Sex trafficking—as defined by the Trafficking Victims Protection Act of 2000—is the “recruiting, harboring, transporting, providing, obtaining, patronizing, or soliciting of an individual through the means of force, fraud, or coercion for the purpose of commercial sex.”1 In 2020, 7,648 cases of sex trafficking were reported to the National Human Trafficking Hotline, with the highest number of cases noted in California (1,334), Texas (987), Florida (738) and New York (414).2

Health care settings are an important

Recognizing Human Trafficking Victims as Patients in the ED

How understanding the proper protocols can mean the difference between life and death

by ALI POURMAND, MD, MPH, RDMS, FACEP; AND BRIDGET MAR-CINKOWSKI, BS

Sex trafficking—as defined by the Trafficking Victims Protection Act of 2000—is the “recruiting, harboring, transporting, providing, obtaining, patronizing, or soliciting of an individual through the means of force, fraud, or coercion for the purpose of commercial sex.” In 2020, 7,648 cases of sex trafficking were reported to the National Human Trafficking Hotline, with the highest number of cases noted in California (1,334), Texas (987), Florida (738) and New York (414). Health care settings are an important
ACEP Now Welcomes New Assistant Editor

Amy Ho, MD, is the newest member of the ACEP Now editorial team. In her role as Assistant Editor, Dr. Ho will work in conjunction with Medical Editor in Chief Cedric Dark, MD, MPH, FACEP, to primarily oversee the podcast and digital content for the magazine. Dr. Ho is director of clinical informatics and an EM faculty member at John Peter Smith Hospital in Fort Worth, Texas. She’s also an attending physician at Baylor University Medical Center in Dallas.

President Biden Signs Dr. Breen Bill

On March 18, President Biden signed into law the ACEP-supported Dr. Lorna Breen Health Care Provider Protection Act. ACEP worked with Sen. Tim Kaine (D-VA) to develop this legislation honoring Dr. Breen, which provides mental health and substance-use disorder support for health care clinicians. Look for a detailed breakdown of this bill’s path from idea to law in the May issue of ACEP Now.

ACEP and MAG Withdraw Georgia Lawsuit

In response to the discontinuation of the Blue Cross Blue Shield Healthcare Plan of Georgia, Inc. (BCBSHP)’s “avoidable ER” program, which reviewed claims on behalf of its individual insured members for payment regarding emergency room services, ACEP and the Medical Association of Georgia (MAG) have agreed to withdraw the lawsuit filed in July 2018 in the U.S. District Court for the Northern District of Georgia. ACEP and MAG originally brought the lawsuit against BCBSHP over concerns the insurer’s program would result in violations to the federal prudent layperson standard. “This is a mutually successful outcome of a three-year long lawsuit in Georgia,” said ACEP President Gillian Schmitz, MD, FACEP. “We believe this is the best outcome for Georgia patients and emergency providers alike, and this decision will allow our members to focus on providing quality care and treatment to those patients who walk through their doors and to continue to save lives.”

Although the legal applicability of this settlement is limited to Georgia, ACEP believes this case sets a strong precedent nationwide as we fight back against similar dangerous policies in other states.

ACEP Finalizes New Strategic Plan

After more than eight months of collaboration and hard work, ACEP has finalized its strategic roadmap to guide the next three to five years. It features strategies and tactics that fall into five key areas:

1. Advocacy: Fighting for your rights across all levels, including federal, state, local, facility and administrative
2. Career Fulfillment: Tackling tough issues head-on and working with you to tackle frustrations that get in the way of career satisfaction
3. Member Engagement & Trust: Making it easier for you to connect with your corner of the ACEP community
4. Practice & Innovation: Revolutionizing acute, unscheduled care, developing new career opportunities and taking the lead in reshaping the emergency medicine workforce landscape
5. Resources & Accountability: Ensuring the thoughtful acquisition and management of resources to achieve our strategic goals

How did we get to this final plan? It started back in July 2021 when more than 100 ACEP members and staff were divided into eight action teams to provide in-depth feedback on ACEP’s strategic pillars. Once those drafts were developed, all ACEP members were invited to comment on the strategies in Oct. 2021. Those comments were sent back to the action teams, who reviewed and revised their plans to incorporate member feedback. The final strategic plan was reviewed and approved by the Board at January 2022 and is now available to view at acep.org/strategic-plan.

Find MyEMCert Success with PEERcert+

Your MyEMCert prep should be as efficient and effective as possible, which is why ACEP modeled PEERcert+ questions after the ABEM writing process. Our questions mirror how EM physicians manage specific presentations in their everyday practice. Because ACEP expects emergency physicians to demonstrate cognitive expertise in each MyEMCert topic area, we ensure PEERcert+ covers the topics most relevant to the exam, but we also aim to help you become a better physician by keeping you apprised of best practices in patient care.

All eight of your PEERcert+ modules are tailored to cover the topics designated by ABEM and, as such, includes core content questions, case series questions, and key advance questions—all of which are high-quality, thoroughly reviewed, board-style questions to help you efficiently prepare for the exam. PEERcert+ can help you succeed—not only on exam day but also in your everyday practice. We know you don’t want to just take an exam—you want to be the best emergency physician you can be. Learn more at acep.org/peercertplus.

Apply for ACEP Committees by May 15

If you want to take your ACEP involvement to the next level, consider applying to serve on an ACEP committee! By serving on one of ACEP’s 30+ committees, you can have a direct impact on the work that is important to the membership. The application deadline is May 15; learn more at acep.org/committees.

Call for Applications for the 2022 ACEP QI Challenge

The ACEP Quality & Patient Safety Commit tee (QPSC), in partnership with the Section of Quality Improvement and Patient Safety (QIPS), is pleased to announce a Call for Applications for the 2022 ACEP QI Challenge. QIPS, Applications are due May 31; learn more at acep.org/QICchallenge.
The University of Washington is a service mission-based program with an academic focus and lens. We are dedicated toward improving the communities we serve through training exceptional clinicians who are prepared to thrive in any clinical environment.

We have four core training sites that provide exceptional depth and breadth. Our residents train at Harborview Medical Center, a Level 1 trauma center and the county hospital for King County; The University of Washington, a quaternary care hospital with highly complex patient care; Seattle Children’s Hospital, and Valley Medical Center, a high-volume community hospital.

Three of these hospitals (Harborview, The University of Washington, and Seattle Children’s) are referral hospitals for Washington, Wyoming, Alaska, Montana, and Idaho. If patients from these states are too complex to be cared for in their communities, they are transferred to our care. This means our residents see a variety of traumatic injuries, complicated and complex pathology, and learn to care for patients from a variety of cultures and living environments far beyond the boundaries of King County.

What other opportunities does your program offer?

Specialty educational pathways: If you have an interest, we likely have faculty to help develop it further: Population health, global health, addiction medicine, climate change, EMS, medical education, ultrasound, critical care, quality improvement, neurocritical care, and research.

Rotate in a low-resource setting: All our senior residents have the opportunity to rotate in a setting where they can learn about caring for acutely ill and injured patients from rural areas where there are few specialists.

What do you love about this program?

The faculty and residents at the University of Washington are some of the most incredibly smart, fun, dedicated, welcoming, ethical, and engaged people I know.

—Fiona Gallahue, MD, FACEP, residency program director

University of Washington emergency medicine residents gather at the Center for Urban Horticulture for the Annual Program Review (photo taken in 2019).
Going Global: the Netherlands

by CEDRIC DARK, MD, MPH, FACEP, MEIC

Last time on World TravelERS we visited with ACEP Now columnist Dr. Ryan Radecki in New Zealand, a country whose health care system runs similar to Britain’s National Health Service due in part to their inclusion in the United Kingdom’s Commonwealth of Nations. Also termed the Beveridge system, named after William Beveridge who designed the UK system, New Zealand’s system is also strikingly similar to the United States’ Veterans Affairs Medical Centers.

This month we visit the Netherlands, a nation of 17 million people famous for its tulips, windmills, and wooden clogs. The Dutch possess a different type of health care system, one which began in 1941, and followed the German (or Bismarck) model. In 2006, the Netherlands merged the traditional public and private insurance markets into one universal social health insurance program that is underpinned by nonprofit private insurance and mandatory coverage. The Dutch model is a compulsory system that leaves fewer than 0.2 percent of people uninsured—all residents are required to purchase statutory health insurance from private insurers and all insurers are required to accept all applicants.

If that sounds familiar to you, well, it should because that’s what the Affordable Care Act (ACA) did several years ago for the individual insurance market in the United States. Just like with the ACA, a standard benefit package in the Netherlands includes things like hospital care, physician care, home nursing, mental health care,

HINA GHORY, MD, FACEP

ED Medical Director and Chair, CareWell Health Medical Center (New Jersey)

For new ACEP Fellow Dr. Hina Ghory, life is a balance between family time, work, and hobbies. When she’s not in the emergency department (ED), you can find her serving at the free health clinic at her community mosque or as a volunteer physician at Camp Nejeda, a summer camp for children with Type 1 diabetes (her daughter was diagnosed when she was 13 months old).

Dr. Ghory discovered a knack for drawing and painting as a middle school student in Pakistan—a hobby that continues to bring her joy and life-balance. A realistic artist who specializes in drawing animals with chalk pastels and charcoal, Dr. Ghory likes to dedicate her artwork to her kids because, “they like to feel like they’re part of my art.” She often gifts her drawings to friends and family.

How has working on your art helped you feel more balanced during the pandemic?

I'm in my happy place when I have time to work on my art. During the pandemic, I was able to set up a better, more user-friendly space for me to do my art. I learned of some stressful information over the weekend and the best way to deal with that was to work on an art project. For me, art is a way to de-stress.

A high school teacher once told me that, those of us who like to do realistic art are not satisfied until we see whatever we’re working on ‘take a breath.’ And that’s something that rings very true with me. If I start a new art project, it’s almost like I’m really driven. I get very focused on that piece of work and I push it and push it until I actually see it really come to life. That’s what really is very satisfying for me.

“Mandarin Duck” is one of Dr. Ghory’s favorite artworks she’s created.

5 Fun Things with Dr. Ghory

1. Listening to: Bollywood music.
3. Watching: Our whole family is watching “Merlin” these days. It’s really nice that now that [our kids] are at an age where they are interested in watching more than just cartoons.
4. Treating myself with: I like to have two pieces of Godiva chocolate with chai. I make a really good chai!
5. Excited about: I’m really excited about my new job as medical director and getting to work with the whole hospital on different issues. Personally, we’re taking the kids to Disney World, so that’s going to be fun.

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.
and prescription drugs. However, there are some things that are left out. People tend to purchase supplementary insurance to cover items such as dental care, alternative medicine, physiotherapy, eyeglasses, or contraceptives.

To learn more about the Dutch health care system, I spoke with Dr. Terrence Mulligan, adjunct professor of Emergency Medicine at the University of Maryland School of Medicine, vice president for the International Federation for Emergency Medicine, and a board member for the American Academy of Emergency Medicine. Dr. Mulligan lived in the Netherlands from July 2006 through November 2010 and went back two to three months per year over a period of three years.

In the U.S., we tend to see people that lose their insurance or are in between insurances. Do people wind up in between insurance at all or is it just a seamless transition if they want to go from one insurer to another insurer without having any detriment to their health care plan?

Dr. Terry Mulligan: Everybody there has private health insurance and you are mandated by the government to have private insurance. If you cannot afford it, then you are enrolled in government subsidy programs that work with you to determine when, why, and how it is that you can’t afford it. One of the big barriers to buying private insurance in the U.S. is the unbelievably enormous cost. I think it’s somewhere between $15,000 and $20,000 for a family if you just buy it on the open market. In the Netherlands, my whole family was covered at a cost of about 1,000 euros a year out of pocket. My employer paid for another 1,000 or so, and the government picked up 2,000 or 3,000 of that. It is a private insurance market, but it’s mostly provided by government subsidy.

There are a couple other things that were mandated as part of this private insurance competition market—it is all not-for-profit. That doesn’t mean that people aren’t making a living, not-for-profit doesn’t mean that people don’t do it for the wrong reasons, but they have mandates on the way that those insurance companies behave in that there’s no cherry picking. There are little to no copays or out-of-pocket costs. There are very few exemptions and [their system] encourages a lot of intra-company streamlining and efficiency building, kind of proprietary gamesmanship in order to make themselves more competitive in that market.

What is the greatest lesson you think you learned from the Dutch that could inform how we might structure our health care system in the U.S. moving forward?

TM: The things about [the Dutch] experience that showed how successful they were and things that we should borrow are that they’re very open to looking outside the field of medicine. For example when they borrowed pieces from IT and from the internet, [in the early 2000s] online teaching and learning was still kind of a new thing. They had a lot of sharing and collaborations. Also, look outside your borders, your country borders, your ethnic borders, your language borders, your socioeconomic borders. There are a lot of countries where everyone speaks English, but they might not open their arms to somebody coming in and teaching in English. [The Dutch] are very open to outsiders and outside concepts.
warning, according to Anton Volosovets, MD, Dr. Sc., head of the department of emergency medicine at Shupyk National Healthcare University of Ukraine in Kyiv.

“People in occupied regions are without food, electricity, and gas, which leads to humanitarian catastrophe,” Volosovets says. “Children are dying without receiving basic life support. From the beginning of the war, we know of about 38 murdered children and 71 children who were wounded.”

ACEP Liaison Vitaliy Krylyuk, MD, a surgeon and emergency physician at the Ukrainian Scientific and Practical Center of Emergency and Disaster Medicine, a division of Ukraine’s Ministry of Healthcare in Kyiv, says what is going on is not a military operation, but terrorism. “It’s like World War III,” he says. “They [the Russians] absolutely don’t have any humanitarian principles.”

On March 1, ACEP released the following statement commending the bravery and steadfast commitment of emergency physicians currently treating patients in Ukraine.

“ACEP proudly supports the emergency physician colleagues currently working in Ukraine,” said Gillian Schmitz, MD, FACEP, president of ACEP. “Emergency physicians across the world make a promise to treat anyone, anytime, and that means during conflict, disaster, pandemic, or any other difficult time. ACEP members are courageously rising to meet the moment and treat patients under extraordinary circumstances and incredible duress.”

Brian R. McMurray, MD, FACEP, an attending physician at Vanderbilt University School of Medicine and ACEP’s Lead Ambassador to Ukraine, has been to Ukraine more than 40 times. We spoke with him via Zoom when he was in a location near the Moldovan border, working with local officials to set up deliveries of humanitarian supplies. Long-time friends with Dr. Krylyuk, McMurray says he wishes he could be with his colleague in Kyiv, but the corridors used for getting in and out of the city are not safe. That evening, he met a couple of families in the border town where he is staying; they had evacuated through one of these corridors after spending 12 days in their basement. “They finally couldn’t stand it anymore,” he says. “They just got to the Moldovan border earlier today, dropped off their wives and kids and are headed back to the battle ground. That is a microcosm of Ukraine today.” He added that men who are 18 to 60 years old in Ukraine are required to serve in the war unless they have three children or more, and that even if it weren’t required, they want to fight for their country.

“I came here for my first visit in 1996,” McMurray says. “Five years into their separation from the Soviet Union. Now they know freedom and they’re not about to become a Soviet puppet republic ever again.”

Coping
Ukrainians are undergoing great stress, fear, anger, pain, hatred, and despair, says Volosovets. For health care workers who remained in Ukraine, there are long hospital shifts amidst a fear for the safety of their own families. There is constant doom-scrolling online for news about the war and its victims and a feeling of uncertainty for the future.

“All these factors simply crush your nervous system and deplete its reserves,” he says. “I’m glad that I’m not only an emergency medicine doctor but also a neurologist. I was trained to keep my mind calm and logical even in the most harsh situations.”

This knowledge also helps Volosovets treat patients and help colleagues, relatives, and friends by teaching them relaxation techniques, breathing exercises and special physical exercises to remain calm. “The best treatment from anxiety and fear is work,” he says. “Work that helps my country and makes our common victory closer.”

ACEP does not coordinate disaster relief, but works to connect those who want to help with those who need assistance. Visit acep.org/globalconflict to learn about various relief organizations. You’ll find an article from ACEP’s International EM section about how to join an International Medical Response Team, plus a link to the International Relief forum in ACEP’s EngagED platform where emergency care clinicians can post opportunities to serve and support.
In Kyiv, emergency physicians are seeing polytrauma, gunshot patients, brain concussions and other injuries. They are also seeing cases like heart attacks and strokes. For triage, Volosovets and his colleagues are using the standard M.A.R.C.H. approach (Massive hemorrhage, Airway, Respiration, Circulation, Head injury/Hypothermia) with further evacuation to hospitals with proper specialization, when possible, by ambulance or in the case of non-urgent injuries with the help of military or civilian transport.

However, there are great problems with transportation logistics inside towns due to the destruction of bridges and buildings. “Our ambulances are suffering most because of it,” Volosovets says. “Also, it appears that hospitals and doctors are a favorite target for Russians. They are intentionally bombarding our hospitals, killing our doctors and shooting at ambulances. The sign of a red cross has been turned into a target.”

Nonetheless, Ukrainian doctors remain true to their commitment to treat all injured people, including Russian soldiers. “They have received proper treatment in our war hospitals alongside our soldiers,” Volosovets says. “We do not make any difference between our patients.” He added that the question of judgment for war crimes is not a doctor’s jurisdiction and although the Russians are not respecting international laws of war and the Geneva Convention, Ukrainian doctors remain bound to these laws and medical ethics.

While some of Volosovets’ colleagues have sent their spouses and children to safer parts of the country or to neighboring countries, he and his family have decided to remain in Kyiv. Dr. Krylyuk’s parents, grandparents, sister, and nephew evacuated to western Ukraine near the Romanian border. “I feel very calm because I know my family is absolutely safe now,” he says. “Also, it appears that hospitals and doctors are a favorite target for Russians. They are intentionally bombarding our hospitals, killing our doctors and shooting at ambulances. The sign of a red cross has been turned into a target.”

Volosovets says, will enable Ukraine to win this war. “And we win it not just for ourselves. We win it for the idea of worldwide safety, stability of borders and ideals of democracy, free will and independence,” he says. “Because if we fall, it would be a signal for every tyrant on Earth.”

Dr. McMurray also welcomes correspondence from ACEP members seeking information about how help in person in Ukraine. He can be reached at: BRIANMCM52@aol.com

“Some of my colleagues even take their families with them to the hospital and simply live there alongside patients. They think that it would be safer—hoping that Russians won’t shoot missiles in hospitals. Reality is quite the opposite, as we can see,” Volosovets says.

Protocols

After so many years, emergency medicine in Ukraine has had to catch up to emergency medicine in U.S. Dr. Krylyuk says their triage system was not set up for mass casualties. “We just started to organize the triage system in our civilian hospital because this situation was completely unexpected,” he says. “It was unimaginable.”

We spoke with Dr. Krylyuk on March 10 at a time when there was a full in the fighting in Kyiv, with Ukrainians holding back Russian troops. He and his colleagues were spending their time preparing for the possibility of mass casualties and working out the logistics and protocols to put in place that would involve alternate ambulance routes to the hospital, number of stretchers needed, record-keeping for unknown patients, and color coding for triage. The system is based on international protocol and assisted by Dr. Krylyuk’s multiple visits to the U.S. in the past (where he attended ACEP’s scientific meetings) as well as his visits to Canada, Israel, and western Europe. “I have taken many courses and imagined how to create this and organize a system,” he says.

Dr. Krylyuk has created protocol documents that he says might ordinarily take a year to get the stamp of approval from the government. With the urgency of the current situation, however, that approval was granted in days. Now, for example, instead of it taking 20–30 minutes to send a patient to several different buildings for a transfusion, blood is available in the operating room and other places in the hospital where it may be needed immediately.

Supplies and Donations to Hospitals

Blood supply is currently plentiful in Kyiv. Volosovets says he is proud of his people; in the first days of the war, they received so much donor blood that for the first time in his memory they received blood banks were overfilled. “We are all trying to do our best now,” he said.

They do need medical supplies, medication, equipment, and combat med kits, however.

RENEÉ BACHER is a freelance medical writer located Baton Rouge, Louisiana.
ACEP4U: Supporting Research that Moves the Specialty Forward

by JORDAN GRANTHAM

One of the ways ACEP pushes for the advancement of emergency physicians is by encouraging and promoting innovative research that makes an impact on daily practice. You may already be familiar with the Emergency Medicine Foundation and ACEP’s annual Research Forum, but those are only a couple ways to get involved with emergency medicine research. Whether you’re an investigator, participant, or consumer, there is a role for everyone.

Emergency Medicine Foundation (EMF)

For a deep dive into emergency medicine (EM) research, we should start with the Emergency Medicine Foundation (EMF). Founded in 1973 by ACEP leaders, EMF is a 501(c)3 nonprofit that has awarded more than $18 million in research grants. In 2022, EMF is expected to award $1.3 million in funding to EM researchers, including $250,000 in new grants to support research on current issues: the EM workforce, the value of emergency medicine, and physician wellness. This year’s awards will be announced in the summer and projects will begin in July. To get a better understanding of the grants funded by EMF, visit https://www.emfoundation.org/grantee/grantees-2021-2022/ to meet the 2021-2022 grant recipients and learn more about their research projects. To learn how you can support EMF’s mission and contribute to the funding of research that drives emergency medicine forward, visit emfoundation.org.

ACEP Research Forum

It’s time to submit your ACEP22 Research Forum abstracts! The Research Forum, held annually in conjunction with the ACEP Scientific Assembly, is emergency medicine’s premier research event. The Research Forum typically selects more than 400 abstracts per year, presented live and virtually during the event. To be considered for the 2022 Research Forum, held Oct. 1–3 in San Francisco, submissions are due May 18 at acep.org/RF. When the Research Forum is an excellent opportunity for investigators to present their research, it’s also a popular event for ACEP22 attendees who want to hear about new findings, discuss advances in the specialty and understand practical applications for new data. Top abstracts are featured during its three plenary sessions, the State-of-the-Art sessions feature conversations with prominent research leaders, the Brooks E. Bock Lecture features new advances and exciting research, and the Editor’s Pearls workshop provides tips for progressing from an abstract to a peer-reviewed publication. Planning is well underway for the 2022 Research Forum—look for a more detailed schedule in August.

Research Abstracts On-Demand

Last year was an especially prolific year for the Research Forum because of the addition of a special edition forum dedicated to COVID-19 research. Both events contained high-quality abstracts, many of which are now available on-demand in ACEP’s Online Learning Collaborative (acep.org/ocl).

EM Basic Research Skills (EMBRs)

For early researchers who want to hone their skills, the EM Basic Research Skills Conference is the right spot. EMBRs is a nine-day, two-session program (fall and spring) providing a broad overview of the basics of research, from idea to IRB approval to final presentation and publication. The course includes an introduction to statistics and statistical software, plus sessions on publishing and presenting. Save the date for the next EMBRS sessions: Oct. 17–22, 2022 and April 13–15, 2023. Learn more at acep.org/EMBRs.

EM Practice Research Network

If you want to support emergency medicine research without actually doing the research, EMPRN could be the perfect fit for you. By joining this network, you’re committing to completing up to four research surveys per year covering an extensive range of subjects within your specialty. Participating in these surveys is a way to help investigators reach REAL emergency physicians, giving you a voice on issues critical to emergency medicine. Join the practice research network at acep.org/EMPN.

SIX WAYS TO SUPPORT EMERGENCY MEDICINE RESEARCH

1. Apply to serve on the ACEP Research Committee (deadline: May 15).
   acep.org/committee-applicants

2. Join the ACEP Research, Scholarly Activity and Innovation Section.
   acep.org/emresearchsection

   acep.org/empn

4. Participate in the annual Research Forum as a presenter or attendee (abstracts due May 18).
   acep.org/RF

5. Donate to the Emergency Medicine Foundation.
   emfoundation.org

6. Apply for an EMF research grant.
   emfoundation.org

Research, Scholarly Activity and Innovation Section

ACEP’s Research, Scholarly Activity and Innovation Section is a community for networking, sharing ideas and collaborating on resources to help the emergency medicine research community. You’ll find many resources developed by the section on ACEP’s research web page (acep.org/research), including:

- Emergency Care Research Primer, a digital guide covering research topics, mentoring, research training, grant writing, presenting, publishing, and other aspects of successful research careers.
- Resident Research and Scholarly Activity Primer, a new digital book to help residency and research leadership implement scholarly activity to engage and inspire future generations of EM researchers.

Research Publications and Podcasts

Keep updated on new research through ACEP’s peer-reviewed journals and journal podcasts.

- Annals of Emergency Medicine is the number one journal in emergency medicine and is celebrating its 50th anniversary this year (annemergmed.com). Listen to the Annals of Emergency Medicine Podcast, hosted by Ryan Radecki, MD, FACEP, and Rory Spiegel, MD, on all major listening platforms.
- JACEP Open, the official open access journal of ACEP, is a complementary publication to Annals (JACEPopen.com). Find the JACEP Open Podcast, hosted by Matthew DeLaney, MD, FACEP, and Jeffrey Jarvis, MD, FACEP, on all major listening platforms or visit acep.org/podcasts to see the full podcast family.

Sarah Keene, MD, addresses the crowd during the Emergency Medicine Foundation’s Awards Showcase during ACEP21 in Boston.
2022 Course Topics

- IV Ketamine for Depression and Suicidality in the ED?
- Is Thrombolysis Needed Prior to Clot Extraction in Stroke?
- COVID Therapies: What Works, What Doesn’t - Part 1
- Posterior Circulation Stroke – A Tough Diagnosis
- LP for Subarachnoid Hemorrhage: Who Gets It?
- 2021 AHA Chest Pain Guidelines: Game Changer - Part 1
- 2021 AHA Chest Pain Guidelines: Game Changer - Part 2
- Bronchiolitis: Less is More
- Post Cardiac Arrest Pearls
- Pearls from Risk Management Monthly - Part 1
- Pearls from Risk Management Monthly - Part 2
- Tranexamic Acid – Lessons Learned
- Importance of Shared Decision Making
- The 2021 AAP Guidelines for Febrile Infants - Part 1
- The 2021 AAP Guidelines for Febrile Infants - Part 2
- PE – Overtesting / Disposition
- Critical Care Grab Bag
- Trauma Pearls from the Recent Medical Literature
- Emergency Medicine New Products - Part 1
- Emergency Medicine New Products - Part 2
- Sexually Transmitted Infections – 2021 Guidelines
- New Advances in Prehospital Care
- Visual Diagnosis Challenges - Part 1
- Visual Diagnosis Challenges - Part 2
- What’s New in ED Airway Management?
- Reader Beware – Predatory Publishing / Preprints
- Important Recent EM Literature - Part 1*
- Important Recent EM Literature - Part 2*
- ED Staffing and Operations Forum*
- Diagnostic and Therapeutic Controversies*

*Topics listed with an asterisk (*) are 90-minute faculty panel discussions; all other topics are 30 minutes.

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By Anand Swaminathan, MD, MPH

As the COVID-19 pandemic rages into its third year, we continue to face the massive challenge of limited targeted therapeutics. Early on, a host of pharmaceuticals were repurposed to fight COVID despite insufficient evidence. In the face of a novel virus, this was a reasonable approach, but the majority of these agents (e.g., hydroxychloroquine, ivermectin, colchicine and azithromycin) have been found to have no benefit in subsequent high-quality research. Despite the normal setbacks in research, we have identified a handful of useful therapeutics. It’s critical that clinicians stay current on the changing landscape of COVID medications. Let’s sort through the tidal wave of publications to get to the good stuff.

Monoclonal Antibodies (mAbs)

Mechanism of action: Give patients antibodies against SARS-CoV-2 early in their disease course to help stop cellular invasion and thus the development of severe COVID. It should be noted that mAbs have never been shown to be effective in patients who are:

- Seropositive for SARS-CoV-2 antibodies (e.g., once you have a polyclonal antibody response to infection, a monoclonal antibody isn’t going to help)
- Previously vaccinated

Millions of doses of bamlanivimab, etesevimab (and combination of the two) and the REGN-COV2 cocktail (casirivimab/imdevimab) have been administered, but the medications are currently not in use due to lack of efficacy against the Omicron variant. Currently, sotrovimab is the only mAb available for use against Omicron in the United States but is extremely limited in availability. mAbs play a limited role in the pandemic in part due to rapid development of resistance. Efficacy research is often rendered obsolete by the rise of a new variant. Publication of the RECOVERY trial’s final casirivimab/imdevimab results is a good example; by the time all the data were available, analyzed and published, the Omicron variant was dominant, making this mAb cocktail useless. Additionally, mAbs are expensive, limited in availability and extremely resource-intensive, further limiting their utility. Due to these limitations, we continue to see new mAbs getting emergency use authorization, including the most recent bebtelovimab, without any clinical data.

Bottom line: Patients presenting early in their disease course (prior to mounting an antibody response) who are unvaccinated or are immunosuppressed and are unable to mount a normal response to vaccination may benefit from mAbs. Ideally, point-of-care testing would be available to determine which patients are seronegative, but this is not currently feasible.

Antiviral Agents

Mechanism of action: Although they have different specific mechanisms, all direct-acting antiviral agents seek to prevent the development of severe COVID-19. As a result, these agents only work when started (very) early in the disease course.

Remdesivir was the first targeted antiviral agent to gain widespread use based on ACTT-1, which demonstrated a four-day-shorter time to recovery versus placebo. Closer review of the data, however, demonstrated that the benefit was only seen in those receiving oxygen but not high-flow or non-invasive ventilation. Additionally, although recovery was more rapid, hospital length of stay was unchanged (perhaps due to the need to finish the course of remdesivir, which is only available intravenously). Subsequent data from the World Health Organization demonstrated no significant benefit in mortality, initiation of mechanical ventilation or duration of hospital stay with remdesivir treatment. These findings were echoed in the DisCoVeRy trial, and ultimately, we should conclude from the available high-quality evidence that remdesivir does not have a significant benefit in patients requiring hospitalization for COVID-19. This makes sense because patients requiring hospitalization are likely out of the early phase of infection where antivirals have benefit and have entered the inflammatory phase.

More recently, the PINETREE investigators found a 4.6 percent absolute reduction in hospitalization (NNT ~22) when remdesivir was given to outpatients with COVID-19 early in the disease course (<7 days from onset) as three once-daily infusions. This significant reduction is important but will require validation. Additionally, many hospital systems and communities are unable to support outpatient infusion.

The major limitation with remdesivir treatment is the resource utilization required by an intravenous medication. This limitation has seemingly been overcome with the more recent emergency use authorizations for molnupiravir and Paxlovid. Molnupiravir was shown to result in a 27 percent absolute decrease...
crease (30 percent relative reduction) in hospitalization when administered within five days of disease onset. Molnupiravir appears to have teratogenic properties limiting its use.

When compared to placebo, nirmatrelvir/ritonavir ( Paxlovid ) resulted in a 5.8 percent absolute reduction (86 percent relative reduction) in hospitalization or death when given within five days of symptom onset. Side effects were minimal. Paxlovid use is limited by availability as well as numerous drug interactions.

The major issue with both oral antivirals is the ability to get to these patients early in the disease process. This requires that patients immediately recognize their symptoms could be due to SARS-CoV-2 infection, get rapid access to a diagnostic test, get test results quickly, get a prescription from a clinician and get that prescription filled. Overcoming these obstacles is a massive challenge for many.

**Bottom line:** Remdesivir does not appear to play a significant role in patients requiring hospitalization with COVID-19 but may be beneficial early in disease to prevent hospitalization; however, massive resources are required for administration. Molnupiravir and Paxlovid both offer significant benefit if early administration is possible.

**Steroids**

**Mechanism of action:** Serious outcomes (hospitalization, end-organ damage, mechanical ventilation, death) are driven by the hyperactive host inflammatory response. Both agents work by suppressing the cytokine pathway.

**Initial studies on tocilizumab failed to show consistent benefits.** This may have been a result of corticosteroids not being used in tocilizumab in either the control group or treatment arm. The RECOVERY Collaborative remedied that situation with its large high-quality study where the majority of patients received steroids. It found that in hypoxic COVID patients with signs of systemic inflammation (C-reactive protein ≥75 mg/L), tocilizumab, when added to dexamethasone, improved 28-day mortality by 4 percent (NNT = 29). Additionally, the tocilizumab group performed better in terms of their secondary endpoints of mechanical ventilation and discharge home.

Studies on baricitinib have been less straightforward. Early studies showed suggestions of benefit but, as with tocilizumab, did not have widespread use of systemic steroids. Most patients in the COV-BARRIER trial did receive steroids as standard care. The trial fell short in showing a statistically significant benefit for its primary outcome of disease progression in patients with hypoxemia and signs of systemic inflammation (elevated C-reactive protein, D-dimer, lactate dehydrogenase or ferritin). There was a significant improvement in mortality (secondary outcome) that was more pronounced in patients with hypoxemia (9.5 percent reduction).

**Bottom line:** Patients who have severe COVID-19 with signs of systemic inflammation and hypoxia should be considered for tocilizumab treatment in conjunction with systemic steroids. Baricitinib requires further research but may (or may not) be a reasonable adjunct in patients with systemic inflammation and hypoxia.

**Pharmacoequity**

Regardless of the agent, pharmacoequity ("Ensuring that all individuals, regardless of race and ethnicity, socioeconomic status or availability of resources, have access to the highest-quality medications required to manage their health needs," according to Statice Dustezena, PhD) is a paramount consideration. There is emerging evidence of racial disparities in the administration of monoclonal antibodies, remdesivir and dexamethasone. Communities of color have been disproportionately affected by COVID-19 throughout the pandemic. We must ensure that all patients have access to the best available treatments.

The need for antiviral medications and mAbs to be start-

ed very early in the disease course is particularly challenging because of the numerous obstacles to overcome to reach those treatments. Streamlining the process to get tested and access medications as well as reducing or eliminating costs are critical to achieving pharmacoequity.

**References**

HUMAN TRAFFICKING

CONTINUED FROM PAGE 1

point of access for trafficked persons. In a study of 173 survivors of human trafficking, nearly 70 percent of individuals were seen by a health care provider while being trafficked; the ED is the most frequently accessed of these settings.1 The study sought to improve the health care settings most frequently visited by victims of human trafficking. Unfortunately, as many as 90 percent of sex-trafficked persons may go unrecognized by their physicians.2 Why do victims so frequently go undetected in the ED? This problem is due in part to medical staff often lacking the necessary training to identify trafficking victims and health care institutions rarely implementing standardized procedures to guide staff on the appropriate actions.

Recognizing Human Trafficking in the ED

An important first step in improving ED staff’s recognition and response to trafficking is implementing educational interventions. In fact, ACEP’s 2020 Policy Statement on human trafficking recommends that “emergency medical services (EMS), medical schools, and emergency medicine residency curricula should include education and training in recognition, assessment, documentation, and interventions for patients surviving human trafficking” and that “ED and EMS staff receive ongoing training and education in the identification, management, and documentation of human trafficking victims.”3 Many studies have shown that various formats—including didactic sessions, online modules, interactive workshops and case-based simulations—effectively increase ED staff’s baseline knowledge of sex trafficking and improve preparedness to identify and assist victims, but are infrequently identified.4–6 To address this issue, we developed and piloted a training intervention for physicians on human trafficking and how to identify and treat these patients. Included in the intervention participants were emergency medicine residents, ED attendings, ED nurses, and hospital social workers. Prior to the intervention, 4.8 percent felt some degree of confidence in their ability to identify and 7.7 percent to treat a trafficked patient. After the 20-minute intervention, 53.8 percent felt some degree of confidence in their ability to identify and 56.7 percent care for this patient population. Because this problem is global, we created a website that includes an instructive toolkit and an interactive course for self-learning and/or assessment. This intervention will give emergency physicians the tools they need to assess and treat a patient who might be a victim of human trafficking.7 Emergency physicians are on the frontlines of identifying and caring for trafficked persons. However, most emergency providers have never received training on trafficking, and studies report a significant knowledge gap involving this important topic. Workshops often employ a “train-the-trainer” model to address clinicians’ knowledge gaps involving various topics (including trafficking).

Of note, most successful educational interventions were less than one hour long, suggesting that improvements are attainable even with time constraints. An important aspect of educational interventions is a focus on warning signs and symptoms that should alert emergency physicians to further investigate whether the patient may be a victim of trafficking. Examples of these warning signs include inconsistencies in one’s explanation of an injury, accompanying person speaking on behalf of the patient, signs of physical or sexual abuse, medical neglect, untreated sexually transmitted infections.
and/or excessively anxious behavior. These trainings should also emphasize the importance and application of trauma-informed care.

Once emergency staff has a foundational understanding of sex trafficking, the next step is to implement a standardized screening tool. Emergency physicians and nurses should utilize a screening tool any time they have a reason to suspect a patient may be in a trafficking situation; an understanding of potential warning signs is key as these red flags will alert the clinician to proceed with a formal screening. Importantly, the threshold for suspicion should be kept low to reduce the likelihood of missing a case of trafficking. Many screening tools exist, although they vary considerably in length and design. To date, two screening tools have been validated for use in the emergency department setting.

The Greenbaum Tool (see Figure 1) was developed specifically for use in pediatric emergency departments in patients between the ages 11 and 17.

Rapid Appraisal for Trafficking (RAFT) tool (see Figure 2) was validated in 2021 for use in the adult ED patient population and is a comprehensive trafficking screening tool for use in health care settings. These screening questionnaires should be readily available to ED staff—either at the nurses’ station or embedded in the electronic medical record—or should be memorized and rehearsed for faster recall.

Setting Protocols in Place

When faced with a positive screen, ED staff may be unsure of how to best assist their patient. Thus, another crucial step to improve care of trafficking victims is the implementation of standardized protocols. These protocols should integrate a screening tool with guidelines for the next steps to assist the victim. The HEAL Trafficking and Hope for Justice’s Protocol Toolkit is a great starting point for health care institutions to develop their own protocols. When developing a protocol, it is necessary to identify local organizations and services that can assist victims as the patient may have many immediate needs that need to be addressed including housing, medical follow-up, mental health services and substance use treatment. Moreover, these protocols will provide procedures to ensure the safety of the patient and staff as well as guidelines on when to involve outside agencies, such as local, state, and federal law enforcement and child protective services.

In the often- hectic environment of the ED, it is no surprise that sex trafficking victims often slip through the cracks. However, there are feasible steps that can be taken to ensure ED staff are properly trained and have the necessary tools to identify and assist victims.

References


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The Rapid Code Status Conversation

Mastering the crucial skill of rapid code status conversations

by ALEXANDER ZIRULNIK, MD, MPH; KEI OUCHI, MD, MPH; DAVID WANG, MD; AND EMILY AARONSON, MD

As emergency physicians, we are trained in the core procedures surrounding critical illness and resuscitation, such as endotracheal intubations, central venous catheter placement and chest tube thoracostomies. However, a critical component of the initial resuscitation that is often not recognized as a critical procedure is the rapid code status conversation. Concepts surrounding goals of care, communication of challenging news, and recognition of palliative care basics are fundamental for modern emergency physicians to practice compassionately and effectively. More than 75 percent of Americans visit an emergency department within the last six months of life. As such, it is not surprising that the treatment decisions made in the emergency department affect the trajectories of care of these patients. To that end, understanding the nuances and specific skills needed to care for patients at the end of life is critical for emergency physicians. This includes ending resuscitation efforts if they are not aligned with the patient’s goals of care. In addition to this being a core component of high-quality patient-centered care, there have also been several “wrongful life” lawsuits in which doctors did not follow advance directives (MOLST or POLST forms) or the direction of health care proxies, further reinforcing the importance of this issue.

Goals of care is a term frequently used when referring to a patient’s intubation or code status; however, the term should instead be understood more broadly and relate to every facet of care that a patient receives. Unfortunately, many patients have never had a goals-of-care conversation prior to arrival in the emergency department. Some who have cannot recall it or arrive without documentation of it. Of course, the challenge of having these conversations in the emergency department is the time-pressed environment we work in, clinical instability of our patients, and our lack of longitudinal relationships.

In addition to patient access to more “upstream” goals-of-care conversations in the outpatient setting, or with clinically stable patients in the emergency department leveraging the interdisciplinary team such as registered nurses or social workers, it remains critical that all emergency physicians are facile with the rapid code status conversation: a conversation that elicits the critical information we need to ensure goal-concordant care in a way that is amenable to our time-pressured environment. However, when surveyed, 80 percent of residents expressed a need for more training in palliative medicine. Much like any other procedure taught to us in training, we have outlined the key components of a rapid code status conversation, leveraging prior work, that should only take minutes to complete.

1. Establish Urgency and Elicit Understanding

Promptly establish rapport with the patient/surrogate by introducing yourself and the situation. Establish urgency regarding the patient’s clinical condition and ask permission to discuss next steps. Before moving on, establish what the patient/surrogate already knows regarding the patient’s condition, which will enable you to be more efficient and not repeat information that is already known.

2. Break the Bad News

Obtaining permission prior to this step allows for the patient or family/friend to emotionally prepare and gives them a sense of control. After obtaining permission, deliver the headline using simple, straightforward lay terms. Often, this a time for the physician to recognize and respond to emotions as they arise.

3. Learn Their Story

Understanding

It is important to concisely learn the patient’s history and values related to an acceptable quality of life. The physician may first use an alignment statement to frame the conversation. An example of this may be, “For us to decide what’s best for your loved one, it’s important that I understand more about them—what they are and what matters most to them.” Included in this step is learning about the patient’s baseline quality of life, which will allow both for prognostication and recommendations. Even as some patients hope to avoid death and we as physicians attempt to prevent it, many patients identify scenarios that they deem worse than death. In a cohort study, more than 50 percent of those surveyed said that relying on a breathing machine to live was worse than death. Nearly half of respondents also stated that the inability to get out of bed is worse than death. Living in a nursing home was also worse than death for 75 percent of Americans visit an emergency department within the last six months of life.

4. Summarize and Recommend

Recommends (Intubation Example)

Based on what you’ve shared with me and what is most important to you, I worry that you won’t be able to return to the quality of life that is important to you or even how you were yesterday. I recommend that we use treatment focused on...

No Intubation

...trying to recover from this illness. This means supporting your body in recovering from this illness with intensive treatments, including a ventilator, while doing everything we can to ensure that you are as comfortable as possible.

The headline using simple, straightforward lay terms. Often, this a time for the physi- cian to recognize and respond to emotions as they arise.

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percent of older adults. Unknown to most of the general population, one in three older adults who are intubated in the emergency department will not survive the hospitalization. Among those who do survive, nearly 80 percent will be discharged somewhere other than home, such as a long-term care facility or nursing home.¹

4. Summarize and Recommend

After reviewing the patient’s values and acceptable quality of life, the emergency physician should summarize what they heard from the patient or surrogate before moving on to recommendations. It is critical that any recommendation aligns with the patient’s values and is not biased on the clinical presentation or assumptions made about the patient’s prior quality of life. The physician should reflect on whether the treatment course will realistically allow for the patient to return to the quality of life they experienced prior to this acute illness. Using the example related to endotracheal intubation:

Palliative care is best when it serves the patient throughout their life-limiting illness. However, many emergency physicians find themselves initiating core palliative concepts, such as goals-of-care conversations, to patients in extremis or their loved ones. In only a few minutes, using the steps and tools mentioned here, physicians can master the crucial procedure of rapid code status conversations and can deliver care that is aligned with the patient’s values and goals.²

References

DR. ZIRULNIK is a second-year resident in the Harvard Affiliated Emergency Medicine Residency. DR. OUCHI is an Assistant Professor of Emergency Medicine at Brigham and Women’s Hospital/Brigham and Women’s Hospital.
The Case
A 61-year-old man presented to the emergency department with a documented chief complaint of chest pain.

The triage nurse documented, “Pt here w/ c/o legs vibrat- ing and abdomen feels like is going to explode. Pt denies chest pain. Pt states he had one episode of loose stools today after eating radishes, tomatoes, eggs and [lox]. Pt also has central vitamin. Pt w/multiple complaints.”

His vital signs showed a blood pressure of 169/84, pulse 66 bpm, respira- tions 18/minute and a temperature of 96.6 degrees F.

After reviewing the patient, the emergency physician documented, “abrupt onset of the sensation that he had a lid of a paint can that began in his epigastrium and slammed up into his jaw and then came down and continues to compress upon his abdomen. It came abruptly after he loaded the car.”

His past medical and surgical history was positive for aortic valve replacement, but he denied coronary artery disease and history of abdominal aortic aneurysm.

His medication list included warfarin, metoprolol, and a multivitamin.

The physical examination was noteworthy for a tender epigastrium, and an aortic pulsation was palpable in his abdomen despite his large body habitus.

Labs were ordered, including a CBC, CMP, troponin, CK, PT and PTT. None of these had any remarkable results. The INR was therapeutic at 2.8.

An ECG was obtained, and the doctor documented, “First-degree AV block, normal axis, T-wave inversions in aVL without prior for comparison.”

As is evident from the history and exam, the doctor was very worried about aortic pathology, especially the possibility of an abdominal aortic aneurysm. However, the patient had a documented anaphylactic allergy to contrast dye. Therefore, a noncontrast CT of the abdomen and pelvis was ordered.

The results are shown here:

The doctor wrote a good note summarizing the findings, concluding, “the patient was admitted given our uncertainty as to the patient’s pain. He was clearly uncomfortable.”

The hospitalist came and saw the patient, writing an admis- sion H&P with essentially the same information and conclu- sions. She consulted cardiology as well, who saw the patient concluding, “the patient was admitted given our uncertainty.

Labs were ordered, including a CBC, CMP, troponin, CK, PT and PTT. None of these had any remarkable results. The INR was therapeutic at 2.8.

A repeat ECG showed ST changes (however, no specific tracings was included in court records), and the intervention- al cardiologist decided to take the patient to the cardiac catheterization lab.

The patient’s wife contacted an attorney, who reviewed the case and offered to take it on contingency.

One of the main issues the emergency physician faced was the discrepancy in the chart about the patient’s chest pain. The H&P specifically stated the patient did not have chest pain, but the final admitting diagnosis was “chest pain.” Further, the triage nurse listed “chest pain” as the chief complaint, yet the triage note clearly stated he denied chest pain.

The patient did not have any imaging of his chest, neither an X-ray nor CT scan, during the emergency department stay. The plaintiff’s attorney was very critical that the emergency physician diagnosed “chest pain” but never obtained any chest imaging.

The plaintiff also alleged an EMTALA violation. They felt that the failure to obtain a chest X-ray represented a failure to conduct a medical screening exam. An emergency medi- cine expert witness opined that this patient’s workup was substantially different than that of other patients presenting with the same documented chief complaint (chest pain) to the same hospital.

The plaintiff’s attorney was able to force the emergency department to turn over records on all chest pain patients who had presented to the emergency department during the four weeks preceding this patient’s death. There were 222 chest pain patients during that period, and 212 had some type of chest imaging. The plaintiff’s EMTALA expert stated that the “[h]ospital, to a reasonable degree of medical certainty, violated EMTALA.”

The defense hired their own emergency med- cine expert to counter these claims. He wrote that the patient “repeatedly denied chest pain to each [member of the health care team]. A chest radio- graph is NOT part of a medical screening evaluation, specifically in a patient not complaining of chest pain.”

Outcome
The defendants and plaintiff ultimately agreed to arbitration. At arbitration, the case is decided by a neutral third party, thereby sparing both sides the time and expense of a trial.

Before arbitration, they reached a high-low agreement, which guarantees the plaintiff a minimum financial recovery but also caps the maximum amount, regardless of outcome.

The arbitrator returned the following decision:

The arbitrator awarded the plaintiff $791,500, paid entirely by the cardiologist’s malpractice insurance. The actual amount paid was $500,000 due to the cap from the high-low agreement.

Discussion
This case embodies an emergency physician’s worst nightmare. The patient had an extremely rare but life-threatening diagnos- is. Multiple issues distracted the emergency physician from the diagnosis and necessary workup, including the patient’s insistence that he did not have chest pain and his prior allergy to contrast. However, this case highlights the critical impor- tance of trying to avoid glaring discrepancies in the medical record, which can be easily used to make the physician appear inattentive.

The legal outcome here will also be surprising to many readers. Although it is relieving that the emergency physician did not lose the lawsuit, the fact that the cardiologist took the blame alone seems rather arbitrary and unjust. I would posit that if there is true medical liability in this case, it should have been shared among all parties.

Unfortunately, this case illustrates a pattern that has been identified in many malpractice cases. When a dissection is not diagnosed in the emergency department, the patient is often admitted to a chest pain observation unit or floor bed, where they suddenly decompensate. The true diagnosis eventually becomes identified, whether by echocardiogram or CT scan, but the patient does not ultimately survive to surgery. Reviewing the medical and legal outcomes in cases like these can help emergency physicians take better care of their patients and learn to document in a more effective and protective way.

To read the entire medical record from this case, as well as deposition transcripts from all parties and excerpts from the expert witness opinions, visit www.medicalreviewer.com/case-12-chest-pain.
Evaluating Your Youngest Victims in Child Abuse Cases

When toddlers present to the ED with indications of child abuse, it’s important to know how to gently evaluate and test...

The Case
A two-year-old girl presents with a rash on her face. This was first noticed when the child was picked up from the babysitter. Per parents, the child is otherwise healthy. She has been fussy and has vomited once.

How would you manage this child? What laboratory and imaging studies, if any, do you order?

Bruising From Abusive Trauma
The diagnosis of abusive trauma in children, particularly very young children, can be extremely challenging. Bruising is the most common presentation of child abuse. Certain patterns of bruising should raise the level of suspicion for physical abuse, including patterned bruising, any bruising on a nonambulatory child, and bruising to the torso, ears, or neck in a child under age four (i.e., TEN-4 bruising). Once abuse is suspected in a child with bruising, further medical workup, often including imaging and lab testing, may be indicated.

Laboratory Testing
In children with bruising concerning for abuse, the emergency physician should first determine whether bruising is due to trauma or to a bleeding disorder. Laboratory evaluation may not be required in cases where abuse has been witnessed, disclosed or in cases of patterned bruising. The most common bleeding disorders, which mimic nonaccidental trauma, are idiopathic thrombocytopenic purpura (ITP) and von Willebrand disease. Initial laboratory testing may not be required in cases of patterned bruising, any bruising on a nonambulatory child, and bruising to the torso, ears, or neck in a child under age four (i.e., TEN-4 bruising). Once abuse is suspected in a child with bruising, further medical workup, often including imaging and lab testing, may be indicated.

Radiologic Evaluation
Skeletal survey
The presence of skeletal fractures may support the diagnosis of abusive trauma. A skeletal survey is indicated in all cases of suspected nonaccidental trauma in children under the age of two years. The yield of skeletal surveys drops dramatically in children over the age of five years; whether to obtain a skeletal survey in children between the ages of two and five years should be left to physician judgement. Consultation with a child abuse pediatrician, if available, may be useful in making this determination.

A skeletal survey differs from what is commonly referred to as a babygram. While a babygram is composed of only one or two images that encompass the entire child, a skeletal survey consists of multiple views of the appendicular and axial skeleton. Images should include AP views of the arms, forearms, femurs, lower legs, feet, abdomen, lumbar sacral spine, and bony pelvis; PA view of the hands; AP and lateral views of the thorax and cervical spine; lateral view of the lumbar spine; and frontal and lateral views of the skull. The skeletal survey should ideally be performed by a technician with experience in obtaining these views and interpreted by a pediatric radiologist. If the child is to be transferred to a tertiary care center with a child protection team, the skeletal survey may be deferred until the child is under the care of the child protection team if agreed upon prior to transfer.

CT/MRI
Children with suspected head trauma should undergo CT or MRI. CT is readily available and has high sensitivity and specificity for intracranial hemorrhage. Skull and facial bone fractures may also be seen on CT. MRI is superior to CT in the diagnosis of shear injury and brain edema; MRI should be considered if there are findings on CT imaging or if CT is negative, but there is a high level of suspicion for intracranial injury.

Case Conclusion
The child has a pattern injury to her cheek consistent with having been struck with an open hand. Given the facial bruising, labs, a CT of the head, and a skeletal survey were all obtained. CT did not show any acute traumatic injury. The skeletal survey showed old rib fractures. Labs were not consistent with a bleeding disorder. The hospital’s child protection team is contacted and an investigation begins.

References
There is a debate going on in the inpatient world among hospitalists, bed management and other hospital leaders and managers. It is one that emergency physicians should familiarize themselves with because it affects hospital-wide patient flow and thereby boarding in the emergency department. The debate is whether hospitalists should work in geographic zones in the hospital. You may hear it discussed using a number of terms including geographic localization, geographic rounding, geographic cohorting, or simply geography. Geography refers to the organization and attribution of patients to a team operating in a defined area, typically a unit or a floor.

In the late 1990s, geography was a promising strategy for hospitalist medicine. Referring to the placement of patients in one unit or geographic area, this strategy allows the healthcare team to work together in proximity. It improves communication, improves productivity, removes wasted time spent in transit and improves length of stay by expediting discharge. As servers in the hospitality industry discovered, it is much more efficient for waitstaff to have all their tables in one area. Patient care teams found similar advantages when working in one hospital area. Most nurses, whether working inpatient or emergency department, have assignments involving contiguous rooms. Hospitalists also saw advantages in doing the same with their patient assignments. Geographic localization was coupled with another innovation: separating the admitting role and the rounding role for hospitalists. Thus, the “triagist” role was born. Separating these roles improved efficiency and throughput.

**FIGURE 1:** Conceptual model depicting impact of geographical localization of general medical teams on quality of care. Mediating factors that lead to better quality of care are described in blue boxes. Mediating factors that are unintended and lead to worsening quality of care are described in grey boxes. The impact on domains of quality of care is described in pink boxes. ‘↑’ indicates an increase; ‘↓’ indicates a decrease; Interdisciplinary Rounds.

However, in the 2000s, hospital bed capacity became even tighter, and medical centers increased in size and complexity. Many hospitalist services gave up geographic localization. For the sake of capacity, patients were now assigned to whatever staffed bed was available. At the same time, there was a growing concern in health care for the handoff of patients. Consequently, instead of patients being handed off to a single physician staffing one unit, patients remained with their admitting team. Hospitalists had patients scattered all over the hospital, covering massive inpatient footprints. Insidiously, hospitalists gave up the concept of dedicated geography, often resulting in patients landing on many different floors in different towers. The walk between patients situated in the farthest points of the hospital might exceed 20 minutes!

Meanwhile, the rest of the care team (nurses and case managers) continued to work in a unit-based model. The care team became fragmented, and communication became faulty. Facts about a patient’s care and course that were small but consequential were not shared in a systematic manner. Traditional rounding with the care team was abandoned.

Today, hospitalized patients are increasingly complex, and there are many necessary interfaces between care team members, sub-specialists and families during the hospital stay. Robust and regular communication has become essential to optimize patient care. Thus, the fractured care team can suffer from lapses in communication, which, in turn, result in delays in and dangers to patient care.

The pendulum appears to be swinging back in favor of geographic localization. In one study surveying hospitalists, 85 percent reported geographic localization and rounding was the most efficient care model. Studies have shown that when patients are geographically located in proximity to their care team members, communication is improved, and this translates into improvements in length of stay and decreased total rounding time. Geographic localization increased the direct communication between members of the care team and increased the likelihood that these team members could correctly identify one another. When residents have geographic localization, the number of rapid response calls goes down. Further, geographic localization was viewed to have a positive effect on the resident experience.

Geographic Localization Pro’s
• Saves time
• Quick service to patient
• Better HCAHPS
• Better communication
• Shorter LOS and lower readmission rates
• Reduction in sentinel events
• Reduced time on round

Geographic Localization Con’s
• Too many hand-offs
• Interruptions on work rounds
• Load leveling is difficult
• Stationary work environment

The Medical College of Wisconsin reported that promoting continuity (at least seven on-service cycles) were associated with lower mortality, lower readmission rates, higher rates of discharge to home and lower 30-day post discharge Medicare costs.9,10

The case for geographic localization is getting stronger in the hospitalist medicine literature. Strategies that help reduce hospital length of stay and improve discharge efficiency are also important to the emergency physician because these strategies will ultimately reduce boarding in the emergency department. As emergency physicians, we know first-hand the advantages in communication and workflow found by working in geographic zones. Most of our work in designated zones (physician-in- triage, fast track, mid track, acute care) and lead care teams dedicated to the patients placed in a particular zone.

When hospitalists consider the “geography” question, we can bring an understanding of the issue both in the inpatient and ED universes. We should support the geographic localization strategy, as it will affect patient flow downstream in our emergency departments.

References

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Where Are All the Children Going? ED Pediatric Patients Are Decreasing

How an aging population is aging out younger patients

by JAMES J. AUGUSTINE, MD, FACEP

Pandemic-related challenges continue to arise, and emergency physicians continue to manage the many implications. More forward planning will be a priority, as hospital and health care leaders look to emergency department leaders for guidance on planning. The performance of emergency departments in 2020 has been summarized by the Emergency Department Benchmarking Alliance (EDBA) in its annual survey report. One of the operational changes that occurred in the pandemic year was an ongoing decrease in young patients presenting to community emergency departments.

Children have comprised a large mix of patients since the advent of emergency services. There has been some inconsistency in the definition of children, but in 1982, the leaders of emergency services agreed that the data definition of pediatrics would be individuals under the age of 18.1 What is the definition of pediatrics in young patients presenting to community hospital emergency departments? In 2006, the leaders of emergency services agreed that the data definition of children, but in 2006, the leaders of emergency services agreed that the data definition of pediatrics would be individuals under the age of 18.1

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Another source of data on ED visits is the Centers for Disease Control and Prevention (CDC) ED survey from the National Center for Health Statistics. That study has documented a decrease in ED visits by young persons. The CDC has used a different methodology and counts visits for patients under the age of 15 in all emergency departments including all children’s hospitals. In its survey, the percentage of ED patients under the age of 15 in 1992 was 25.4 percent, and in 2018, the visits were about 19.7 percent across all emergency departments.2 The EDBA data survey for 2020 allows a focus on community emergency departments, and in those facilities, the percentage of patients under age 18 is 13 percent. The data in Figure 1 display the trends in ED pediatric visit rates in community hospitals over the last 17 years. The last eight years in particular show a decrease in visit rates.

Visits by Kids Down to 13 Percent

One reason is the growing percentage of patients over the age of 64 who are being seen. The percentage of patients seen in general service emergency departments who are over age 64 has increased. The CDC data showed an 8.6 percent mix of patients over the age of 64 in 1992, the first year of its study. The number and percentage of senior persons are increasing in the general population, and in 2018, the CDC survey counted 17.9 percent of ED patients being over the age of 64.

The EDBA survey shows an even larger presence of senior patients in the ED population. The 2020 report data, displayed in Figure 2, count about 23 percent of ED visits that are persons over the age of 64. That data report excludes children’s hospitals. Therefore, some change in ED visits relate to the trends of an aging American population.

What Other Factors May Be Contributing to the Decrease in ED Visits by Children?

There are increasing pathways to unscheduled care for children and their parents. That includes expanded hours for pediatricians, the larger presence of urgent care centers in many metropolitan areas and the emerging presence of telehealth.

The role of emergency physicians has dramatically changed in response to the COVID-19 pandemic, and trends suggest emergency departments will see older, higher-acuity patients with more complex medical needs. The emergency department remains the portal for all patients, and general service emergency departments must be prepared for persons of any age. Even if the inpatient areas of the hospital do not care for children, the emergency department must provide initial care for all who will either be admitted or transferred.

Recent publications point to the need for all emergency departments to be better prepared for ill or injured children and increase access to preparedness materials.3,4

Thirteen percent of children present to community emergency departments these days. The relative infrequency of pediatric ED patients must not change the need to be prepared to care for them, including the equipment, processes, and training available in general service emergency departments.

References


FIGURE 1 (ABOVE): Percentage of ED patients seen in general service EDs who are under age 18, trended since 2003.

FIGURE 2 (LEFT): Percentage of patients in general service EDs over age 64, by ED cohort.
Questions and Answers Regarding Migraines and Occult Infections

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

The best questions often stem from the inquisitive learner. As educators, we love, and are always humbled by, those moments when we get to say, “I don’t know.” For some of these questions, you may already know the answers. For others, you may never have thought to ask the question. For all, questions, comments, concerns, and critiques are encouraged. Welcome to the Kids Korner.

Question 1: Are triptans effective in treating acute migraine in pediatric patients?

According to a 2019 Practice Guideline Update summary published by the American Headache Society and the American Academy of Neurology, ibuprofen should be the “initial treatment option to reduce pain in children and adolescents with migraine (Level II).” Triptan usage is only recommended for migraine treatment of adolescents. In general, according to evidence reviewed by this subcommittee, triptan nasal sprays tend to be more effective at pain resolution at two hours compared to oral formulations of triptans except in the instance of a combined sumatriptan/naproxen oral tablet. Nasal spray formulations recommended include Sumatriptan NS 20mg and Zolmitriptan NS 5mg. One of the biggest controversies surrounding migraines and triptans in children is the high placebo effect that can range from 30–61 percent as well as the fact that most studies involve non-emergency department outpatient settings, making it more difficult to apply this literature to an emergency department population.

A 2016 Cochrane review found that triptans, as a class, were superior to placebo for headache relief in children (RR 1.67; 95 percent CI 1.06-2.62) and adolescents (RR 1.32; 95 percent CI 1.19-1.47). These studies included 7,799 pediatric patients. Studies incorporated into the review also found an increase in minor adverse events in adolescents including taste disturbance, nasal symptoms, dizziness, fatigue, and nausea/vomiting; there were no reported serious side effects.

While triptans do appear to be another possible emergency department migraine treatment option, triptans do not appear to be used as frequently as other abortive migraine medications in the emergency department setting. The exact reason for this is unknown.

Summary

Triptans appear to be effective in treating acute migraine in adolescents and are recommended in practice guidelines by the American Headache Society and American Academy of Neurology. However, triptans are used infrequently in the emergency department.

Question 2: What does the literature say regarding the work up for serious bacterial infection(SBI) in well-appearing febrile infants and children who have not received conventional routine immunizations?

With the conventional utilization of vaccines in infants and young children, the workup of the well appearing febrile infant/child has grown simpler with less routine bloodwork overall. Today, the more complicated patient evaluation might be the child who has not received routine immunizations. While Covid vaccinations in children has been a recent hot topic, this discussion focuses on conventional routine vaccinations in infants and young children.

The literature is extremely limited on this specific topic. We were only able to identify two articles. The first is a five-year retrospective study of children aged two to 36 months and their association with occult bacteremia. Children with high-risk medical conditions were excluded. A total of 5,534 blood cultures were obtained. Unvaccinated children were defined as not receiving any Haemophilus B (Hib) or pneumococcal (PCV) vaccines. Under-vaccinated children were defined as receiving only one set of vaccines by five months of age or one to two sets by seven months of age. Children over seven months of age were defined as under-vaccinated if they had received less than three sets of immunizations. The primary outcome was the rate of positive blood cultures in three groups: unvaccinated, under-vaccinated, and vaccinated.

The authors randomly selected 200 blood cultures per year for a total number of 1,000 blood cultures—of which 143 were excluded because patients either had co-morbidities predisposing to bacteremia or a lack of vaccination records—leaving 857 blood cultures for analysis. These results were then extrapolated back to a total number of 5,534 blood cultures. This extrapolation method seems to be one of the limitations of the study.

Unvaccinated and under-vaccinated children represented 15.2 percent and 6.6 percent of the total study population, respectively. The relative risks of occult bacteremia in unvaccinated (0.79; 95 percent CI 0.59-1.09) and under-vaccinated (1.20; 95 percent CI 0.92-1.57) children were not significant when compared to fully vaccinated children. This might suggest that herd immunity plays a role in the rate of bacteremia in this study. The reported rate of positive blood cultures was 6.8 percent. However, after contaminants were removed, the rate was only 1.5 percent suggesting a three-fold ratio of contaminant to true positive blood cultures. These data may help you to sleep a tiny bit better if a blood culture is not drawn on an unvaccinated or under-vaccinated well-appearing febrile child.

The second article on this topic provides a very brief review of fever without a source and offers a potential evaluation algorithm for febrile well-appearing unvaccinated children three to 24 months of age.

Summary

Overall, the data on occult bacteremia in unvaccinated well-appearing febrile children in the post-vaccine era is extremely limited. At this time, no literature suggests that their work up should deviate from that of the vaccinated child.

References

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Ensuring that care in the ED is provided by physician-led teams

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Baylor College of Medicine is located in the world’s largest medical center in Houston, Texas. The Baylor Emergency Medicine Residency was established in 2010, and received department status in Jan 2017. Our residency program has grown to 10 residents per year in a 3-year format. We offer a highly competitive academic salary and benefits commensurate to academic level and experience.

Our academic program is based out of Ben Taub General Hospital, Baylor St. Luke’s Medical Center, DeBakey VA Medical Center, and Texas Children’s Hospital. Ben Taub General Hospital is the largest Level 1 trauma center in southeast Texas with certified stroke and STEMI programs that sees nearly 80,000 emergency visits per year. Baylor St. Luke’s Medical Center is home to the Texas Heart Institute and is a tertiary referral center with multiple transplant programs and many high acuity patients. Texas Children’s Hospital is consistently ranked as one of the nation’s best, largest and most comprehensive specialty care pediatric hospitals. These affiliations, along with the medical school’s preeminence in education and research, help to create one of the strongest emergency medicine experiences in the country.

**MINIMUM REQUIREMENTS**

- **Education:** M.D. degree or equivalent
- **Experience:** Previous experience in Research, Simulation and Toxicology strongly preferred but not required
- **Licensure:** Must be currently boarded or board eligible in Emergency Medicine and eligible for licensure in state of Texas.

Those interested in a position or further information may contact  Dr. Dick Kuo via email [dckuo@bcm.edu] or by phone at 713-873-2626. Please send a CV and cover letter with your past experience and interests.

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