lack of a position on a particular issue or politician. But ACEP cannot be a single-topic organization because all of our members have different single issues.

SOLUTIONS: ACEP must evaluate issues and our agenda using two principles. First, is it of primary importance to emergency physicians' practices? Second, is the topic particular to providing emergency care rather than an interest of just some emergency physicians? If other organizations can address a problem, then ACEP should tread carefully. Since everybody is potentially an emergency patient, all issues are significant to some emergency physicians. But by focusing on concerns meeting the criteria of both directly relevant to emergency physicians and limited to emergency medicine, ACEP can be more effective. We cannot allow ACEP's efforts to be undermined by partisanship nor distracted by issues not unique to emergency medicine.

Transparent decision making is paramount. Over the last few years, ACEP markedly improved its communication and messaging to members. ACEP redesigned its website, distributes multiple newsletters, and maintains a strong social media presence. ACEP does a great job reporting its activities and positions. Going forward, we should better explain the process, criteria, and reasoning behind our decisions. This will dispel the notion that ACEP makes partisan decisions. ACEP's goals are to ensure emergency physician practices remain economically viable and fulfilling, allowing us to provide our patients quality emergency care.

As a member of your Board of Directors, I pledge to improve transparency so all members feel they have influence and access to the reasoning behind ACEP's decisions. I will work for ACEP to target matters of common interest to all board-certified emergency physicians. This will improve our cohesiveness and increase membership, making ACEP more effective at representing emergency physicians' issues.

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See full prescribing information for complete boxed warning
Treatment with ANDEXXA has been associated with serious and life threatening adverse events, including:
- **Arterial and venous thromboembolic events**
- **Ischemic events, including myocardial infarction and ischemic stroke**
- **Cardiac arrest**
- **Sudden deaths**

Monitor for thromboembolic events and initiate anticoagulation when medically appropriate. Monitor for symptoms and signs that precede cardiac arrest and provide treatment as needed.

INDICATIONS AND USAGE

ANDEXXA is indicated for patients treated with rivaroxaban or apixaban, when reversal of anticoagulation is needed due to life-threatening or uncontrolled bleeding.

This indication is approved under accelerated approval based on the change from baseline in anti-FXa activity in healthy volunteers. An improvement in hemostasis has not been established. Continued approval for this indication may be contingent upon the results of studies to demonstrate an improvement in hemostasis in patients.

Limitation of Use

ANDEXXA has not been shown to be effective for, and is not indicated for, the treatment of bleeding related to any FXa inhibitors other than apixaban or rivaroxaban.

CONTRAINDICATIONS

None.

WARNINGS AND PRECAUTIONS

Thromboembolic and Ischemic Risks

The thromboembolic and ischemic risks were assessed in 185 patients who received the Generation 1 product and in 124 patients who received the Generation 2 product. The median time to first event was six days, and patients were observed for these events for 30 days following the ANDEXXA infusion. Of the 86 patients who received Generation 1 product and were re-anticoagulated prior to a thrombotic event, 11 (12.7%) patients experienced a thromboembolic, ischemic event, cardiac event or death.

Monitor patients treated with ANDEXXA for signs and symptoms of arterial and venous thromboembolic events, ischemic events, and cardiac arrest. To reduce thromboembolic risk, resume anticoagulant therapy as soon as medically appropriate following treatment with ANDEXXA.

The safety of ANDEXXA has not been evaluated in patients who experienced thromboembolic events or disseminated intravascular coagulation within two weeks prior to the life-threatening bleeding event requiring treatment with ANDEXXA. Safety of ANDEXXA also has not been evaluated in patients who received prothrombin complex concentrates, recombinant factor VIIa, or whole blood products within seven days prior to the bleeding event.

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ADVERSE REACTIONS

The most common adverse reactions (≥ 5%) in patients receiving ANDEXXA were urinary tract infections and pneumonia.

The most common adverse reactions (≥ 3%) in healthy volunteers treated with ANDEXXA were infusion-related reactions.

Clinical Trials Experience

Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in the clinical trials of a drug cannot be directly compared to rates in the clinical trials of another drug and may not reflect the rates observed in clinical practice.

In the pooled safety analysis of clinical trials of ANDEXXA, 223 healthy volunteers received FXa inhibitors followed by treatment with ANDEXXA. The frequency of adverse reactions was similar in the ANDEXXA-treated group (120/223, 54%) and the placebo-treated group (54/94, 57%). Infusion-related adverse reactions occurred in 18% (39/223) of the ANDEXXA-treated group, and was the only adverse reaction that occurred more frequently than in the placebo group. No serious or severe adverse reactions were reported.

The ANNEXA-4 study is an ongoing multinational, prospective, open-label study using ANDEXXA in patients presenting with acute major bleeding and who have recently received an FXa inhibitor. To date, safety data are available for 185 patients who received the Generation 1 product and for 124 subjects who received the Generation 2 product. Fifty-nine percent of the 185 patients who received the Generation 1 product and 69% of the 124 patients who received the Generation 2 product were older than 75 years. Patients had received either apixaban (98/185; 53%) or rivaroxaban (72/185; 40%) as anticoagulation treatment for atrial fibrillation (143/185; 77%) or venous thromboembolism (48/185; 26%). In the majority of patients, ANDEXXA was used to reverse anticoagulant therapy following either an intracranial hemorrhage (106; 57%) or a gastrointestinal bleed (58; 31%), with the remaining 21 patients (11%) experiencing bleeding at other sites. Patients were assessed at a Day 30 follow-up visit following infusion of ANDEXXA.

Deaths

In the ongoing ANNEXA-4 study, there were 25 deaths (14%) amongst the 185 patients receiving the Generation 1 product. These deaths occurred prior to the Day 30 follow-up visit. Eight patients died within ten days after the ANDEXXA infusion. The percentage of patients, by bleeding type, who died prior to the Day 30 follow-up visit was: 14% for intracranial bleeding, 10% for gastrointestinal bleeding, and 19% for other bleeding types. There were 23 deaths (18%) amongst the 124 patients who received Generation 2 that occurred prior to the Day 30 follow-up visit.

Thromboembolic Events

In the ongoing ANNEXA-4 study, 33/185 (17.8%) patients receiving the Generation 1 product experienced one or more of the following overall thromboembolic events: deep venous thrombosis (11/33; 33%), ischemic stroke (9/33; 24%), acute myocardial infarction (5/33; 15%), pulmonary embolism (5/33; 15%), cardiogenic shock (3/33; 9%), sudden death (2/33; 6%), congestive heart failure (2/33; 6%), acute respiratory failure (2/33; 6%), cardiac arrest (1/33; 3%), cardiac thrombus (1/33; 3%), embolic stroke (1/33; 3%), iliac artery thrombosis (1/33; 3%), and non-sustained ventricular tachycardia (1/33; 3%). The median time to the first event in these 33 subjects was six days. Eleven of 33 (33%) patients were on antithrombotic therapy at the time of the event. Patients who received the Generation 2 product experienced a similar rate of overall thromboembolic events (17.7%) as the Generation 1 product.

No thromboembolic events were observed in 223 healthy volunteers who received FXa inhibitors and were treated with ANDEXXA.

Infusion-related Reactions

Infusion-related reactions occurred in 18% (39/223) of ANDEXXA-treated healthy volunteers vs. 6% (6/94) of placebo-treated subjects. These reactions were characterized by a range of symptoms including flushing, feeling hot, cough, dysgeusia, and dyspnea. Symptoms were mild to moderate in severity, and 90% (35/39) did not require treatment. One subject with a history of hives prematurely discontinued ANDEXXA after developing mild hives.

Immunogenicity

As with all therapeutic proteins, there is the potential for immunogenicity. Using an electrochemiluminescence (ECL)-based assay, 145 Generation 1 ANDEXXA-treated healthy subjects were tested for antibodies to ANDEXXA as well as antibodies cross-reacting with Factor X (FX) and FXa. Low titers of anti-ANDEXXA antibodies were observed in 26/145 healthy subjects (17%); 6% (9/145) were first observed at Day 30 with 20 subjects (14%) still having titers at the last time point (Days 44 to 48). To date, the pattern of antibody response in patients in the ongoing ANNEXA-4 study who received the Generation 1 product has been similar to that observed in healthy volunteers with 6% (6/98) of the patients having antibodies against ANDEXXA. None of these anti-ANDEXXA antibodies were neutralizing. No antibodies cross-reacting with FX or FXa were detected in healthy subjects (0/145) or in bleeding patients (0/98) to date. There is insufficient data to assess for the presence of anti-ANDEXXA antibodies for subjects received the Generation 2 product.

Detection of antibody formation is highly dependent on the sensitivity and specificity of the assay. Additionally, the observed incidence of antibody (including neutralizing antibody) positivity in an assay may be influenced by several factors, including assay methodology, sample handling, timing of sample collection, concomitant medications, and underlying disease. For these reasons, comparison of the incidence of antibodies to ANDEXXA with the incidence of antibodies to other products may be misleading.

USE IN SPECIFIC POPULATIONS

Pregnancy

Risk Summary

There are no adequate and well-controlled studies of ANDEXXA in pregnant women to inform patients of associated risks. Animal reproductive and development studies have not been conducted with ANDEXXA.

In the U.S. general population, the estimated background risk of major birth defects and miscarriage in clinically recognized pregnancies is 2 to 4% and 15 to 20%, respectively.

Clinical Considerations

Labor or Delivery

The safety and effectiveness of ANDEXXA during labor and delivery have not been evaluated.

Lactation

Risk Summary

There is no information regarding the presence of ANDEXXA in human milk, the effects on the breastfed child, or the effects on milk production.

The developmental and health benefits of breastfeeding should be considered along with the mother's clinical need for ANDEXXA and any potential adverse effects on the breastfed child from ANDEXXA or from the underlying maternal condition.

Pediatric Use

The safety and efficacy of ANDEXXA in the pediatric population have not been studied.

Geriatric Use

Of the 185 patients who received the Generation 1 product in the ANNEXA-4 study of ANDEXXA, 161 were 65 years of age or older, and 113 were 75 years of age or older. Of the 124 subjects who received the Generation 2 product, 92 subjects were 75 years of age or older. No overall differences in safety or efficacy were observed between these subjects and younger patients, and other reported clinical experience has not identified differences in responses between elderly and younger patients; however, greater sensitivity of some older individuals cannot be ruled out.

The pharmacokinetics of ANDEXXA in older (65 years; n=10) patients were not different compared to younger (18-45 years; n=10) patients.

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TOGETHER, WE HEAL

New Point-of-Care App Designed to Fill Gaps

Emergency physicians collaborate to develop bedside tools for ACEP's new app

by JORDAN GRANTHAM

Emergency physicians are innate problem solvers. If they see a gap, they work to close it. When they identify a need, they figure out how to fill it. Those natural instincts, combined with a desire to help people, are the fuel for some of the most impactful clinical developments in emergency medicine.

Like most inventions, ACEP's point-of-care (POC) app was born out of necessity. Expert panels had worked tirelessly to develop valuable bedside tools for emergency physicians related to atrial fibrillation, buprenorphine use, acute pain management, and more, but feedback showed that some were unable to access those web-based tools easily during an ED shift. Sometimes, it was because of a poor internet connection; other times, it was simply having no time to stop at a desktop computer to view the tool.

Alexis LaPietra, DO, FACEP

Christopher Baugh, MD, MBA, FACEP

The usability gap was clear: We needed to improve access by circumventing the variability of the internet and making these POC tools easy to use on the move. Enter emPOC, ACEP's new native app that takes five of the most-used bedside tools—AFIB (atrial fibrillation and flutter), BUPE (buprenorphine use in the emergency department), ADEPT (agitation in the elderly), MAP (management of acute pain), and iCar2e (suicide assessment)—and puts them in your pocket. Available in Apple's App Store and Google Play, emPOC is a free app exclusively available to ACEP members.

AFib Assistance

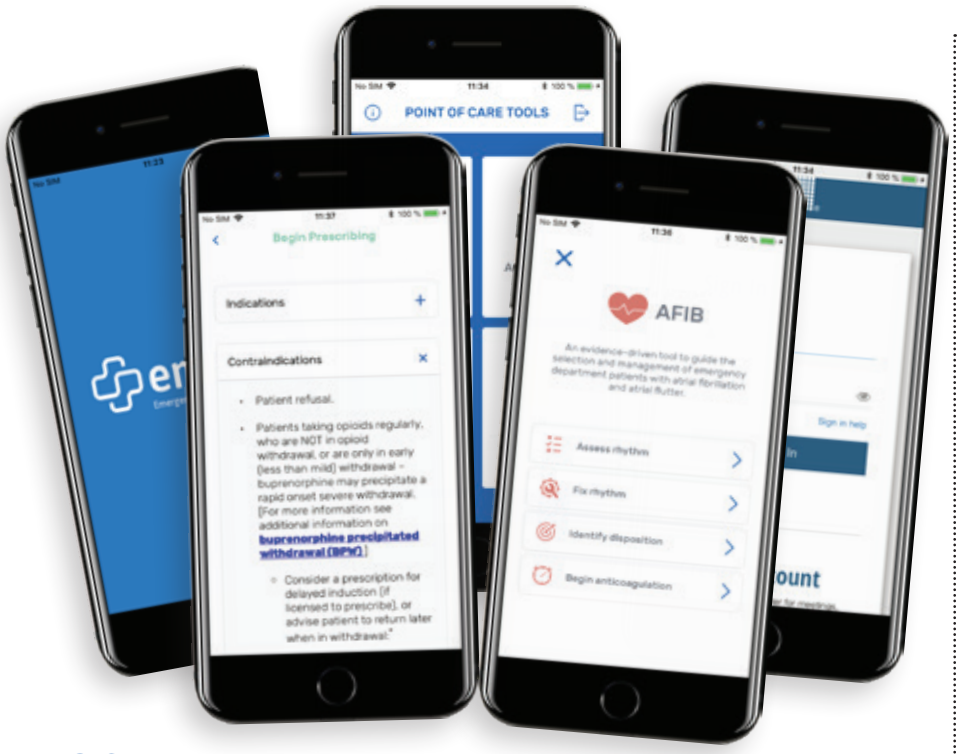
Christopher Baugh, MD, MBA, FACEP, chair of the ACEP Expert Panel on Atrial Fibrillation, has built a career on plugging gaps. He's been interested in observational medicine, leadership, and finance from the beginning, earning his MBA while getting his medical degree. As he dug into observational medicine as an intern at Massachusetts General Hospital, he noticed "a problem everyone had," which was that some patients need more time for treatments and diagnostic testing and end up getting admitted from the emergency department into inpatient services, even though inpatient services isn't designed for those quick admissions. He felt like it wasn't the best use of resources.

He started studying the patients who were admitted for short stays, and atrial fibrillation (AFib) jumped out as one of the most frequently encountered conditions. One thing led to another, and Dr. Baugh was soon conducting a pilot at his institution around developing a protocol to discharge AFib patients in a timelier manner. That pilot turned into a paper, and soon Dr. Baugh was tapped to lead ACEP's Expert Panel on Atrial Fibrillation.

Dr. Baugh was excited to take his local work and try to make a national impact, and he welcomed the challenge of managing a multidisciplinary expert panel. The panel immediately started working toward several different deliverables. First, it set out to develop a pathway, an example protocol for AFib as a starting point for peer physicians that could be modified depending on ED variables, such as the presence of an observation unit or ability to consult. The panel also developed example efficiency and outcome metrics so those who implemented the new AFib protocol would be able to make sure the changes were having the intended effect. Then it did expert consensus statements examining topics such as electrocardioversion, chemical cardioversion, adequate weight control, etc.

Dr. Baugh said the panel envisioned this tool helping the physician who wants to change protocol but needs a resource to help them navigate the process. "The goal of the panel was to give people a road map or toolkit of how to get there so we can be that resource for them."

Once the paper was developed, the expert panel worked with ACEP staff to build the online AFib POC tool that took the protocol from the paper and broke it down in a simplified, streamlined way that made it easy to reference quickly while on shift. Once the online tool was created and the need for the native app version was identified, the panel consulted on the conversion from the web tool to the app. ACEP members can choose whether to access the AFib tool through the emPOC app or the ACEP website, but the content is the same.



POC Tools You Need When You Need Them

emPOC is ACEP's new point-of-care app that puts helpful bedside tools in your pocket for easy access during busy shifts.

- AFIB (atrial fibrillation and flutter)
- BUPE (buprenorphine use in the ED)
- ADEPT (agitation in the elderly)
- MAP (management of acute pain)
- iCar2e (suicide assessment)

emPOC is for ACEP members only and can be downloaded on iTunes and Google Play.

A Protocol for Pain

Alexis LaPietra, DO, FACEP, was an EM resident as the opioid crisis was gaining momentum, and she felt conflicted about how to navigate pain management within the emergency department. "It was a strange place to be in where I'm dispensing or prescribing opioids but also seeing the significant harm associated with opioid prescribing," Dr. LaPietra said. "I thought, is there a way to do this better? I want to do better, and I don't want to do harm."

At the end of her residency, she spoke with her chairman, Mark Rosenberg, DO, MBA, FACEP, about her growing interest in pain management. He suggested a fellowship where she could spend a year learning about pain management by rotating through almost every other specialty at St. Joseph's Regional Medical Center in Paterson, New Jersey, with the goal of coming back to the emergency department with new processes for pain management.

At the end of her fellowship, she became the medical director in charge of EM pain management at St. Joseph's, the third largest emergency department in the country, which sees more than 170,000 annual visits from its diverse, urban community. She then collaborated with other leaders in the pain management space to help develop the Alternative to Opioids (ALTO) protocol, which she describes as a "cheat sheet for how to treat pain on a shift in the emergency department."

"I really wanted [ALTO] to be easy because pain is so complex. Pain is so hard to treat," Dr. LaPietra said. "You're in a busy ED, you're doing CPR on one bed, you're running a stroke code on the other bed, but a patient with pain deserves that much attention. ... I wanted to take the legwork out of it, take the guesswork out of it."

Once ALTO was up and running in New Jersey, Dr. Rosenberg encouraged Dr. LaPietra to take what she had learned to the national level by petitioning ACEP to start a pain management section. She quickly got the signatures of support she needed and was soon chairing ACEP's brand-new Pain Management and Addiction Medicine Section. That role led to Dr. LaPietra leading ACEP's expert panel that recently developed the MAP tool, a collaborative process involving pain management section members from across the country.

When the section agreed it wanted to tackle this project to make it easier to manage pain for the types of conditions physicians see daily in the emergency department, it sent out a call for content. It wanted to know what others were doing on the front lines for pain management. The results indicated key topics that had a lot of buzz and good evidence that formed the basis of the MAP tool—forearm nerve block, intra-articular posterior shoulder injection, ketamine for acute pain, ketamine for chronic non-cancer pain, nitrous oxide, posterior tibial nerve block, sphenopalatine ganglion block, and trigger point injection.

Dr. LaPietra and the rest of the expert panel focused on whittling down the literature into the most relevant information and summarizing it into a bulleted format so that the protocol could be processed very quickly in busy emergency departments.

"You sometimes can't go to the bathroom during an ED shift, so how are you supposed to stop and look up a journal article?" Dr. LaPietra said. "... We're on shift, and we just want to get the gist of what's going on from a trusted source, and that's where you can use [the MAP tool] in the middle of your crazy shifts while you're managing 16 patients."

The content was reviewed multiple times, with all parties weighing in to make sure it would be easy for different practice settings to utilize. The pain management expert panel participated in the beta testing for the online tool and the app, checking for accuracy and functionality.

Now that MAP is available in a native app, Dr. LaPietra is thrilled that all ACEP members

can access the tool just like the section leaders originally intended. "This tool was always meant to be used at bedside for the busy doc who feels like they are stuck and just needs to spend 30 seconds figuring out their game plan. ... We needed it to be disseminated in a streamlined way in the same way we're used to practicing, which is jumping on our phone if we need some answers," Dr. LaPierta said.

Building Consensus

For both Dr. LaPietra and Dr. Baugh, being chosen to lead the development of these impactful bedside tools was an honor and privilege—and an education on the art of collaboration and consensus.

"The nice thing is I didn't do it all by myself," Dr. LaPietra said. "I had a lot of national contributors. I ran things by other experts when I wasn't quite sure. It showed me the importance of collaboration, the importance of stepping up and leading when you feel like there's passion and you have something to say."

For Dr. Baugh, there was deep satisfaction in helping to build a tool that physicians can use on a daily basis to take better care of patients. "As an academic emergency physician, that's really what you're trying to do, right? You're trying to make a difference in your specialty."

Dr. LaPietra and Dr. Baugh are able to look back at how their paths led them to this point and how one simple step can chart a new course. Their message to other ACEP members who want to influence clinical practice is simple: Start the conversation.

"There is so much clinical expertise out there in the country that is going untapped," Dr. Baugh said. "There is an opportunity to contribute, and that's the bottom line. You have to be willing to have the conversation, to put it out there that you're interested in making a change. You'd be surprised how much one conversation leads to another."

Dr. LaPietra thinks one of the best ways to get involved with ACEP's clinical efforts is by joining the section(s) that align with personal passions. "Through the section structure, you're able to engage with individuals nationally who have similar interests, and that opens so many doors for projects you didn't know existed."

She said the sections also help personalize ACEP and give you a way to plug into a large national organization in a more manageable way. "To define your tribe within our big tribe, you should use the sections. That way, you know you've come into a group with common interests where the possibilities are endless because this is where that topic is being mastered."

Plug In

One simple way for ACEP members to contribute to ACEP's clinical efforts right away is simply by providing feedback on the POC tools and the new emPOC app. The app has a section allowing users to submit questions and feedback, and ACEP staff is monitoring the feedback closely as they work to continually refine and improve the tool. More POC tools will be added to the app during phase II, so now is the perfect time to submit feedback or suggestions for the next iteration.

MS. GRANTHAM is ACEP's communications manager.

Thank You, Contributors!

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Join our Editorial Board

Attention Emergency Medicine Experts

A call to join the editorial board for what is to be the leading new Open Access journal in the field. *Journal of the American College of Emergency Physicians Open* (*JACEP Open*) will start accepting papers this fall, post papers online in **January 2020**, and publish its first issue in **February 2020**.

JACEP Open seeks individuals with experience in peer review and editing to join our exciting new venture as decision editors. Editors will be fully involved in the peer review process, including the review of submitted manuscripts, soliciting comments from expert peer reviewers, and helping the Editor in Chief choose the best articles to feature in the journal.

We seek:

- to bring together a broad range of experts in emergency care from around the world;
- individuals who will further the mission of the journal, including encouraging submissions from peers internationally;
- people who will be energetic and invested in the success of the journal.

Please join our Editor in Chief, Dr. Henry Wang, in blazing this exciting trail. Send your CV and a letter of interest to Martha Villagomez, **mvillagomez@acep.org**.

About Dr. Wang:

Henry E. Wang, MD, MS is Professor and Vice Chair for Research of the Department of Emergency Medicine at the University of Texas Health Science Center at Houston. He is one of the world's most prolific emergency medicine scientists and is internationally recognized for his scientific work in out-of-hospital airway management, resuscitation, and sepsis epidemiology.

Dr. Wang was a Deputy Editor for *Annals of Emergency Medicine* and has served on the editorial boards of *Academic Emergency Medicine*, *PeerJ* and *Prehospital Emergency Care*.

American College of Emergency Physicians® ADVANCING EMERGENCY CARE

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19-RM000620

FACEPs IN THE CROWD

ZACHARY DAVID LEVY MD, FACEP

Zachary David Levy MD, FACEP, is an assistant professor of emergency medicine and neurosurgery at the Zucker School of Medicine at Hofstra/Northwell in Hempstead, New York. He works part-time in the neurology ICU and part-time in the emergency department there. **He's also an accomplished crossword puzzle constructor** and has recently had his puzzles featured in *The Wall Street Journal* and the *LA Times.*

IRENE TIEN MD, FACEP

Irene Tien, MD, FACEP, is associate chair of the department of emergency medicine at Newton-Wellesley Hospital in Newton, Massachusetts. Her husband coerced her into trying **high-performance driving** (code for "driving fast around the track for fun") in 2010 and she's been hooked ever since! Dr. Tien does not typically enter races, but she has participated in "lemons racing," in which drivers race cars that are bought and prepared for $500 or less.

HEIDI KNOWLES MD, FACEP

Heidi Knowles, MD, FACEP, is assistant medical director at John Peter Smith Hospital in Fort Worth, Texas; core faculty for its EM residency program; and past president of the Texas College of Emergency Physicians. Dr. Knowles is also **a serious beekeeper.** (That led us to wonder: Is there any other kind?) Five years after starting, she now has nine "amazing hives." Naturally, she came to beekeeping by chance while doing some research on how to make mead.

KNOW AN EMERGENCY PHYSICIAN WHO SHOULD BE FEATURED IN "**FACEPS IN THE CROWD**"? SEND YOUR SUGGESTIONS TO **ACEPNOW@ACEP.ORG.** LEARN HOW TO BECOME A FACEP AT **WWW.ACEP.ORG/FACEPSINTHECROWD**.

By the Numbers

FIREARM INJURIES

IN 2017

60%

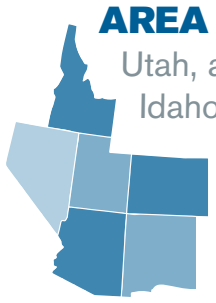
of U.S. gun deaths were due to suicide

NATIONALLY

90%

of suicide attempts with a gun are fatal

FIREARM SUICIDE RATES ARE HIGHEST IN THE INTERMOUNTAIN AREA (Nevada, Utah, and parts of Idaho, Arizona, Colorado, and New Mexico) and **RURAL AREAS.**



FIREARM SUICIDES ARE RARELY REPORTED by the news media unless they happen in a public space or are a murder-suicide.

ASKING SUICIDAL PATIENTS ABOUT FIREARM ACCESS may help with risk stratification and intervention.

CURRENTLY

<50%

of suicidal patients discharged home are asked about firearm access prior to discharge.

Suicide Awareness Week is Sept. 8–14. Watch for more information from ACEP soon.

Compiled by AFFIRM research. Visit **ACEPNow.com** for the sources of these statistics.

DREXEL/HAHNEMANN RESIDENCY

CONTINUED FROM PAGE 1

mian. "You don't want any gaps in your training because it can affect your licensing and getting through boards. It's been a lot of waiting and unclear answers, mainly because something like this hasn't happened at this magnitude and size."

Search for Information and Answers

According to *The Philadelphia Inquirer*, in a Philadelphia Court of Common Pleas lawsuit against Hahnemann and its owners, Drexel University called the closure "the largest orphaning of medical residents in the history of the United States."[1]

There are 570 residents currently employed at Hahnemann, and 45 of them are in emergency medicine.

> Hahnemann has been a staple of the community for so long ... no one ever imagined it would close, and certainly not on a 30-day or 60-day time frame.
> —*Liz Calhoun, MD*

Some foreign medical residents on J-1 visas could face deportation if they fail to secure new accredited residency positions within 30 days of the hospital's closure.[2] The hospital's owners—American Academic Health System LLC (AAHS), an affiliate of Paladin Healthcare—announced Hahnemann would close on Sept. 6, 2019, though as of July 16, its plan had not yet been approved.

The signs were there for months, said

CONTINUED *on page 19*

VISIT NUZYRA.COM/AVAILABLE-NOW TO EXPLORE THE CLINICAL DATA AND SIGN UP FOR MORE INFORMATION

INDICATIONS AND USAGE

NUZYRA™ is a tetracycline class antibacterial indicated for the treatment of adult patients with the following infections caused by susceptible microorganisms:

Community-Acquired Bacterial Pneumonia (CABP) caused by the following: *Streptococcus pneumoniae*, *Staphylococcus aureus* (methicillin-susceptible isolates), *Haemophilus influenzae*, *Haemophilus parainfluenzae*, *Klebsiella pneumoniae*, *Legionella pneumophila*, *Mycoplasma pneumoniae*, and *Chlamydophila pneumoniae*.

Acute Bacterial Skin and Skin Structure Infections (ABSSSI) caused by the following: *Staphylococcus aureus* (methicillin-susceptible and -resistant isolates), *Staphylococcus lugdunensis*, *Streptococcus pyogenes*, *Streptococcus anginosus* grp. (includes *S. anginosus*, *S. intermedius*, and *S. constellatus*), *Enterococcus faecalis*, *Enterobacter cloacae*, and *Klebsiella pneumoniae*.

USAGE

To reduce the development of drug-resistant bacteria and maintain the effectiveness of NUZYRA and other antibacterial drugs, NUZYRA should be used only to treat or prevent infections that are proven or strongly suspected to be caused by susceptible bacteria.

IMPORTANT SAFETY INFORMATION

CONTRAINDICATIONS

NUZYRA is contraindicated in patients with known hypersensitivity to omadacycline or tetracycline class antibacterial drugs, or to any of the excipients.

WARNINGS AND PRECAUTIONS

Mortality imbalance was observed in the CABP clinical trial with eight deaths (2%) occurring in patients treated with NUZYRA compared to four deaths (1%) in patients treated with moxifloxacin. The cause of the mortality imbalance has not been established. All deaths, in both treatment arms, occurred in patients > 65 years of age; most patients had multiple comorbidities. The causes of death varied and included worsening and/or complications of infection and underlying conditions. Closely monitor clinical response to therapy in CABP patients, particularly in those at higher risk for mortality.

The use of NUZYRA during tooth development (last half of pregnancy, infancy and childhood to the age of 8 years) may cause permanent discoloration of the teeth (yellow-gray-brown) and enamel hypoplasia.

The use of NUZYRA during the second and third trimester of pregnancy, infancy and childhood up to the age of 8 years may cause reversible inhibition of bone growth.

Hypersensitivity reactions have been reported with NUZYRA. Life-threatening hypersensitivity (anaphylactic) reactions have been reported with other tetracycline-class antibacterial drugs. NUZYRA is structurally similar to other tetracycline-class antibacterial drugs and is contraindicated in patients with known hypersensitivity to tetracycline-class antibacterial drugs. Discontinue NUZYRA if an allergic reaction occurs.

Clostridium difficile associated diarrhea (CDAD) has been reported with use of nearly all antibacterial agents and may range in severity from mild diarrhea to fatal colitis. Evaluate if diarrhea occurs.

NUZYRA is structurally similar to tetracycline-class of antibacterial drugs and may have similar adverse reactions. Adverse reactions including photosensitivity, pseudotumor cerebri, and anti-anabolic action which has led to increased BUN, azotemia, acidosis, hyperphosphatemia, pancreatitis, and abnormal liver function tests, have been reported for other tetracycline-class antibacterial drugs, and may occur with NUZYRA. Discontinue NUZYRA if any of these adverse reactions are suspected.

Prescribing NUZYRA in the absence of a proven or strongly suspected bacterial infection is unlikely to provide benefit to the patient and increases the risk of the development of drug-resistant bacteria.

ADVERSE REACTIONS

The most common adverse reactions (incidence ≥2%) are nausea, vomiting, infusion site reactions, alanine aminotransferase increased, aspartate aminotransferase increased, gamma-glutamyl transferase increased, hypertension, headache, diarrhea, insomnia, and constipation.

DRUG INTERACTIONS

Patients who are on anticoagulant therapy may require downward adjustment of their anticoagulant dosage while taking NUZYRA.

Absorption of tetracyclines, including NUZYRA is impaired by antacids containing aluminum, calcium, or magnesium, bismuth subsalicylate and iron containing preparations.

USE IN SPECIFIC POPULATIONS

Lactation: Breastfeeding is not recommended during treatment with NUZYRA.

To report SUSPECTED ADVERSE REACTIONS, contact Paratek Pharmaceuticals, Inc. at 1-833-727-2835 or FDA at 1-800-FDA-1088 or www.fda.gov/medwatch.

Please see Brief Summary of Full Prescribing Information on the following pages.

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US-NUA-0056 12/18

UNIVERSITY OF NEBRASKA EM

RESIDENCY SPOTLIGHT

UNIVERSITY OF NEBRASKA MEDICAL CENTER

Twitter: @NebraskaEM

Location: Omaha, Nebraska

Year founded: 2004

Number of residents: 10 per class, three-year program

SECRET WEAPONS (MEDICAL)

Fellowship-trained faculty in ultrasound, critical care, sports medicine, EMS, toxicology, health care policy and advocacy, and education. Offers fellowships in ultrasound, informatics, and technology, with plans to inaugurate an EMS fellowship in 2020 and medical education coming in the near future.

SECRET WEAPONS (NONMEDICAL)

Omaha is home to one of the world's best zoos (Omaha's Henry Doorly Zoo & Aquarium). Four Fortune 500 headquarters call Omaha home, as does one of the world's richest people, billionaire Warren Buffett. We host multiple sporting events annually including the NCAA Men's College World Series and Olympic swim trials. Most important, the Reuben sandwich was invented in Omaha!

—Chad Branecki, MD, program director

TRIVIA

Nebraska emergency medicine is the program located closest to the geographical center of the United States of any residency.

NUZYRA™ (omadacycline) injection for intravenous use
NUZYRA™ (omadacycline) tablets, for oral use

BRIEF SUMMARY OF FULL PRESCRIBING INFORMATION

For complete details, please see Full Prescribing Information.

INDICATIONS AND USAGE

Community-Acquired Bacterial Pneumonia (CABP)
NUZYRA is indicated for the treatment of adult patients with community-acquired bacterial pneumonia (CABP) caused by the following susceptible microorganisms: *Streptococcus pneumoniae, Staphylococcus aureus* (methicillin-susceptible isolates), *Haemophilus influenzae, Haemophilus parainfluenzae, Klebsiella pneumoniae, Legionella pneumophila, Mycoplasma pneumoniae,* and *Chlamydophila pneumoniae.*

Acute Bacterial Skin and Skin Structure Infections (ABSSSI)
NUZYRA is indicated for the treatment of adult patients with acute bacterial skin and skin structure infections (ABSSSI) caused by the following susceptible microorganisms: *Staphylococcus aureus* (methicillin-susceptible and -resistant isolates), *Staphylococcus lugdunensis, Streptococcus pyogenes, Streptococcus anginosus* grp. (includes *S. anginosus, S. intermedius,* and *S. constellatus*), *Enterococcus faecalis, Enterobacter cloacae,* and *Klebsiella pneumoniae.*

USAGE: To reduce the development of drug-resistant bacteria and maintain the effectiveness of NUZYRA and other antibacterial drugs, NUZYRA should be used only to treat or prevent infections that are proven or strongly suspected to be caused by susceptible bacteria. When culture and susceptibility information are available, they should be considered in selecting or modifying antibacterial therapy. In the absence of such data, local epidemiology and susceptibility patterns may contribute to the empiric selection of therapy.

CONTRAINDICATIONS: NUZYRA is contraindicated in patients with known hypersensitivity to omadacycline or tetracycline-class antibacterial drugs, or to any of the excipients.

WARNINGS AND PRECAUTIONS

Mortality Imbalance in Patients with Community-Acquired Bacterial Pneumonia-Mortality imbalance was observed in the CABP clinical trial with eight deaths (2%) occurring in patients treated with NUZYRA compared to four deaths (1%) in patients treated with moxifloxacin. The cause of the mortality imbalance has not been established.

All deaths, in both treatment arms, occurred in patients >65 years of age; most patients had multiple comorbidities. The causes of death varied and included worsening and/or complications of infection and underlying conditions. Closely monitor clinical response to therapy in CABP patients, particularly in those at higher risk for mortality.

Tooth Discoloration and Enamel Hypoplasia-The use of NUZYRA during tooth development (last half of pregnancy, infancy, and childhood up to the age of 8 years) may cause permanent discoloration of the teeth (yellow-gray-brown). This adverse reaction is more common during long-term use of the tetracycline class drugs, but it has been observed following repeated short-term courses. Enamel hypoplasia has also been reported with tetracycline class drugs. Advise the patient of the potential risk to the fetus if NUZYRA is used during the second or third trimester of pregnancy.

Inhibition of Bone Growth-The use of NUZYRA during the second and third trimester of pregnancy, infancy and childhood up to the age of 8 years may cause reversible inhibition of bone growth. All tetracyclines form a stable calcium complex in any bone-forming tissue. A decrease in fibula growth rate has been observed in premature infants given oral tetracycline in doses of 25 mg/kg every 6 hours. This reaction was shown to be reversible when the drug was discontinued. Advise the patient of the potential risk to the fetus if NUZYRA is used during the second or third trimester of pregnancy.

Hypersensitivity Reactions-Hypersensitivity reactions have been reported with NUZYRA.

Life-threatening hypersensitivity (anaphylactic) reactions have been reported with other tetracycline-class antibacterial drugs. NUZYRA is structurally similar to other tetracycline-class antibacterial drugs and is contraindicated in patients with known hypersensitivity to tetracycline-class antibacterial drugs. Discontinue NUZYRA if an allergic reaction occurs.

***Clostridium difficile*-Associated Diarrhea**-*Clostridium difficile* associated diarrhea (CDAD) has been reported with use of nearly all antibacterial agents and may range in severity from mild diarrhea to fatal colitis. Treatment with antibacterial agents alters the normal flora of the colon leading to overgrowth of *C. difficile. C. difficile* produces toxins A and B which contribute to the development of CDAD. Hypertoxin producing strains of *C. difficile* cause increased morbidity and mortality, as these infections can be refractory to antimicrobial therapy and may require colectomy. CDAD must be considered in all patients who present with diarrhea following antibacterial drug use. Careful medical history is necessary since CDAD has been reported to occur over two months after the administration of antibacterial agents. If CDAD is suspected or confirmed, ongoing antibacterial drug use not directed against *C. difficile* may need to be discontinued. Appropriate fluid and electrolyte management, protein supplementation, antibacterial drug treatment of *C. difficile*, and surgical evaluation should be instituted as clinically indicated.

Tetracycline Class Effects-NUZYRA is structurally similar to tetracycline-class of antibacterial drugs and may have similar adverse reactions. Adverse reactions including photosensitivity, pseudotumor cerebri, and anti-anabolic action (which has led to increased BUN, azotemia, acidosis, hyperphosphatemia, pancreatitis, and abnormal liver function tests), have been reported for other tetracycline-class antibacterial drugs, and may occur with NUZYRA. Discontinue NUZYRA if any of these adverse reactions are suspected.

Development of Drug-Resistant Bacteria: Prescribing NUZYRA in the absence of a proven or strongly suspected bacterial infection is unlikely to provide benefit to the patient and increases the risk of the development of drug-resistant bacteria.

ADVERSE REACTIONS: The following clinically significant adverse reactions are described in greater detail in the Warnings and Precautions section of the labeling:

- Mortality Imbalance in Patients with Community-Acquired Bacterial Pneumonia
- Tooth Development and Enamel Hypoplasia
- Inhibition of Bone Growth
- Hypersensitivity Reactions
- Tetracycline Class Effects

Clinical Trials Experience-Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in the clinical trials of a drug cannot be directly compared to rates in the clinical trials of another drug and may not reflect the rates observed in practice.

Overview of the Safety Evaluation of NUZYRA: NUZYRA was evaluated in three Phase 3 clinical trials (Trial 1, Trial 2 and Trial 3). These trials included a single Phase 3 trial in CABP patients (Trial 1) and two Phase 3 trials in ABSSSI patients (Trial 2 and Trial 3). Across all Phase 3 trials, a total of 1073 patients were treated with NUZYRA (382 patients in Trial 1 and 691 in Trials 2 and 3) of which 368 patients were treated with only oral NUZYRA.

Imbalance in Mortality: In Trial 1, eight deaths (2%) occurred in 382 patients treated with NUZYRA as compared to four deaths (1%) in 388 patients treated with moxifloxacin. All deaths, in both treatment arms, occurred in patients >65 years of age. The causes of death varied and included worsening and/or complications of infection and underlying conditions. The cause of the mortality imbalance has not been established *[see Warnings and Precautions (5.1)]*.

Serious Adverse Reactions and Adverse Reactions Leading to Discontinuation: In Trial 1, a total of 23/382 (6.0%) patients treated with NUZYRA and 26/388 (6.7%) patients treated with moxifloxacin experienced serious adverse reactions. Discontinuation of treatment due to any adverse reactions occurred in 21/382 (5.5%) patients treated with NUZYRA and 27/388 (7.0%) patients treated with moxifloxacin.

Most Common Adverse Reactions: Table 4 lists the most common adverse reactions occurring in ≥2% of patients receiving NUZYRA in Trial 1.

Table 4: Adverse Reactions Occurring in ≥2% of Patients Receiving NUZYRA in Trial 1

Adverse Reaction	NUZYRA (N = 382)	Moxifloxacin (N = 388)
Alanine aminotransferase increased	3.7	4.6
Hypertension	3.4	2.8
Gamma-glutamyl transferase increased	2.6	2.1
Insomnia	2.6	2.1
Vomiting	2.6	1.5
Constipation	2.4	1.5
Nausea	2.4	5.4
Aspartate aminotransferase increased	2.1	3.6
Headache	2.1	1.3

Serious Adverse Reactions and Adverse Reactions Leading to Discontinuation: In the pooled ABSSSI trials, serious adverse reactions occurred in 16/691 (2.3%) of patients treated with NUZYRA and 13/689 (1.9%) of patients treated with comparator. Discontinuation of treatment

third-year emergency medicine resident Liz Calhoun, MD. "They've been cutting corners where they could—the quality of supplies has decreased, they stopped repairing elevators and buildings," Dr. Calhoun said. "There's been evidence that it's been on rapid decline."

In April 2019, Hahnemann's financial troubles became apparent when owners cut 175 jobs. According to the *Inquirer*, the company sent letters to incoming residents to assure them their positions were not in jeopardy.

But residents say they were otherwise largely kept in the dark.

"We had been hearing about it in the news, and a lot of faculty weren't that concerned. They said that it's a major hospital and it would be impossible for it to fold in a matter of months," said Dr. Abrishamian. "I got notice of the closure through group chat, and it's all been secondhand information from the news."

> **You don't want any gaps in your training because it can affect your licensing and getting through boards. It's been a lot of waiting and unclear answers.**
> *—Matt Abrishamian, MD*

In a letter to colleagues, Drexel's president, John Fry, wrote: "We have been preparing for some months for this unfortunate outcome, even as we did everything possible ... to prevent the closure of Hahnemann, which has a long and storied history with the College of Medicine, and with the city of Philadelphia."

Residents have been scrambling to find new placements, a process complicated by uncertainty over when their funding will be released, which many of the programs accepting transferring residents would require. (The hospital has since announced a timeline for releasing the funding.) Some new residents had only just arrived in Philadelphia when the hospital announced its closure. On July 24, Hahnemann announced that it will be releasing the residents' funding, with plans for all funding to be released Aug. 6.[3] Residents will continue to be paid until Aug. 25 or until they start at a new residency program.

Support from Colleagues in Medicine

Residents say they have received a tremendous amount of support from program faculty, professional organizations, and other area hospitals, including Thomas Jefferson University Hospital and Temple University Hospital, which have agreed—like other area institutions—to take on as many of Hahnemann's residents as they can.

"The emergency medicine resident community stands united and we applaud the ongoing work of multiple organizations including the AAMC (Association of American Medical Colleges), ACGME (Accreditation Council for Graduate Medical Education), AMA (American Medical Association), CORD (Council of Residency Directors in Emergency Medicine), and ECFMG (Educational Commission for Foreign Medical Graduates)," wrote Hannah Hughes, MD, MBA, President-Elect of the Emergency Medicine Residents' Association (EMRA), in a statement for *ACEP Now*. "EMRA has reached out to the Drexel EM community to offer our full support as the program and trainees find a solution to continue their commitment to education and patient care. We stand ready to assist in any way, shape, or form."

Local program directors came together on July 17 to offer residents a citywide interview day "to offset the stress of interviewing," said Dr. Calhoun, who, with her husband, owns a home in the area and is hoping to stay in the region, although she is also considering the best next step for her career.

On July 10, Hahnemann, Drexel, and Tower Health announced a letter of intent to transfer the majority of Hahnemann/Drexel's residency and fellowship programs to Tower Health. But while that may help new interns and future emergency medicine residents, Dr. Calhoun said Tower Health does not currently have the capacity to train senior residents. Drexel referred questions regarding resident displacement to AAHS, who did not respond to questions via email or telephone.

According to EMRA, there are more than 2,500 annual emergency medical residency spots in the United States, and abrupt residency closures are uncommon. However, said Dr. Hughes, there have been a few closures of ACGME-accredited programs in recent years due to natural disasters (Hurricane Katrina), hospital bankruptcy, and failed contract negotiations.[4]

Loss of Critical Part of Community

Hahnemann University Hospital was established in 1848 as the Homeopathic Medical College of Philadelphia and later renamed. It merged with several other medical schools, and, in 1998, Tenet Healthcare acquired

CONTINUED *on page 20*

NUZYRA™ (omadacycline) injection for intravenous use
NUZYRA™ (omadacycline) tablets, for oral use

due to adverse events occurred in 12 (1.7%) NUZYRA treated patients, and 10 (1.5%) comparator treated patients. There was 1 death (0.1%) reported in NUZYRA treated patients and 3 deaths (0.4%) reported in linezolid patients in ABSSSI trials.

Most Common Adverse Reactions: Table 5 includes the most common adverse reactions occurring in ≥2% of patients receiving NUZYRA in Trials 2 and 3.

Table 5: Adverse Reactions Occurring in ≥2% of Patients Receiving NUZYRA in Pooled Trials 2 and 3

Adverse Reaction	NUZYRA (N = 691)	Linezolid (N = 689)
Nausea*	21.9	8.7
Vomiting	11.4	3.9
Infusion site reactions**	5.2	3.6
Alanine aminotransferase increased	4.1	3.6
Aspartate aminotransferase increased	3.6	3.5
Headache	3.3	3.0
Diarrhea	3.2	2.9

*In Trial 2, which included IV to oral dosing of NUZYRA, 40 (12%) patients experienced nausea and 17 (5%) patients experienced vomiting in NUZYRA treatment group as compared to 32 (10%) patients experienced nausea and 16 (5%) patients experienced vomiting in the comparator group. One patient (0.3%) in the NUZYRA group discontinued treatment due to nausea and vomiting.

*In Trial 3, which included the oral loading dose of NUZYRA, 111 (30%) patients experienced nausea and 62 (17%) patients experienced vomiting in NUZYRA treatment group as compared to 28 (8%) patients experienced nausea and 11 (3%) patients experienced vomiting in the linezolid group. One patient (0.3%) in the NUZYRA group discontinued treatment due to nausea and vomiting.

**Infusion site extravasation, pain, erythema, swelling, inflammation, irritation, peripheral swelling and skin induration.

Selected Adverse Reactions Occurring in Less Than 2% of Patients Receiving NUZYRA in Trials 1, 2 and 3: The following selected adverse reactions were reported in NUZYRA-treated patients at a rate of less than 2% in Trials 1, 2 and 3. *Cardiovascular System Disorders:* tachycardia, atrial fibrillation; *Blood and Lymphatic System Disorders:* anemia, thrombocytosis; *Ear and Labyrinth Disorders:* vertigo; *Gastrointestinal Disorders:* abdominal pain, dyspepsia; *General Disorders and Administration Site Conditions:* fatigue; *Immune System Disorders:* hypersensitivity; *Infections and Infestations:* oral candidiasis, vulvovaginal mycotic infection; *Investigations:* creatinine phosphokinase increased, bilirubin increased, lipase increased, alkaline phosphatase increased; *Nervous System Disorders:* dysgeusia, lethargy; *Respiratory, Thoracic, and Mediastinal disorders:* oropharyngeal pain; *Skin and Subcutaneous Tissue Disorders:* pruritus, erythema, hyperhidrosis, urticarial.

DRUG INTERACTIONS

Anticoagulant Drugs-Because tetracyclines have been shown to depress plasma prothrombin activity, patients who are on anticoagulant therapy may require downward adjustment of their anticoagulant dosage while also taking NUZYRA.

Antacids and Iron Preparations-Absorption of oral tetracyclines, including NUZYRA, is impaired by antacids containing aluminum, calcium, or magnesium, bismuth subsalicylate, and iron containing preparations.

USE IN SPECIFIC POPULATIONS

Pregnancy: Risk Summary—NUZYRA, like other tetracycline-class antibacterial drugs, may cause discoloration of deciduous teeth and reversible inhibition of bone growth when administered during the second and third trimester of pregnancy.

The limited available data of NUZYRA use in pregnant women is insufficient to inform drug associated risk of major birth defects and miscarriages. Animal studies indicate that administration of omadacycline during the period of organogenesis resulted in fetal loss and/or congenital malformations in pregnant rats and rabbits at 7 times and 3 times the mean AUC exposure, respectively, of the clinical intravenous dose of 100 mg and the oral dose of 300 mg. Reductions in fetal weight occurred in rats at all administered doses (*see Data*). In a fertility study, administration to rats during mating and early pregnancy resulted in embryo loss at 20 mg/kg/day; systemic exposure based on AUC was approximately equal to the clinical exposure level. Results of studies in rats with omadacycline have shown tooth discoloration.

The estimated background risk of major birth defects and miscarriage for the indicated population is unknown. All pregnancies have a background risk of birth defect, loss, or other adverse outcomes. In the U.S. general population, the estimated background risk of major birth defects and miscarriage in clinically recognized pregnancies is 2 to 4% and 15-20%.

Results of animal studies indicate that tetracyclines cross the placenta, are found in fetal tissues, and can have toxic effects on the developing fetus (often related to retardation of skeletal development). Evidence of embryotoxicity also has been noted in animals treated early in pregnancy.

Lactation: Risk Summary—There is no information on the presence of omadacycline in human milk, the effects on the breastfed infant or the effects on milk production. Tetracyclines are excreted in human milk; however, the extent of absorption of tetracyclines, including omadacycline, by the breastfed infant is not known.

Because there are other antibacterial drug options available to treat CABP and ABSSSI in lactating women and because of the potential for serious adverse reactions, including tooth discoloration and inhibition of bone growth, advise patients that breastfeeding is not recommended during treatment with NUZYRA and for 4 days (based on half-life) after the last dose.

Females and Males of Reproductive Potential

Contraception *Females*: NUZYRA may produce embryonic or fetal harm. Advise patients to use an acceptable form of contraception while taking NUZYRA.

Infertility *Males*: In rat studies, injury to the testis and reduced sperm counts and motility occurred in male rats after treatment with omadacycline.

Females: In rat studies, omadacycline affected fertility parameters in female rats, resulting in reduced ovulation and increased embryonic loss at intended human exposures.

Pediatric Use-Safety and effectiveness of NUZYRA in pediatric patients below the age of 18 years have not been established. Due to the adverse effects of the tetracycline-class of drugs, including NUZYRA on tooth development and bone growth, use of NUZYRA in pediatric patients less than 8 years of age is not recommended.

Geriatric Use-Of the total number of patients who received NUZYRA in the Phase 3 clinical trials (n=1073), 200 patients were ≥65 years of age, including 92 patients who were ≥75 years of age. In Trial 1, numerically lower clinical success rates at early clinical response (ECR) timepoint for NUZYRA-treated and moxifloxacin-treated patients (75.5% and 78.7%, respectively) were observed in CABP patients ≥65 years of age as compared to patients <65 years of age (85.2% and 86.3%, respectively). Additionally, all deaths in the CABP trial occurred in patients >65 years of age. No significant difference in NUZYRA exposure was observed between healthy elderly subjects and younger subjects following a single 100 mg IV dose of NUZYRA.

Hepatic Impairment-No dose adjustment of NUZYRA is warranted in patients with mild, moderate, or severe hepatic insufficiency (Child-Pugh classes A, B, or C).

Renal Impairment-No dose adjustment of NUZYRA is warranted in patients with mild, moderate, or severe renal impairment, including patients with end stage renal disease who are receiving hemodialysis.

OVERDOSAGE No specific information is available on the treatment of overdosage with NUZYRA. Following a 100 mg single dose intravenous administration of omadacycline, 8.9% of dose is recovered in the dialysate.

Visit NUZYRA.com to learn more about NUZYRA

To report SUSPECTED ADVERSE REACTIONS, contact Paratek Pharmaceuticals, Inc. at 1-833-727-2835 or FDA at 1-800-FDA-1088 or www.fda.gov/medwatch

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PARATEK®

Based on 10/2018 US-NUA-0032
US-NUA-0059 12/18

Hahnemann. Shortly after, Drexel took over management of the academic institution. In early 2018, AAHS purchased Hahnemann and nearby St. Christopher's Hospital for Children from Tenet.

"Hahnemann has been a staple of the community for so long, and even though for 20 or 30 years the hospital has been on shaky ground, no one ever imagined it would close and certainly not on a 30-day or 60-day time frame," said Dr. Calhoun.

Despite the September closure date, Hahnemann—considered a safety-net hospital for the area—stopped admitting patients through the emergency department on July 17 and planned to operate effectively as an urgent care center, open only to noncritical cases.

The closure will also send ripple effects through other regional hospitals at which Hahnemann/Drexel residents worked. For instance, Dr. Calhoun said that residents staff overnight shifts at the emergency departments and intensive care units of community hospitals in the Mercy Health system and that, with residents leaving, those hospitals will be scrambling for solutions.

Seeing the decline at Hahnemann has also been challenging, she said. "We have white boards with services that are no longer available. We're just not seeing as many ambulances. There is no longer trauma or stroke or STEMI, no labor and delivery services, no elective OR cases ... There are still sick patients who walk themselves through the door but certainly at a decreased volume and decreased acuity from several weeks ago."

But she and her colleagues are trying to take it all in stride. "In emergency medicine, you need to be able to handle whatever's thrown at you and keep a level head," Dr. Calhoun said. "We were taught resilience early on, so hopefully we are stronger in the end, but we still have a difficult couple of weeks ahead."

Protestors march around the building on July 11, 2019 after a rally to protest the imminent closure of Hahnemann University Hospital.

NURPHOTO / CONTRIBUTOR

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EM LITERATURE OF NOTE

PEARLS FROM THE MEDICAL LITERATURE

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The Glorious Final Days of Guaiac

It's time to abandon fecal occult blood testing in the ED

by RYAN PATRICK RADECKI, MD, MS

If a test result does not impact management of a patient—or, worse, is misleading—should the test even be performed? Scrutiny about the guaiac-based fecal occult blood test and its role in the emergency department is long overdue. By carefully assessing this question, some hospitals have correctly concluded that it is time to retire fecal occult blood testing (FOBT).

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The FOBT legend begins in the annals of screening for lower gastrointestinal malignancy. Small amounts of heme present in a stool sample react with a hydrogen peroxide–based developer to oxidize guaiac-infused paper, resulting in a blue color.[1] Small amounts of blood, potentially from an otherwise asymptomatic early malignancy, may trigger appropriate downstream screening. Ultimately, population-based cancer screening using FOBT was popularized in the 1990s after several trials demonstrated mortality reductions.[2] While we do not perform cancer screening in the emergency department, we may take an interest in the presence or absence of blood in the stool. Thus, this inexpensive, readily available test became part of the armamentarium of the emergency department.

Problems with FOBT

Unfortunately, guaiac-based FOBT is not a good test. When used for cancer screening, the sensitivity for malignancy—using heme positivity as a surrogate—is quite poor. Estimates for sensitivity of a single sample range from 15 to 30 percent.[3] Because of these limitations, the typical collection procedure involves providing the patient with three separate cards upon which to collect samples from six different stools. These cumbersome procedures have coaxed the movement from guaiac-based kits toward immunochemical assays, whose sensitivity is sufficient with only one sample. Worse still with respect to ED practice, both sensitivity and specificity of guaiac-based FOBT for malignancy decrease with samples collected by digital rectal exam compared to those collected from spontaneously passed stool.[4]

Meanwhile, the list of sources of false-positive guaiac-based FOBT results is extensive. Nongastrointestinal blood, such as epistaxis, may produce a positive result unrelated to a clinically important etiology. Many foods can confound results of the guaiac-based FOBT, including meat products containing nonhuman heme and vegetables containing peroxidases, such as broccoli. When guaiac-based FOBT is used in outpatient screening, patients are instructed to abstain from such foods, which is not an option in the emergency department. The subjective nature of judging the color-based outcome on the card also leads to both false positives and false negatives.

These data do not generalize well to the emergency department. In the first place, the FOBT is designed to detect blood from an occult lower intestinal source rather than clinically important upper gastrointestinal bleeding. Understandably, as we are using this test outside its defined scope, we have little data with which to accurately describe its sensitivity and specificity. One small study evaluated three different stool tests for lower gastrointestinal bleeding in patients with anemia and known upper gastrointestinal lesions, and the guaiac-based test was positive in only 11 of 42 patients.[5] The same study evaluated patients with quantities of ingested blood up to 15 mL; only one of 12 study subjects resulted a positive guaiac-based test.

With this excess of data throwing the utility of FOBT into question, the onus ought to be on those who would support its use in clinical settings to demonstrate its value. Hospitals that retrospectively evaluated the effect of guaiac-based FOBT on downstream testing have found profound mismatch between test results and follow-up endoscopy.[6] This finding is consistent with surveys of the perceived value of the test across the spectrum of general practitioners as compared with gastroenterologists—a scant minority of gastroenterologists reported FOBT as appropriate for use in the emergency department, and the majority do not rely on the test to alter management.[7]

Eliminating the Test

In response, several hospitals have specifically removed the test either from use in the emergency department or the entire hospital.[8,9] Parkland Hospital in Dallas, for example, retrospectively evaluated their practice patterns and identified FOBT as a low-value intervention used outside its appropriate scope. After a marginally successful initial attempt at reducing its use through educational interventions, the hospital simply eliminated the test. The discontinuation was led by the gastroenterology group, justifying their de-adoption by focused dissemination of cases in which the FOBT result had misled physicians. For example, there had been a colonic neoplasm thought to have been missed due to a false-negative FOBT collected by digital rectal examination. In many cases, unnecessary upper endoscopies were performed in response to false-positive results.

While a simple, sensitive, and specific test for upper gastrointestinal bleeding would certainly be of value, for want of such test, we should not mischaracterize and rely upon a poor one. It is absolutely time to retire—as my institution has—the guaiac-based FOBT from emergency department and inpatient use.

The opinions expressed herein are solely those of Dr. Radecki and do not necessarily reflect those of his employer or academic affiliates.

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NEW COLUMN

DOING THE MATH TO BENEFIT OUR SPECIALTY

THE EQUITY EQUATION

DR. COLDEBELLA is clinical assistant professor of emergency medicine at the University of South Carolina School of Medicine in Greenville and an emergency physician at Prisma Health–Updstate.

DR. PILARSKI is associate professor of emergency medicine at Medical College of Wisconsin/Froedtert Hospital in Milwaukee.

Flexible Clinical Scheduling During Pregnancy

Planning for staff needs benefits the whole department

by LARISA COLDEBELLA, MD; AND ALICIA PILARSKI, DO

As a specialty, emergency medicine attracts physicians who run on variety and adrenaline. Of course, there are downsides, specifically related to the cumulative burdens of shift work and working nights. These risks are amplified for emergency physicians who become pregnant and continue to work clinically.

We wanted to further understand these risks so that departments can rely on data and adopt evidence-based practices. A working group of practicing emergency physicians was assembled for this project. The group included women who currently practice in academic and community settings (with diverse payer models) and who are members of several committees within various EM organizations (including FemInEM leadership). The group included some who have experienced childbearing and child rearing and others who have not. Our literature review (using Medline, Google Scholar, PubMed, and reference searches) and consensus-building methodology were modeled on best-practice procedures used for similar efforts in many areas of medicine, and it revealed four areas to focus recommendations: clinical scheduling during pregnancy, communication and training, span of parental leave, and the return-to-work period. For this column, we will focus solely on the best-practice recommendations for clinical scheduling during pregnancy.

Because night shift work can increase fatigue, decrease mental wellness, and cause physical ailments, investigators have evaluated the effects of night shifts on adverse pregnancy outcomes.[1,2] A meta-analysis published in 2000 in *Obstetrics & Gynecology* found that physically demanding work was associated with preterm birth, small gestational age, and hypertension or preeclampsia.[3] Other occupational exposures significantly associated with preterm birth included prolonged standing (defined as more than three hours per day or the predominant occupational posture) (odds ratio [OR], 1.26; 95% CI, 1.13–1.40), shift and night work (OR, 1.24; 95% CI, 1.06–1.46), and high cumulative work fatigue score.[3] In 2014, Stocker et al demonstrated that night shifts were associated with increased early spontaneous pregnancy loss (n=13,018; OR, 1.29; 95% CI, 1.11–1.50, I o percent).[4] A more recent meta-analysis published in 2016 stated the weight of evidence begins to point to working at night, whether in fixed or rotating shifts, as a risk factor for miscarriage.[5]

Clinical Scheduling During Pregnancy

Because early spontaneous abortion, preterm labor, and other adverse pregnancy outcomes are associated with night shifts, we recommend that:

- First-trimester pregnant physicians (12 weeks or fewer) and third-trimester pregnant physicians (28 weeks or more) have the option to opt out of night shifts.

Because physically demanding work is significantly associated with preterm birth and appropriate staffing of the department should be prioritized, we recommend that:[3]

- In the event of staffing shortages, pregnant physicians in the third trimester have the option to remain exempt from mandatory addition of clinical hours (ie, mandatory overtime).
- Scheduling for pregnant physicians in the third trimester should prioritize easily cancellable/coverable shifts to minimize departmental disruption in the event of medical necessity or early delivery.

These recommendations should not take the place of the pregnant physician's preference. For example, physicians who work fixed night shifts for extended periods are likely to have chosen this schedule and may be a self-selected population with high tolerance for night shifts. This tolerance may be related to age, circadian preferences, or situational and psychological preferences specific to the individual. Furthermore, pregnant women preparing for an unpaid maternity leave may, in fact, be looking to work additional clinical hours. While it is optimal that such transient increases in clinical hours occur during the second trimester, a woman may choose to work additional hours well into her third trimester out of necessity or preference. Rather than instituting a blanket policy excluding night shifts or additional clinical hours, we recommend that pregnant physicians be allowed a degree of autonomy over whether night shifts or additional hours are right for them during the most vulnerable trimesters of pregnancy.

Feasibility and Financial Implications

Covering shifts with little notice, especially night shifts, can create a financial strain for emergency departments. Sites in which the trust level is high between providers and leadership will foster earlier notification of issues that impact the schedule, including pregnancy, and allow for creative solutions. Sites may choose to distribute the shifts among existing providers. For small groups, this may cause some shared sacrifice of increased shifts, yet individuals may realize that their temporary increased shift load may be offset by a reduction in the future due to unexpected illness or family emergency. Sites may consider hiring moonlighters who can be utilized during periods of staff shortages, which can include situations beyond pregnancy to include unexpected resignations, sabbaticals, and medical illnesses. At sites with a large academic or administrative load, these duties may be able to be shifted to gravid physicians requesting or requiring a reduced clinical load, and providers who typically do this type of work can be temporarily diverted toward more clinical work. This model can also be considered for other employees requiring limitations due to medical restrictions.

Thoughtful scheduling and planning during physician pregnancy stands to benefit all members of a department. While no single practice of emergency medicine is the same, it is imperative that departments and groups make evidenced-based policies to support emergency physicians during these transitional times. In reviewing the aforementioned recommendations, we hope that future scheduling policies for emergency physicians will use these data to promote healthy pregnancies, well-balanced physicians, and successful careers for our colleagues.

"The Equity Equation" is curated by Dara Kass, MD, and Uché Blackstock, MD.

New York emergency physician Dr. Nathalie Mathieu stopped by Studio ACEP in Washington, D.C., during ACEP17.

PHOTO: ACEP

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THE NEXT GENERATION OF EM

RESIDENT VOICE

DR. CHERNOBY is chief resident at Indiana University Department of Emergency Medicine in Indianapolis and a trustee of the Indiana State Medical Association.

PHOTO: KIMBERLY CHERNOBY

Dr. Kimberly Chernoby (back row, third from left) attended the signing ceremony for a law protecting pregnant minors that started as a resolution she brought to her state medical association.

The Power of Advocacy

Working with state lawmakers to make a difference for young pregnant patients

by KIMBERLY CHERNOBY, MD, JD, MA

In most states, minors who are pregnant can consent for their own care. But as I learned when I was an intern at Indiana University, Indiana was, at that time, one of 14 states that did not allow female minors consent over their medical care by virtue of being pregnant. Their medical care could only be consented to by their parents or guardian, with exceptions for emergent situations.

This first came to my attention when I encountered a nulliparous patient I treated at our county hospital who was under the age of 18. She was screaming in pain, just hours into what would be a lengthy labor course. She just wanted someone to make the pain stop. I innocently asked why she couldn't just have an epidural like other laboring women on the floor. With a dumbfounded look, the OB residents informed me that—of course—she could not have an epidural because she was a minor and her parents were not at bedside to consent for the procedure. In just 24 hours, she would have full consent over her own infant's medical care. But in this moment, she couldn't even consent for her own. It was absurd.

From that moment, I became determined to do something. I wanted to make sure that no more minor women would be denied the choice of an epidural, the most common form of labor analgesia, nor access to any other pregnancy-related care for that matter. So I decided I was going to try to change the law.[1]

Long Process to a Law

Fortunately, I was already an alternate trustee of my state medical association. At our annual convention in fall 2018, I brought forward a resolution to the House of Delegates asking the association to pursue this legislative change. While I knew that Indiana was not a bastion of liberal policy, I did not realize just what I had done.

After my resolution passed by a large majority, physicians who were interested in helping (but who felt they could not publicly speak on the issue) slipped me torn pieces of paper with their contact information. One physician even emailed my department chair.

After the resolution passed, the association carried on the bulk of the work. We were able to find a state senator who was willing to author the bill, Sen. Jean Leising, a former nurse. The first stop for the bill was the senate's Health and Provider Services Committee.

I was given the opportunity to testify before the committee. I was genuinely surprised by the concerns of the senators. The proposed law gave pregnant women ages 16 and 17 the ability to consent to their own medical care but only if their parents were not available after attempted contact. Self-consent was only to be granted for 60 days following the birth. As some predicted, many senators were troubled about intruding on parental rights, but they were also concerned that the young women might request a postpartum intrauterine contraceptive device that would provide long-term contraception that their parents had not consented to and which would extend beyond the 60-day consent period without parental involvement. I was skillfully aided in my testimony by the state American College of Obstetrics and Gynecology chapter, who assured the senators that reliable contraception would prevent a risky repeat pregnancy within too short an interval and that was both desirable and essential to combating our state's high infant and maternal mortality rates.

We hit some other obstacles along the way, including HIPAA concerns about alerting parents when their children were pregnant. Ultimately though, the bill was passed unanimously by both the state house of representatives and state senate, before finally being signed by the governor on April 29, 2019. Being present for the signing and being presented with the governor's signing pen are memories from residency I will cherish forever.

Policy as a Way to Help Patients

I've wanted to be a doctor for as long as I can remember, and my inspiration for doing so, like most others, has been a desire to help others. As I progressed through school, I realized that through health policy I could help patients even if they don't present to my emergency department during a shift. Through just one policy change, I could care for more patients than I could possibly ever see in my clinical practice alone.

More than 1,000 girls under age 18 will give birth in Indiana this year. I am proud to say that as of this past July 1, when the newest class of interns began their clinical career, these girls now have the legal right and ability to consent to their own medical care. It is my hope that no intern will have their hands legally tied when providing basic medical care to a young pregnant patient, whether they want to provide an ultrasound, epidural analgesia, or any other procedure.

The power of the resident voice is greater than I realized. As trainees in emergency medicine, we bear witness to the failings of our health care system every day. Because we are not accustomed to these injustices, we are perhaps more likely to speak out and act. As frontline witnesses to these issues, our policymakers view us not just as trainees but as trusted experts. If and when we see something wrong, we have the power to use our voices to bring about positive change and can dramatically improve the health and well-being of our patients.

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USE YOUR VOICE

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NEW COLUMN

PROTECT YOURSELF FROM LEGAL RISK

MEDICOLEGAL MIND

DR. PENSA is clinical associate professor of emergency medicine at the Warren Alpert School of Medicine of Brown University in Providence, Rhode Island; associate director (education) of the Emergency Digital Health Innovation program at Brown; and creator and host of the podcast "Doctors and Litigation: The L Word."

I've Been Sued—Now What?

Examining the process and stigma of malpractice suits

by GITA PENSA, MD

PHOTO: SHUTTERSTOCK.COM

When I was first named in a medical malpractice lawsuit, I was working solo nights in a community emergency department. I was five years out of residency, just hitting my stride as an ever more competent and confident physician. One summer night in 2006, I cared for a young woman with a complex and confusing presentation. I was attentive, thoughtful, and thorough. But the simple act of picking up that chart set in motion a painful journey through the medical malpractice litigation machine that would span 12 years, two jury trials, and more sleepless nights than I can count.

I remember with crystal clarity the moment I was given notice of the suit. In that instant, my whole carefully constructed professional persona was smashed—not only by the knowledge that I had been named as the sole physician defendant in what would become a very high-stakes lawsuit but also with guilt over my patient's outcome, fear that I actually was the incompetent physician the legal complaint described so vividly, and an overwhelming sense of shame and isolation.

Nothing in my training had prepared me for this. We'd had some lectures on defensive charting and risk management (as if risk can be truly "managed" in emergency medicine) but not one word about what happened after you were actually named. What then? I was a pariah; obviously we weren't taught about this because it simply didn't happen to good doctors who followed the risk management golden rules, the thinking went. I had no idea whom to turn to or even what the next step was in the legal process, but I didn't want to talk to anyone around me. My personal shame kept me from reaching out to other physicians who might have been able to help (had I even known who they were), and I simply had never heard of any relevant resources to consult.

Experience makes a fine teacher, and what I now understand is that litigation happens to the majority of emergency physicians over the course of their career. Education about the process and its emotional impact should be included in our training. If knowledge and simulation are keys to mastering complex and terrifying procedures, litigation is no different. We have a burnout and suicide problem in medicine, as we are slowly starting to acknowledge; litigation stress, while not the only cause, plays a front-and-center role in it.[1,2]

Over the past two years, I have been collecting interviews with physicians who have been though the litigation process as well as psychologists, lawyers, and other published experts on medical malpractice litigation. Recently, I have started to assemble these into a series of free podcasts, entitled "Doctors and Litigation: The L Word." My hope is to educate physicians on the "what happens next" of being sued and also to destigmatize the process itself, shining a light on litigation stress and "malpractice stress syndrome."

Litigation Stress: What Is It?

If you've lived through litigation, you likely have a sense of what litigation stress is, but you may not have known that it exists as a well-defined term. You simply know it because you've experienced it in some form: sleeplessness, anxiety or depression, depersonalization or burnout, imposter syndrome, disordered eating. What you may not know is that litigation stress is a normal and expected human reaction to an abnormal psychological stressor. As much as physicians, especially emergency physicians, like to think they are exempt from normal human emotions and reactions to stressful situations, they are not. Pretending otherwise is to our detriment.

In the coming months, this column will cover topics such as litigation stress. We will discuss how to prepare practically and psychologically for depositions and trial, plus explore the ethics of expert witness testimony, the effect of litigation on relationships, and many more common problems. By doing this, we will not only arm ourselves with knowledge and know-how, we will decrease any sense that we are in this alone. Trust me, we're not.

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

How to Get Good Advice at a Fair Price

PHOTO: SHUTTERSTOCK.COM

Don't be afraid to pay for quality financial guidance

by JAMES M. DAHLE, MD, FACEP

Q. I feel like I need a financial adviser, but they're so expensive. How can I avoid being ripped off?

A. I have spent many years helping doctors who wish to be their own financial planner and investment manager to write and follow a financial plan. Given the plethora of resources online and in your local library, it is entirely possible to do this yourself. This approach has certain advantages, not the least of which is saving thousands of dollars in advisory fees every year—savings that can be either spent on luxuries

CONTINUED *on page 26*

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Those interested in a position or further information may contact Ms. LaShaune DeJean via email at LaShaune.DeJean@bcm.edu or by phone at 713-873-2626. Please send a CV and cover letter with your past experience and interests.

or profitably invested toward your financial goals.

Nevertheless, I estimate that 80 percent of doctors want and perhaps even need a good financial adviser and should not feel ashamed of meeting with one. The key is to make sure you are getting good advice at a fair price. Obviously, it can be tricky for someone who needs advice to determine the quality of the recommendations and service, but ensuring a fair price only requires basic math skills and a knowledge of the going rate for this service.

The rule of thumb is that high-quality financial advice costs a four-figure amount per year, ie, between $1,000 and $10,000. If you are paying more than $10,000 per year, you can almost surely get the same (or better) advice and service for less money. If you are paying less than $1,000 per year, you are unlikely to actually be receiving high-quality, personalized advice.

The rule of thumb is that high-quality financial advice costs a four-figure amount per year, ie, between $1,000 and $10,000.

So What *Am* I Paying?

Unfortunately, the industry has placed several obstacles in the way of determining what you are actually paying. There are multiple compensation models, and the actual transfer of money to the adviser only rarely involves the obvious writing of a check. Often the method of compensation introduces conflicts of interest into the relationship. This is most evident when a commissioned salesperson of financial products is masquerading as a financial adviser. If you are not aware of how and how much you are paying your adviser, determine that immediately. If a review of your contract and account does not make this amount obvious, then the next question you should ask your adviser ought to be, "How do I pay you, and how much have I paid you in the last year?" Good advisers are not offended by this question. They know their value and want a good fit with clients willing to pay for that value.

CLASSIFIEDS

Toledo, Ohio

The Department of Emergency Medicine at The University of Toledo Medical Center is seeking an energetic, highly motivated, and talented physician to join The Emergency Medicine Department.

Join a well-balanced Department with a welcoming environment from colleagues and dedicated support staff. The Level l Trauma Center provides the full spectrum of care with all specialties and subspecialties. The department of Emergency medicine has approximately 36,000 visits a year with high acuity of patients. In this practice, the EM Physician will be scheduled a total of 1,440 hours / year.

We are looking for candidates with strong interpersonal skills and ability to work in a dynamic academic and clinical environment. Applicants must have graduated from an accredited emergency medicine resident program and be board certified by ABEM/ AOBEM.

We offer a competitive salary, academic stipend and excellent benefits.

The University of Toledo is an equal access, equal opportunity, affirmative action employer, and educator.
Our mission is "to serve the Northwest Ohio community and Toledo Area by providing quality health care services in a courteous, compassionate and respectful manner to all people regardless of ability to pay."

For further information call Department of Emergency Medicine AdministratorHesham Youssef, MBA at 419-383-4439 or e-mail hesham.youssef@utoledo.edu.

SEEKING EMERGENCY DEPARTMENT PHYSICIANS

The busiest ED in North Carolina, and one of the top 15 busiest in the nation, treats 95k adult and 35k pediatric cases annually in its 92 beds. We are currently seeking residency trained BC/ BE emergency physicians to work in the 75 bed adult ED. This ED serves a high acuity patient population with 28% annual admission rate. There are over 90 hours of adult physician coverage daily and over 110 hours mid-level coverage daily. It is a Level III Trauma Center with robust hospitalist service, interventional cardiology 24/7, cardiac surgery, neurosurgery, etc. The facility is Chest Pain and Stroke accredited. The EMS system is hospital owned and managed with an award winning paramedic program. Of note, the Pediatric ED is separate and has 17 dedicated beds with an additional 24 hours of physician coverage and 20 hours of mid-level coverage. We welcomed our inaugural class of Emergency Medicine Residents in July 2017. Opportunities exist for both clinical and academic emergency physicians.

EXPECTING TO BE EXCITED AND CHALLENGED?

Come join our team today!

TOP TIER COMPENSATION

The cash compensation package is valued at over $250/hour, including evening, night, and holiday differentials, as well as a quarterly incentive bonus. We offer a generous sign-on bonus plus moving stipend. The comprehensive benefits package includes Malpractice Insurance Paid; CME Time and Allowance; 403(b) match and 457(b); and health, dental, and other desirable benefits.

THE AREA

Cape Fear Valley Health is located in the thriving and diverse community of Fayetteville, NC which consists of more than 319,000 residents. Fayetteville has received the prestigious All-America City Award three times from the National Civic League.

Known for its many golf courses (Pinehurst is located only 30 minutes away), our central location provides easy access to beautiful beaches to our east and to the majestic Blue Ridge Mountains to our west. Our mild climate, low cost of living, and patriotic spirit makes our location ideal for rising healthcare professionals and families.

CAPE FEAR VALLEY HEALTH

Please contact Ashley Dowless, Corporate Director, Physician Recruitment at 910-615-1888 or adowl@capefearvalley.com for additional information.

A strong argument can be made to separate out financial planning from investment management and to pay for those two services separately. Investment management is an ongoing service you will need every month for many years that is most appropriately paid for with a flat annual fee or perhaps a reasonable fee based on a percentage of assets under management (AUM) of well under 1 percent per year. Either way, that fee should add up to a four-figure annual amount. If you are paying an AUM fee, do the math (amount of assets managed multiplied by the fee percentage) each year to ensure the fee is still reasonable. Financial planning, on the other hand, is more of an upfront/one-time activity with a fee of a few thousand dollars. You simply do not need a new financial plan each year. Perhaps it needs updating every few years, but there is no reason to pay for financial planning every single year for decades.

Finding Quality Advice

Once you know you are paying a fair price, you can turn your attention to the quality of the advice. You want your advice to come from an experienced fiduciary, fee-only adviser with a commitment to the profession. You want many of their clients to be dealing with the same financial issues you have: If you owe $300,000 in student loans, ask how many of their clients owe $300,000? If you earn $400,000 a year, how many of their clients have similar incomes? If you are a self-employed physician, how many of their clients are self-employed?

You also want your adviser to avoid methods of investment that have been shown in the academic literature to be less effective. These include stock picking, market timing, the use of actively managed mutual funds, and extreme combinations of investments. It is a good sign if your adviser is talking about keeping costs low, using index funds, and being prepared for any possible future outcome because no one can predict the future.

It can be worthwhile to seek out recommendations for advisers. However, rather than turning to colleagues who use an adviser, I would recommend you reach out to financially knowledgeable colleagues who do *not* use an adviser, as they are more capable of recognizing when an advisor is offering good advice at a fair price. Reputable websites may also provide lists of recommended advisers, but remember to do your own due diligence as well. You should read the required Securities and Exchange Commission disclosure document, titled "ADV2," which can be found at www.adviserinfo.sec.gov/IAPD. Sections five, eight, and nine are particularly important. You should read the adviser's website. You may even consider paying to have a background check done. But at a minimum, do an internet search of the adviser's name and the firm name combined with terms like "scam," "arrest," and "review." Online reviews may be worth looking at, but remember that they are no more accurate for advisers than they are for doctors and are often just as unfair.

If you need financial advice and assistance, do not avoid hiring the help you need just because it costs money and requires a bit of effort. The price is likely well worth paying, and the due diligence can be done quickly and easily. Just ensure you get good advice at a fair price to speed you along your way to financial stability.

CLASSIFIEDS

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Southeast HEALTH

Emergency Medicine Residency Program Director

Level 2 trauma center with high acuity seeks Program Director to help develop and implement a NEW ACGME EM residency. This is an exciting opportunity for an experienced, motivated physician leader to have input in building a program from the ground up. The Program Director will be responsible for the development and operation of the Emergency Medicine Residency Program and will oversee the activities of the residents and other faculty members.

FOR MORE INFORMATION PLEASE CONTACT

Sarah Purvis
Director, Southeast Health Physician Recruitment

office: 334-793-8145 • cell: 334-797-5090
sbpurvis@southeasthealth.org

JOB DESCRIPTION

- Develop and lead the operation of the EM Residency Program
- Oversee the activities of the residents and other faculty members
- Recruit, interview, and select residents, and facilitate the involvement of residents
- Assist the Medical Center in recruiting a sufficient number of appropriately trained and qualified faculty members to conduct the program.
- Participate with the DME/DIO and VPMA in the overall formulation, review and revision of policies and procedures, and structure and content of the curriculum for the program.
- Structure, coordinate, and participate with the faculty in providing a didactic program for residents in compliance with ACGME requirements
- Ideal candidate will have experience developing a program from beginning through implementation & will have strong administrative and team-building skills.
- Additional responsibilities as outlined by ACGME & available to interested candidate

POSITION BENEFITS

- Competitive salary including but not limited to paid vacation, matching retirement, health, dental and vision insurance options
- Commencement bonus and relocation allowance
- CME allowance , paid malpractice and paid licensing fee
- Protected time minimum 50% (20 hours/week) dedicated to program educational and administrative duties

REQUIRED QUALIFICATIONS

- Minimum of 3 years' experience as a core faculty member in an ACGME accredited EM program & 3 years demonstrated exp. in an ACGME leadership role
- Current certification by ABEM or AOBEM;
- Evidence of ongoing involvement in scholarly activity, including peer-reviewed publications

University of Colorado
Anschutz Medical Campus
Department of Emergency Medicine

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The largest academic health care center in the Rocky Mountain region, Denver has also been named one of the best places to live, play, and raise a family. CU Anschutz is leading the way in education, research and patient care. We provide coverage to three hospital based EDs and several freestanding EDs.

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- Pre-hospital care of the injured patient: transport and resuscitation
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Kevin Dunn:
kdunn@cunnasso.com

Cynthia Kucera:
ckucera@cunnasso.com

Phone:
201-767-4170

{ Job Opportunities }

Division Chief, Pediatric Emergency Medicine
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- Experienced leaders with a passion to inspire a team
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- Demonstrate a spark for innovation and research opportunities for Department
- Completion of an accredited Emergency Medicine Residency Program
- BE/BC by ABEM or ABOEM
- Observation experience is a plus

What the Area Offers:

We welcome you to a community that emulates the values Milton Hershey instilled in a town that holds his name. Located in a safe family-friendly setting, Hershey, PA, our local neighborhoods boast a reasonable cost of living whether you prefer a more suburban setting or thriving city rich in theater, arts, and culture. Known as the home of the Hershey chocolate bar, Hershey's community is rich in history and offers an abundant range of outdoor activities, arts, and diverse experiences. We're conveniently located within a short distance to major cities such as Philadelphia, Pittsburgh, NYC, Baltimore, and Washington DC.

FOR ADDITIONAL INFORMATION PLEASE CONTACT:

PennState Health

Susan B. Promes, Professor and Chair, Department of Emergency Medicine c/o Heather Peffley,
Physician Recruiter, Penn State Health Milton S. Hershey Medical Center
500 University Drive, MC A595, P O Box 855, Hershey PA 17033
Email**: hpeffley@pennstatehealth.psu.edu**
or apply online at: **hmc.pennstatehealth.org/careers/physicians**

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Vice Chair of Research

Rutgers, Robert Wood Johnson Medical School
Department of Emergency Medicine

Rutgers is New Jersey's premiere public research university. With a $1 billion commitment to invest in, support and drive groundbreaking, advanced research, the recent Rutgers and RWJ Barnabas Health integrated academic health system aims to further the university's reputation as a leader in academic health care and biomedical research.

Rutgers currently is ranked among the nation's top 20 public universities for research and development expenditures. Rutgers Robert Wood Johnson Medical School is first in the state for research and has steadily attracted increased NIH funding and grants in excess of $1 million, as well as substantially expanded its clinical trials with the launch of a new, world-class adult clinical research center.

The Department of Emergency Medicine is seeking a Vice Chair of Research at the Associate Professor or Professor level, preferably tenure track. The Department's goal is to grow its research and scholarly output while building a nationally recognized research program. The Vice Chair will provide leadership and oversight of the research mission for the Department. Successful candidates will have a demonstrated track record of independently funded research, publication in high-impact, peer-reviewed journals, strong mentorship skills and clear evidence of promoting the academic careers of junior faculty. The Vice Chair must demonstrate expertise in leading research in EM and possess the interpersonal skills to engage, inspire and work across disciplines within a large, diverse organization.

Robert Wood Johnson Medical School and its principal teaching affiliate, Robert Wood Johnson University Hospital, comprise New Jersey's premier academic medical center. A 580-bed, Level 1 Trauma Center and New Jersey's Level 2 Pediatric Trauma Center, Robert Wood Johnson University Hospital has an annual ED census in excess of 90,000 visits. The department has a well-established, three-year Emergency Medicine residency program and an Emergency Ultrasound fellowship.

Qualified candidates must be ABEM/ABOEM certified/eligible. Salary and benefits are competitive and commensurate with experience.

For consideration, please send a letter of intent and a curriculum vitae to:

Robert Eisenstein, MD, Chair, Department of Emergency Medicine
Rutgers Robert Wood Johnson Medical School
1 Robert Wood Johnson Place, MEB 104, New Brunswick, NJ 08901
Email: **Robert.Eisenstein@rutgers.edu** • Phone: **732-235-8717** • Fax: **732 235-7379**

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RUTGERS Robert Wood Johnson Medical School

Emergency Medicine & Toxicology Faculty

Rutgers Robert Wood Johnson Medical School

The Department of Emergency Medicine at Rutgers Robert Wood Johnson Medical School, one of the nation's leading comprehensive medical schools, is currently recruiting Emergency Physicians and Medical Toxicologists to join our growing academic faculty.

Robert Wood Johnson Medical School and its principal teaching affiliate, Robert Wood Johnson University Hospital, comprise New Jersey's premier academic medical center. A 580-bed, Level 1 Trauma Center and New Jersey's only Level 2 Pediatric Trauma Center, Robert Wood Johnson University Hospital has an annual ED census of greater than 90,000 visits.

The department has a well-established, three-year residency program and an Emergency Ultrasound fellowship. The department is seeking physicians who can contribute to our clinical, education and research missions.

Qualified candidates must be ABEM/ABOEM certified/eligible. Salary and benefits are competitive and commensurate with experience. Sub specialty training is desired but not necessary.

For consideration, please send a letter of intent and a curriculum vitae to:

Robert Eisenstein, MD, Chair, Department of Emergency Medicine
Rutgers Robert Wood Johnson Medical School
1 Robert Wood Johnson Place, MEB 104, New Brunswick, NJ 08901
Email: **Robert.Eisenstein@rutgers.edu**
Phone: **732-235-8717** • Fax: **732 235-7379**

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