Wilderness medicine is a well-established and growing subspecialty in emergency medicine, yet its existence, scope of practice, and applicability remain poorly understood to those outside the field. Many envision that wilderness medicine physicians concentrate on those environmental emergencies that all emergency physicians must know (Table 1). And while this is indeed part of the foundation of wilderness medicine, the spectrum now is much more expansive.

In an era of globalization and increasing prevalence of natural and man-made disasters, there are growing intersections with international medicine and disaster medicine. The scope and applicability also continue to expand as humans reach further into all corners of the world, from the deep sea to space. This obliges all emergency physicians to have a better understanding of this subspecialty, which has, in turn, become a goal of the newly created EMRA Wilderness Medicine Committee.

Wilderness medicine is often defined as the practice of medicine in an austere environment with limited resources, or in an environment in which definitive care is greater than two hours away. However, in many ways, its practice actually is a return to the roots of the medical profession. Beginning in the 1970s, editorials in prominent journals (i.e., JAMA and NEJM) started addressing the decreased educational emphasis on performing detailed histories and physical exams. As a result, there are now generations of physicians who have become overly reliant on laboratory and imaging studies.2-5

As high-tech procedural and

continued on page 36
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EM Resident is published six times per year. Ads received by November 1 will appear in the Dec/Jan issue.

EM Resident subscriptions are available only to individuals and institutions that are not considered eligible for EMRA membership as per the EMRA bylaws. For information on how to subscribe please contact Leah Stefanini, 866-566-2492 ext. 3298 or email lstefanini@emra.org.

Four decades ago at one of the first Emergency Medicine Scientific Assemblies, Joseph Waeckerle and a small group of emergency medicine residents founded the Emergency Medicine Residents’ Association. EMRA was established five years before emergency medicine was officially recognized as a specialty, and was the first – and still is the only – independently operated resident organization in the country.

EMRA’s growth during the past 39 years has been remarkable. In 1979, when emergency medicine first became regarded as a specialty, the organization had a total of 283 members and a budget of negative $16. Today EMRA boasts more than 11,000 members and a financially healthy budget in the millions of dollars.

We have made tremendous strides in growing our membership, adding member benefits and promoting emergency medicine education. We have been prolific in our production of resources, including more than a dozen books, a popular bimonthly magazine, a monthly e-newsletter, and an ever-growing provision of free online resources. All told, our members receive over $1,600 worth of free benefits yearly, making EMRA the best value in emergency medicine.

Beyond its resources, EMRA provides emergency residents and students with a platform no other specialty in the house of medicine can offer. Emergency medicine residents have a unified, powerful voice in EMRA. The association has used this voice to advance our educations, advocate for the better care of our patients, and help define the future of our specialty.

The association enables emergency residents to serve on nearly every section and committee in the American College of Emergency Physicians – an invaluable opportunity that allows us to help create policies that shape our careers. Through our representation in the Residency Review Committee, EMRA articulates and defends resident interests and helps shape educational standards. Through our seat on the Emergency Medicine Action Fund Board of Governors and involvement in the Leadership and Advocacy Conference, EMRA is among the key stakeholders in our emergency medicine advocacy efforts. Through our internal committees, task forces, representative council, board of directors and thousands of dollars in grants and scholarships, EMRA provides residents with opportunities present in no other specialty.

As my term as the 39th EMRA president comes to a conclusion, I am still in awe of the many great milestones we’ve crossed and the stellar accomplishments that we, as an organization, have made.

In the past year alone EMRA developed more books then ever before in its history! We have published two new handbooks – the EMRA Critical Care Guide and EMRA Research Guide – and have several more on the way, including the soon-to-be-released EMRA PressorDex, and the EMRA International Handbook. We’ve also unveiled the 2013 EMRA Antibiotic Guide – the latest edition of our highly successful pocket reference book.

This year the association has worked to update and expand its technological infrastructure. Our website, www.emra.org, was updated with a stylish new look, easier navigation and additional resource tools. At ACEP’s Scientific Assembly we celebrated the much-anticipated launch of the EMRA App Suite. Designed to give you the information you need instantly at your fingertips, this growing collection of new mobile applications will include EMRA MDCalc, EMRA PressorDex, the 2013 EMRA Antibiotic Guide, EMRA EM Basics, EMRA PedsMeds, EMRA PedsAirway and EMRA EM-Rashes. We’re proud to say that our association offers more mobile apps then any other nonprofit specialty organization in the house of medicine.

We also have aggressively expanded opportunities for our membership. The association invested an additional $10,000 into new awards this year, and in 2013, EMRA will offer an unprecedented $30,000 worth of grants and awards to residents and students. This year EMRA also welcomed the exciting addition of three new committees – EMS, Wilderness Medicine, and Awards – which will provide new avenues for residents to participate in the association and pursue their interests.

To better serve our members, EMRA also has added a membership development coordinator position to its board of directors. The new position has been created to help expand our benefits, reach out to residents at
a regional and program level, and serve as a powerful member advocate. This year has also seen an exciting expansion of our EMRA staff with the hiring of our new executive director, Michele Packard-Milam, CAE, and new publications and communications coordinator, Rachel Donihoo. They are passionate and skilled advocates of our organization.

EMRA’s success this year, as in years past, is predicated upon the hard work and dedication of many groups and individuals. I would like to acknowledge and extend my sincere gratitude to a few of these people.

To the regional representatives, the EMRA representative council, committee chairs and vice chairs, EMRA representatives to outside organizations, task force members, and the many others who have dedicated their free time and efforts to our organization and our specialty – I offer you my most sincere thanks. I have been blessed to work alongside those individuals and a dedicated board of directors. The board members I have come to know over the past years are a tremendously talented and industrious group, and I appreciate their leadership and vision in guiding our organization to new heights.

Lastly, and perhaps most importantly, I would like to thank our EMRA staff. The ladies of EMRA – Alicia, Chalyce, Leah, Michele, and Rachel – work tirelessly every day to promote our organization, serve our members and champion our interests. They are EMRA’s backbone, and without their hard work, none of this would be possible. Together we have accomplished great things, and I am humbled to have been part of such a wonderful and inspiring group.

Dr. Cameron Decker will serve as the new and 40th EMRA president in the coming year. Cameron is a tireless worker, visionary leader, and (little known fact) a decorated police officer on Houston’s SWAT team. Our organization is in good hands with Cameron, who will continue our proud tradition of placing the interests and education of residents at the center of everything we do.

In parting, I want to thank all of you for your support of EMRA and your dedication to our specialty and to the care of your patients.
Treasurer’s report

Finances strong and primed for growth: 2011-2012 financial report

This October will mark another milestone for our organization. The EMRA Board of Directors will see a few of us step down and pass along our posts to a new band of residents. It is during this changing of the guard that we have the opportunity to look back at the past few years and reflect on the accomplishments of our organization.

During my time with EMRA, I have seen our members and staff dedicate countless hours to the support of the emergency medicine physicians-in-training. We are pleased to see that so many residents and students have benefited from the advocacy efforts, educational offerings, job search assistance, financial planning and career development that the association has to offer. These services could not have been possible without the support of our members. With another wave of enthusiastic residents and students joining the association, it is exciting to imagine what great heights our organization will reach in the years to come.

As a testament to the growing support that our organization provides to medical students, residents and alumni, our annual budget has expanded considerably over the past three years. For the current fiscal year, EMRA has budget over $1.9 million in expenditures for its operations. This represents an annual growth rate of roughly 14% each year for the past three years. These funds will allow continued support of many of the popular programs that our members use each day, as well as the development of many new offerings.

Keeping pace with our expenditures, we are pleased to say that our organization’s revenue has also continued to grow. Much of the credit for this goes to the tireless efforts of our staff, who have helped in the development of multiple sources of financial support. It is because of their work that we have been able to maintain extraordinarily low member dues in spite of our continued growth as an association. In fact, the resident dues have increased only once in our organization’s long history.

For the continued strength of any organization, it is important to remain fiscally protected. Even as we continue to push forward with new initiatives, we have maintained a watchful eye on our investments to ensure that EMRA can continue to provide its services to future generations of physicians-in-training. As we enter this fiscal year, the net equity for our organization totals roughly $2 million. Compare this to our net equity in 2010, which totaled a little over $1.2. With this financial reserve, our organization is in a healthy fiscal position, and can continue to support our continued growth in the years to come.

It has been a great honor and privilege to serve on the EMRA Board of Directors for the past three years. This experience has given me the opportunity to work with a passionate group of residents, students, alumni and staff that are dedicated to our profession. I wish the best of luck to the next generation of EMRA members and can only imagine to what incredible heights you will take this organization.
Boot Scootin’ EMF Party

Private Concert
Featuring Country Recording Artist
Jack Ingram

Monday, October 8, 2012
6:00 pm – 7:30 pm
Wells Fargo Theater, Colorado Convention Center

Tickets: $40
Admission includes drinks and appetizers at the mix and mingle celebration before the show. The party features a western theme to honor our Emergency Medicine Research Trailblazers and our host city.

Purchase Tickets at the following locations in the Colorado Convention Center
- Scientific Assembly Registration Desk
- ACEP Bookstore in the Exhibit Hall
- EMF Donor Lounge – Room 113
- At the Wells Fargo Theater Door at 5:30 pm (the day of the concert)
- Member Services Booth

The Party Before the Opening Party

EM Resident is the bi-monthly magazine of the Emergency Medicine Residents’ Association (EMRA). The opinions herein are those of the authors and not those of EMRA or any institutions, organizations, or federal agencies. EMRA encourages readers to inform themselves fully about all issues presented.

EM Resident reserves the right to review and edit material for publication or refuse material that it considers inappropriate for publication.

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EMRA is pleased to announce the results of the 4th Annual EMRA Photo Contest. The number of entries this year was 114 with photographs coming from all over the world. We are amazed by how multi-talented emergency physicians can be, and our photo contest proves this, once again, to be true. Visit EMRA’s Facebook page to view all contest entries.

**ART PHOTOGRAPHY WINNER**
*Ghost Home*
Braden Fichter, MD
Staten Island University Hospital
Staten Island, NY

**ART PHOTOGRAPHY RUNNER-UP**
*Kettle*
Chris Crowder, MD
Eastern Virginia Medical School
Norfolk, VA

**TRAVEL & LANDSCAPES WINNER**
*Last Day in Patagonia*
Austin Johnson, MD, PhD
Denver Health Medical Center
Denver, CO

**TRAVEL & LANDSCAPES RUNNER-UP**
*Sailing in the Sky*
Ameen Jamali, MD
William Beaumont Hospital
Royal Oak, MI

Special thank you to the judges: Lisa Bundy, MD, Attending Physician, ERMed, LLC, Montgomery, AL and Giuliano De Portu, MD, Emergency Medicine, Ultrasound Fellow, University of Florida-Gainesville
WINNERS

PORTRAITS WINNER
Sacsayhuamán
Matthew Fannell, MD
Texas A&M/Scott and White Temple, TX

NATURE & WILDLIFE WINNER
Multnomah Falls
Michael Martinez, MD
Oregon Health and Science University Portland, OR

MISCELLANEOUS WINNER
Gingerbread Men
Katherine Nacca, MD
SUNY Upstate Medical University Syracuse, NY

PORTRAIT RUNNER-UP
Yogi Bathing
Salil Bhandari, MD
NYU/Bellevue New York, NY

NATURE & WILDLIFE RUNNER-UP
Tiger in Water
Joe Palter, MD
Stroger Hospital of Cook County Chicago, IL

MISCELLANEOUS RUNNER-UP
Reminders of the Past
Laura Medford-Davis, MD
Baylor COM Houston, TX
Ready or not, ACEP’s Scientific Assembly and EMRA’s Fall Representative Council meeting are just around the corner. I hope you’re as excited as I am to reconnect with friends, network within our specialty, benefit from some high-quality educational sessions, and enjoy the Mile High City!

ACEP’s first Scientific Assembly meeting was held in Denver in 1969, making this meeting historic and marking a return to what has now become one of the not-to-miss annual emergency medicine conferences. Scientific Assembly brings together many members of our emergency medicine family, and while the conference can seem intimidating with all it encompasses, there truly is something for everyone offered through the high-quality ACEP and EMRA programming. You can visit www.acep.org/sa for more general information about the conference, and visit www.emra.org for full schedule of EMRA events.

EMRA’s Representative Council will meet on October 9, where we will have the opportunity to elect new members to EMRA’s Board of Directors, discuss resolutions submitted to the Council, and hear from the EMRA program representatives that keep their fellow residents informed and engaged with the organization throughout the year.

In the last column I wrote for EM Resident I highlighted some of the many ways to become more involved with EMRA. Whether this will be your first EMRA meeting or you’re a seasoned veteran, Scientific Assembly will be a time to meet with current EMRA leaders, run for a position on the Board of Directors or get more involved with an EMRA committee.

No matter what your interest or passion, our organization offers a way to cultivate and support your growth as a leader in emergency medicine. If you feel something is missing from EMRA, be sure to write a resolution to be discussed on the council floor to help us continue to grow and offer the best benefits we can to our over 11,000 members!

Serving as your vice speaker for the past year has been an incredible experience and an opportunity for me to learn from and meet so many incredibly passionate and dedicated EMRA members. I often say that I feel my job title actually should be “Listener” and not “Speaker,” since listening to and engaging our EMRA membership is at the core of the position. At Scientific Assembly we’ll say farewell to half of our current EMRA board including our present speaker, Hamad Husainy, and welcome a new group of leaders to the board. EMRA’s rapid turnover in membership and leadership is both one of our key challenges and strengths. Every year we say farewell to our graduating senior residents (who can and should stay involved as EMRA alumni members), and we welcome a new class of interns and aspiring emergency residents to our membership. This constant flow continually revitalizes our organization with new members’ passions and ideas. As I prepare to assume the role of your EMRA speaker of the council, I would like to thank you for giving me the opportunity to serve you and ask that you help me meet your needs by contacting me any time there is something EMRA can do for you.

Safe travels to Denver!
Representative Council Schedule
at Scientific Assembly

Monday, October 8

1:00 pm – 2:00 pm  EMRA Representative Council Conference Committee Orientation
Embassy Suites Denver, Cripple Creek Salon 2, 2nd Floor
This is a mandatory meeting for those individuals who are serving on the Conference
Committees. This includes Reference Committee, Sergeant at Arms and Tellers/Credentialors.

2:00 pm – 3:00 pm  EMRA Regional Representative Meeting
Embassy Suites Denver, Quartz Boardroom, 2nd Floor

3:00 pm – 4:30 pm  EMRA Representative Council Reference Committee Public Hearing
Embassy Suites Denver, Silverton Salon 1, 2nd Floor
REQUIRED FOR EMRA PROGRAM REPS
During this meeting, the Reference Committee hears testimony from the authors of resolutions
being brought forth from the Council and from anyone who would like to speak for or against the
resolutions. This is your opportunity to understand more completely the reasoning and history
behind the business being brought before the Rep Council. A great way to learn, understand and
participate in the Rep Council the following day.

6:00 pm – 8:00 pm  EMRA Representative Council Reference Committee Work Meeting
Embassy Suites Denver, Quartz Boardroom, 2nd Floor
This work meeting is a closed session for the Reference Committee to prepare reports to be
presented to the full Rep Council the following day.

Tuesday, October 9

7:30 am – 8:00 am  Representative Council Welcome Breakfast & Candidate’s Forum
Embassy Suites Denver, Crestone Salon B, 3rd Floor
REQUIRED FOR EMRA PROGRAM REPS
This is an informal breakfast meeting for all Rep Council members where you can meet other
program representatives, the EMRA Board of Directors, Rep Council officers, regional reps and
the candidates who are running for the EMRA office.

7:30 am – 8:00 am  EMRA Representative Council Registration
Embassy Suites Denver, Crystal Foyer, 3rd Floor
REQUIRED FOR EMRA PROGRAM REPS
All program representatives are required to register to receive their voting credentials for the Rep
Council meeting. Be prompt; registration closes at 8:00 am sharp.

8:00 am – 12:00 pm  EMRA Representative Council and Town Hall Meeting
Embassy Suites Denver, Crystal Salon B-C, 3rd Floor
REQUIRED FOR EMRA PROGRAM REPS
This is a formal business meeting where elections and resolution votes will take place. The Town
Hall Forum is an open discussion forum following the business session. This mandatory meeting
is your chance to shape the organization and the specialty. Don’t miss it!

12:00 pm – 1:00 pm  EMRA Representative Council Luncheon and Educational Presentation
Embassy Suites Denver, Silverton Salon 3, 2nd Floor
SPONSORED BY VIDACARE
Not your grandma’s bath salts, not your parents’ pot

ACEP advocacy efforts against designer drugs

If you’ve mentioned the words “spice” or “bath salts” to people outside of emergency medicine – even those in the medical field – you’ve probably heard reactions such as, “Wait, I’m confused. Why would you snort something you’re supposed to take a bath in?”

Emergency medicine always has had close ties to toxicology. As emergency medicine providers – and the first to see overdose patients when they arrive at the hospital (and before they’ve received high doses of benzos) – we’ve had unique experiences with these designer drugs and their effects. We are poised to educate others about these dangerous substances; this past year the American College of Emergency Physicians (ACEP) took the issue all the way to the federal legislators in Washington, DC.

The growing problem

These and other synthetic substances have become popular “legal highs” in recent years, after making their way to the U.S. from Europe.1 They are found in common places such as gas stations, drugstores, and head shops; and are labeled “not for human consumption” as a means of circumventing FDA oversight.2

According to poison control center data, there were approximately 3,200 calls related to designer drugs in 2010; in 2011 there were over 13,000. According to the Drug Enforcement Agency (DEA), 60% of the cases were in patients who were 25 years old or younger.1

ACEP advocacy efforts

As emergency physicians working on the front lines, we get the earliest glimpse of societal trends; ACEP quickly recognized the danger of these designer drugs. While at least 44 states had already banned one or both of the substances,6 ACEP was interested in seeing action taken on the federal level via the Synthetic Drug Abuse Prevention Act of 2012. With this in mind, 500 emergency physicians, residents, and medical students advocated for this legislation at this year’s Leadership and Advocacy Conference in Washington, DC.

My delegation from Rhode Island was fortunate to have its medical toxicologist at the conference. And, while the chemical details he provided were interesting, his stories about extreme patient presentations that place the patient, the public, and the medical and hospital staff in danger really hit home.

Snapshot – Substituted cathinones

Substituted cathinones, derived from the Catha edulis (or khat) plant are known by such names as “bath salts” and “plant food.” They are manmade chemicals related to amphetamines, often containing methylenedioxypyrovalerone (MDPV), mephedrone, and methylone.2 They can lead to impressive patient presentation, including such symptoms as tachycardia, hypertension, severe agitation, extreme paranoia, hallucinations, delusions, and bizarre behaviors. Bath salts can lead to extremely violent behavior, severe seizures, and even death.3,4

1 EM Resident

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An amazing two days after our congressional visits, we received word that an amendment was going before the U.S. Senate to add synthetic drugs to the Schedule I list. Before close of business that very same day, we learned the amendment had been unanimously passed. Just over a month later, President Obama signed the Synthetic Drug Abuse Prevention Act of 2012 into law as part of the Food and Drug Administration Safety and Innovation Act (S. 3187). This law permanently adds a total of 31 compounds to Schedule I, including certain substituted cathinones and compounds found in synthetic marijuana.

By late July, the first nationwide strike on designer drugs took place – Operation Log Jam – during which the DEA confiscated 5 million drug packets and $36 million in cash. They made 90 arrests.

The end?

While this is a great example of how a coordinated advocacy effort truly can enact change – and enact it very quickly – there are many obstacles still ahead. Perhaps the greatest challenge is that the chemists who make these designer drugs are constantly modifying their formulations, which allows them to stay beyond the reach of the law. Equally disturbing is the fact that when patients perceive substances as “legal,” they equate that with being “safe.” As responsible emergency physicians, we need to continue to educate our patients that this is not the case. We also need to expand our focus to include educating the public – long before we meet them as patients – about the very real and severe dangers of designer drugs.

References
What’d the lavage show?

A 62-year-old male presents to the emergency department complaining of loose, maroon-colored stool. You find that his hemoglobin is 8g/dL – a 40% drop since his recent annual physical – and begin hospital admission for your gastrointestinal (GI) bleed patient. The admitting doc promptly asks, “What’d the lavage show?”

In this review of nasogastric lavage (NGL) in the patient with a GI bleed, we review key procedural aspects and associated limitations, including patient perceptions, diagnostic shortcomings, and poor triaging characteristics.

Patient perception

While assessing the usefulness of an invasive medical procedure, the risk of iatrogenic discomfort relative to the potential for clinically useful information is often overlooked. When a visual analog scale has been used to evaluate pain perception during common emergency department procedures, nasogastric intubation has been ranked by patients and practitioners as the most painful procedure – outranking fracture reduction, lumbar puncture, and abscess incision and drainage.1

The addition of a topical anesthetic to facilitate nasogastric tube placement may reduce pain and the gagging sensation – but the remaining discomfort is notable. Using lidocaine gel in particular may actually increase the difficulty of tube insertion.2,3,4

Diagnostic shortcomings

The clinical significance of data gained from NGL in certain GI bleeds has been increasingly criticized. This is particularly true in patients with hematochezia without hematemesis, and when lavage results are negative.

A retrospective review of patients presenting to the emergency department with a history of hematochezia without hematemesis found that, of the 220 patients lavaged, only 4% were clearly negative. Clearly positive results were only seen in 18% of patients (12% of which had minimal evidence of ongoing bleeding).5

Notably, NGL yielded a poor sensitivity of 42%, a specificity of 91%, and a marginally useful negative predictive value (NPV) of 64%.5 With a NPV of 64%, the clinical information gained from a negative lavage nears the utility of flipping a coin.

Another emergency department investigation found that a BUN/creatinine ratio > 30 had similar characteristics as NGL – with a sensitivity of 39% and specificity of 94%.6

In two prospective studies of patients presenting with hematochezia without hematemesis, Laine et al found that 15% of patients with high-risk clinical features (i.e., tachycardia or recent blood transfusion) and negative NGL in fact had an actively bleeding lesion on upper endoscopy.7,8 Similarly, Ahmad et al found that 18% of such patients with high-risk, actively bleeding upper GI lesions had a false-negative NGL, which often lead to a delay in upper endoscopy.7,8 Importantly, when asked to assess nasogastric aspirate for the presence of bile (critical in determining a truly “negative” lavage), physicians are incorrect almost half of the time.9

Potential for useful information?

In addition to diagnostic information, one must assess whether NGL provides useful prognostic value in patient triage. The prognostic characteristics of nasogastric...
aspiration date back to the 1981 American Society for Gastrointestinal Endoscopy surveys, which found, of 1,565 patients studied, a NGL with red blood carried a nearly 18% mortality, versus 6% for a clear lavage, and 10% for “coffee ground” aspirate.10

Less painful assessments such as laboratory values and stool color, however, have shown similar prognostic characteristics. For example, brown, black, and red stool upon presentation have been noted to carry mortality rates of 11%, 8%, and 20%, respectively.10

Moreover, Huang et al found that nasogastric lavage had no effect on mortality, length of stay, the need for surgery, or the number of transfusions. Curiously, NGL was performed more often on patients admitted on the weekend.11

Lavaged patients also were statistically more likely to undergo endoscopy (odds ratio of 1.71), and endoscopy was more urgently performed (hazard ratio of 1.49). Yet the actual clinical significance of this remains uncertain, with no obvious positive critical impact on patient care.11

NGL can be a painful procedure with unclear clinical benefits. While a portion of patients with GI bleeds may benefit from this procedure, the definition of that subpopulation remains blurred. NGL is particularly unlikely to add significant clinical information in patients with hematochezia without hematemesis, and should be considered with potential iatrogenic risks and pain in mind. ■

Disclaimer: The views expressed herein are solely those of the authors and do not represent the official views of the Department of Defense or Army Medical Department.

References

“When asked to assess nasogastric aspirate for the presence of bile (critical in determining a truly ‘negative’ lavage), physicians are incorrect almost half of the time.”

October/November 2012
Match game

“Students want to be residents....residents want to be attendings... and attendings just want to be left alone.” – “ER” (TV series)

The new interns in your program this year had the distinction of being the 60th class to go through the infamous residency “match.” If you are a current resident or a new attending, you probably still remember the trepidation that all medical students share as preparation for the match begins. Much of this fear results from the perceived uncertainty that surrounds this process. Every year approximately 35,000 applicants compete for about 25,000 residency positions in the U.S.

How many hours did you spend scouring the internet, investigating strategies for the match in order to attain the greatest possible advantage? Were you advised to apply to 20 programs, or 30? Were you completely honest about your level of interest in each program that you visited? Were you told that you should rank programs based on your preferences, or instead on your perceived chances of matching to each program?

To understand how to “play the game” of the match, it’s important to first examine the origin of its design. When residencies were first established in the 1900s, hospitals had to compete with each other to sign the best residents as quickly as possible.

The initial outcome of this system resulted in hospitals making offers as early as possible — even as early as the beginning of the third year of medical school. Students began making decisions based upon very limited exposure to their career options, and students felt compelled to accept first offers for fear that other offers might not be extended. As one student put it, “There are very few men who have conceit to pass up a very good appointment in one locality offered early, simply on the gamble of competing for a somewhat more desirable appointment made later in another locality.”

Finally in 1945, an attempt was made to establish a uniform time frame during which positions could be offered to new residents. Under the cooperative plan adopted by the Association of American Medical Colleges, medical schools agreed not to release information about students before an announced date.

Despite the good intentions behind this plan, hospitals still were determined to sign residents as quickly as possible. As a result, students had to make increasingly pressured decisions.

In 1945 offers remained open for 10 days, but by 1949, a deadline of 12 hours was considered too long! Hospitals quickly learned that if too much time was allotted, they would lose their chance to recruit the next most desirable candidate. To reap the benefits of a uniform appointment date while removing the pressure of a deadline, a proposal for a “clearinghouse” was offered, which became the precursor to the residency match we know today.

In 1952 it was decided that a centralized clearinghouse would be used for all internship positions. It should be noted, however, that after the announcement of the original clearinghouse, students pointed out a significant flaw that would put applicants who ranked programs solely by preference at a disadvantage. With the initial design, a student would suffer by ranking first a hospital to which he or she had little chance of matching.
“The best strategy for all students is to rank programs only on preferences – regardless of what other students or programs may do.”

The system would have allowed a student to end up a much lower-ranked hospital, even if that student’s second choice hospital had ranked him or her first.

As a result, the “Boston Pool” algorithm was instituted to continually update rankings. The system would match students to hospitals that ranked the student first, and would remove them if they tentatively matched to another hospital that was ranked higher by the student. This system enabled hospitals to make offers to students starting at the top of their rank lists, and each student would hold on to the position unless a better offer was made.

The stable outcomes of the match process have resulted in very little change over the past 60 years. The most recent revision, implemented in 1998, the algorithm recognizes applicants’ preferences – and matches an applicant as near to their number one choice as possible.

If you are a student entering the match, it is important to fully understand the design of this algorithm in order to develop a ranking strategy. The rank list should be thought of as a list of proposals to residency programs. The program will accept your proposal if an open spot exists; however, the program also retains the right to reject it later if a better suitor arrives. If your proposal is rejected, you simply move to the next program on your list. After your proposal is accepted, another student repeats the process. In this system, the applicant is guaranteed the best available program, and 99.9% of programs have optimal outcomes. If these positive outcomes did not exist, the match would not be still in existence.

The best strategy for all students is to rank programs only on preferences – regardless of what other students or programs may do. Avoid the temptation to rank a lower preference higher on your list for fear of losing a “sure thing.” By ranking a lower preference high, you will lose out completely on the opportunity to match to a more preferred program.

Interestingly, this same strategy also applies to the rank lists developed by the programs. By ranking a backup candidate artificially high out of fear, the program will not gain an advantage, and instead will lose out on the chance to match a more preferred candidate.

If the system works solely by matching listed preferences, the natural incentive for both applicants and programs is to develop strategies or appearances that will raise their respective positions. For example, some programs may call applicants to express interest, or to inform them that their application will be ranked highly. Applicants may view such calls as “promises” and raise the rank of the calling program. Students also commonly feign a great deal of enthusiasm at all potential programs, even at those that will almost certainly be ranked low.

If the natural inclination for both the program and the applicant is to mislead the other on how highly each is preferred, can this introduce a flaw in the match system?

In an article published in the *Journal of Graduate Medical Education,* “Fixing the Match: How to Play the Game,” a detailed example is given of how misrepresentation may affect the results of the match. In short, the described outcome is that overstating preferences does not necessarily hurt the party being lied to. By exaggerating or even lying, however, a student or program can damage long-term reputations.

Completely revealing your preferences also does not offer an advantage. For example, suppose a program learns that an applicant plans to rank it low and, in turn, lowers the applicant’s rank. As a result, the program has decreased the probability of the applicant matching with it, and increased the probability of matching with a less desirable candidate. The best strategy is to avoid misrepresentation, while avoiding full disclosure. The level of interest displayed by the program should also not supersede the applicant’s preference when developing his or her own list.

While the match is often viewed with cynicism and distrust by both students and programs, the system actually eliminates the power differential between the applicant and his or her employer. When entering the match, the ideal strategy is to rank programs based solely on true preferences. This process does not require misdirection or exaggeration. The confidentiality of rankings also is important for reducing incentives for non preference-based rank lists.

If you are entering the match this year, try not to overthink your strategy. Instead, trust that if you professionally and honestly portray yourself to programs and create a rank list based on your true preferences, you will have a great outcome!

References

Every fourth year in the U.S. is an election year. The media blasts us with constant reports on the horse race between presidential candidates. The candidates shower us with television ads and slip flyers under our doors. For many of us, political races also are being held in our home states for critical positions such as governor, senator, and representative. This is a time when we all think about how politics impacts our lives and careers.

So first, make sure you’re registered to vote! For residents, this can be challenging, as we frequently move from state to state to pursue our educations and residencies. To complicate matters, our erratic schedules often prevent us from making it to the polling stations during designated hours. But, there’s a solution! Contact your Secretary of State for an absentee ballot, which will enable you to vote regardless of your November call schedule.

As you consider the candidates, I encourage you to think beyond the social and economic issues that typically affect your choice – think about how each candidate’s policies will affect your career. Visit the candidate’s websites and look for the section on healthcare. What do they say about the future of medicine? If they make flawed statements about saving the healthcare system millions by keeping patients out of the emergency department, I urge you to contact them. Tell them that emergency care makes up only two percent of all healthcare spending. Tell them that CDC statistics show that 92% of emergency department visits are for conditions that require emergency care within two hours of arrival.

We are the only providers available 24 hours a day, 365 days a year, for all patients in need. Tell candidates about the patient you had with a major emergency, who initially appeared to be lower acuity; or explain the challenges your patients have with access to care. Tell them about the excellent care that you provide for patients every day in the emergency department. By reaching out to candidates and politicians – on both state and national levels – we protect patients from dangerous budget cuts. We can help preserve the most effective and efficient parts of the healthcare system.

For the past four years, I have participated in ACEP’s Leadership and Advocacy Conference each May in Washington, D.C. This is the single best opportunity for residents – and all emergency physicians – to make their case to elected officials in person. For the past two years, one of my most exciting duties as legislative advisor has been to organize the Residents and Young Physicians Track at the conference, an opportunity that includes speaking about critical issues in health policy. Ask your program director in advance about finding the time and funding to attend this importance conference.

I’ve reached out to residents in many other ways during my tenure as legislative...
“By reaching out to candidates and politicians – on both state and national levels – we protect patients from dangerous budget cuts.”

advocate. A key goal has been promoting advocacy education in residencies – every emergency medicine resident should understand health policy and advocacy for emergency physicians and patients. Both EMRA and ACEP passed resolutions, which I initiated, supporting and promoting the importance of advocacy education in residency curricula.

Subsequently, EMRA supported strengthening the advocacy portion of the Model of Emergency Medicine. The model serves as the basis of the ABEM examinations and helps program directors create effective training programs. The model now includes both patient and professional advocacy within development of our profession. It discusses understanding EMTALA, evolving trends in healthcare delivery, and the regionalization of emergency care (all important policy and advocacy topics) as part of developing a systems-based practice within our specialty.

There have been some great successes during my time with EMRA. I worked on regulatory advocacy as the organization became a member of the Board of Governors of the Emergency Medicine Action Fund. I participated in state-level advocacy as a physician in Washington State during the state’s failed attempt to cut access to emergency care for Medicaid patients.

As an opportunity for residents to bring advocacy education to their own programs, I restarted Advocacy Week. To keep residents informed about weekly advocacy news, I initiated a drive to encourage residents to sign up for ACEP’s 911 Network. Finally, the valuable EMRA Emergency Medicine Advocacy Handbook was updated and released (the third edition is due out in May 2013)!

It has been my pleasure to serve as your legislative advisor. I hope you’ll continue to stay abreast of advocacy issues throughout your career, assisted by the foundation you built in residency.

I appreciate all of you who have taken the time to learn more about advocacy and health policy during the past two years. I encourage you to continue reading articles in EM Resident and What’s Up in EM. Attend ACEP’s Leadership and Advocacy Conference. Participate in policy and advocacy activities within your residency program. And, perhaps most importantly, take what you’ve learned to the voting booth in November.
The Unofficial Medical Student Guide to Scientific Assembly

October is here – and with it, ACEP’s Scientific Assembly. Big meetings such as Scientific Assembly host countless opportunities for medical students, residents, and practicing physicians to learn, share, network, and play. From research project presentations to student-centered sessions to residency fairs, the conference is a worthwhile venture for any medical student interested in emergency medicine.

For those who plan to attend this or any other major conference, here are answers to some of the most common questions students have, as well as some tips on how to get the most out of attending Scientific Assembly.

How do I get there?

Travel, lodging, food, and bar tabs add up. Quickly. With a mountain of debt already in place, it’s easy to use money as an excuse to miss out. But there are ways to help cover costs!

If you plan ahead, there are scholarship opportunities available from EMRA. Likewise, contact your school’s alumni association or Dean’s office. If you have a research project that’s accepted, other funding sources that support research may help pay your way to Denver. Finally, asking local friends and family for a place to crash is a time-honored cost-cutting measure. If you don’t know any locals, ask another student or resident to split a hotel room.

To register or not to register?

There is no need to pre-register or pay for any of the student-focused EMRA events! If all you hope to do is attend the full day of panels, speakers, and breakout sessions for medical students, all you need to do is show up. That’s right: FREE!

However, if you hope to participate in any other awesome events throughout the week, you have to register for the conference. As always, the earlier you register, the cheaper it is.

What do I do when I get there?

Settle in wherever you’re staying, then figure out the times and locations of the sessions you’d like to attend. For students, there are general sessions, as well as individual breakouts for preclinical students and for third- and fourth-year med students. There’s also a free luncheon for students (bonus!

The student day culminates with a massive residency fair featuring representatives from nearly every residency program in the country. Be armed with questions and don’t be shy! The residents and faculty are there for the students, so meet as many people as you can.

It’s also a good idea to check out as many other events as possible. Poster sessions, demonstration booths, SIMWars competitions – even the hotel lobby and bar – are all great places to hang out and start a conversation. You’d be surprised how excited and welcoming residents and faculty are to interested med students!

Should I go out after?

Socializing is a big part of any major meeting, and Scientific Assembly is no exception. One of the great things about emergency medicine is the people. So if you’re inclined to join along for a dinner or social event, get out there!

The EMRA party is a popular event and student involvement is always encouraged. Stay responsible, however; nobody wants to be “that guy” in front of potential employers.

What do I do when it’s all over?

Once you get home, follow up with any contacts you made. Save business cards and send your thanks to any faculty members you got to know. Keep in touch with other students or residents you met along the way. It’s a fantastic opportunity to make friends across the country, and a great way to learn about different training programs you may not have previously considered.

Attending a major event can be incredibly rewarding and enriching. Student participation is most welcome! Take advantage – learn about the residency application process, the career path, and the latest in emergency medical knowledge.

But most importantly, you’re required to have fun. See you in Denver!
Taking off the white coat for a day

Teamwork is critical component for a functioning emergency department. The team consists of an array of players with varying roles. Physicians, nurses, medical assistants, and patient care assistants all provide direct patient care. In turn, they’re supported by clerks, radiology technologists, environmental support techs, lab techs, phlebotomists, and a host of others. Every single one helps acquire information and care for the patient. Not to be forgotten, radiologists, consultants, and admitting teams provide input to build a disposition. Each patient’s care is dependent upon the synergistic talents of these individuals.

So, where does a medical student fit in? Looking for and understanding the role of each team member is a great first step. Without knowing who does what — or whom to ask for what — a student quickly gets lost within the emergency department’s orchestrated chaos. It’s a challenge to become part of the team, to try to help, and try to learn something — all while staying out of the way.

To understand more about how the team functions and to learn the role of a key team member, I assumed the role of a nurse for a day. As a third-year medical student, the emergency medicine rotation requires students to perform an emergency nursing shift. Without question, becoming a nurse for 12 hours was one of the greatest learning experiences I had during my emergency medicine rotation. During those 12 hours, I was paired up with a few different nurses. Each showed me the best procedure techniques and tricks. With them, I performed ABGs, placed NG tubes, placed peripheral IVs, placed Foleys and straight catheters, attached patients to cardiac monitors, and performed EKGs.

Prior to the nursing shift, I already had great respect for nurses. After walking in their shoes, helping with all their tasks, and seeing what they see, I have a newfound awe. It is a challenge to get an EKG on a patient who’s actively vomiting, to maintain sterility during an in/out catheter, and to get an ABG on someone with a weak pulse. These are all tasks that emergency nurses perform every day — and they perform them effortlessly. I was shocked at how fast they could get two large-bore IVs in a patient during a hectic resuscitation!

As future physicians, it’s important to learn how to function well within these medical teams, where each and every individual has something vital to contribute. Though it may feel more thrilling as a medical student to sew up a laceration, place a central line, or perform a lumbar puncture — we must be aware that IVs, Foleys, ABGs, NGTs, and EKGs are just as important for a patient’s care. It’s quite an eye-opener seeing this from another’s perspective.

“Becoming a nurse for 12 hours was one of the most beneficial learning experiences I had during my emergency medicine rotation.”

Medical Student Luncheon Sponsors

EMRA gratefully acknowledges the following residency programs and chapters for their time and generous support of this year’s Medical Student Luncheon during Scientific Assembly.

Arizona ACEP Chapter
Baylor University
California ACEP
Central Michigan University
College of Medicine
Christiania Care
Florida Hospital Emergency Medicine Residency
Jacobi/Einstein/Montifiore EM Program
JPS EM Residency
Lehigh Valley Health Network
North Shore University Hospital
Emergency Medicine Residency Program
Oregon Health and Science University
SUNY Downstate
University of Alabama
University of Kentucky
University of Nevada
University of Tennessee Chattanooga
University of Wisconsin School of Medicine & Public Health
Yale University School of Medicine
SATURDAY, OCTOBER 6
1:00 pm – 5:00 pm
EMRA Medical Student Governing Council Meeting
Embassy Suites Denver, Quartz Boardroom, 2nd Floor
What can you help accomplish as a member of this council? Come make a difference. All engaged medical students are encouraged to attend this meeting.

5:30 pm – 7:30 pm
EMRA MSCG/EMIG Representative Mixer
Tamayo Restaurant, 1400 Larimer St
Attend this fun and informal social opportunity to meet with other medical students, the MSGC officers, and EMIG representatives from around the country

SUNDAY, OCTOBER 7
8:00 am – 2:00 pm
EMRA MEDICAL STUDENT FORUM

- **ACLS: Advance your Career Longevity and Satisfaction**
  Angela Siler-Fisher, MD, FACEP, Baylor College of Medicine, Ben Taub General Hospital
  Colorado Convention Center, Room 405

- **Career Opportunities in Emergency Medicine Discussion Panel**
  Sara Lary, DO, Loma Linda University; David Farcy, MD, Mount Sinai Medical Center; Jennie Buchanan, MD, Denver Health Medical Center; David Schoenfeld, MD, Beth Israel Deaconess Medical Center in Boston
  Colorado Convention Center, Room 405

- **Medical Student Breakout Sessions**
  - **MSIV – Interview Day Tips**
    Janis Tupesis, MD, FACEP, University of Wisconsin
    Colorado Convention Center, Room 401
  - **MSIII – Taming the Application & Match Ranking Process**
    Micelle Haydel, MD, Louisiana State University, New Orleans
    Colorado Convention Center, Room 402
  - **MSII/II – Opportunities for EM During Preclinical Years**
    Kennon Heard, MD, Rocky Mountain Poison & Drug Center, Denver Health and University of Colorado School of Medicine
    Colorado Convention Center, Room 403
  - **MSIII/IV – What Osteopathic Students Need to Know**
    Marc Squillante, DO, University of Illinois-Peoria
    Colorado Convention Center, Room 404

- **Application and Interview Advice – Intern Panel Discussion**
  Dan Stein, MD, Oregon Health Science University; Steven McQuire, DO, Albert Einstein; Mike Ruygrok, MD, Denver Health; Java Tunson, MD, Denver Health
  Colorado Convention Center, Room 405

- **Medical Student Networking Luncheon/Roundtable Discussion w/Program Directors**
  Colorado Convention Center, Room 501

- **Managing Student Loans:** Jason DiLorenzo, GL Advisor
  Colorado Convention Center, Room 405

2:00 pm – 3:00 pm
EMRA Residency Fair Exhibitor Registration
Colorado Convention Center, Mile High Ballroom 2

3:00 pm – 5:00 pm
EMRA RESIDENCY FAIR
Colorado Convention Center, Mile High Ballroom 2
Attend the EMRA Residency Fair to help you scout out the more than 100 residency programs from around the country. Medical students cannot afford to miss this terrific opportunity to network with program directors, coordinators, and chief residents.
Meet Your Match at
EMRA’s Residency Fair

Sunday, October 7, 2012
3:00 pm – 5:00 pm • Mile High Ballroom 2

If you are a medical student looking for the perfect residency program, be sure to attend our Residency Fair!

Confirmed exhibitors as of 9/25/2012
The infamously difficult auricular compression bandage

There are multiple resources describing the urgency and necessity of draining an auricular hematoma. Without it, the hematoma causes cartilage growth, eventually resulting in cauliflower ear. This cause-and-effect has been ingrained into emergency medicine teaching. Yet there are few descriptions of properly applying the bandage itself.

The bandaging technique described here is most commonly used following evacuation of an auricular hematoma. It’s equally helpful tending to other ear injuries, like extensive lacerations and bite wounds. The overarching goal is to prevent accumulation of subperichondrial blood in – and the ensuing destruction of – the cartilaginous architecture of the outer ear.

Ensuring the bandage has sufficient pressure while also staying appropriately placed is tricky. There’s a simple method, though! Using minimal materials, anyone can create the auricular compression bandage (Image 1). To start, gather these materials:

- 4x4 gauze
- Kerlix bandage
- ACE bandage
- Vaseline gauze or formable auricular splint
- Cotton ball

First, the Vaseline gauze (or auricular splinting material) is carefully packed into the cartilaginous folds of the outer ear, forming a mold in the shape and size of the pinna (Image 2).

Next, after estimating the amount of 4x4 gauze needed to splint the posterior pinna, cut a V-shaped gap in the gauze (Images 3, 4). Apply some of the gauze posterior to the pinna (to prevent flattening of the pinna against the scalp); then place additional gauze over the ear to pancake the pinna (Image 5).

Wrap the Kerlix around the patient’s head, overlapping the forehead superiorly and the chin inferiorly. The purpose of this step is to snuggly hold the 4x4s on the ear and prevent slippage. Then, cover the Kerlix with an ACE bandage to hold the entire dressing tightly in place (Image 6).

The patient should wear the dressing until their follow-up appointment 24 hours later, though it of course may be worn longer if needed.

Step-by-step photographic guidance is infinitely helpful when bandaging an awkward location. Head bandages are particularly difficult. This compression bandage is vital to treat an auricular hematoma. It’s a simple method way to minimize the risk of cauliflower deformation of the ear following hematoma evacuation.

A special thanks to Dr. Anna A. Lerant, Adam A. Bollaert and the Medical Advanced Skill and Simulation Education Center at the University of Mississippi Medical Center for their assistance in obtaining photographs shown in this article.

References
Image 3: A V-shaped area is removed from a 4x4 gauze.

Image 4: The 4x4 gauze is positioned posterior to the outer ear.

Image 5: A bundle of 4x4 gauze is placed overlying the outer ear.

Image 6: Kerlix gauze is tightly wrapped around the head holding the ear dressing in place.

Image 7: Avoid flattening the contralateral ear with the Kerlix gauze dressing.

Image 8: Tightly wrap the ACE bandage around the head to complete the auricular compression bandage.

“The overarching goal is to prevent accumulation of subperichondrial blood in – and the ensuing destruction of – the cartilaginous architecture of the outer ear.”

CANDIDATES AND EMPLOYERS

Connect through EM Career Central at ACEP’s Scientific Assembly

October 8-10, 2012
Denver, Colorado

Located in the
ACEP Resource Center
in the Denver Convention Center

Monday, Oct 8 9:30am–3:30pm
Tuesday, Oct 9 9:30am–3:30pm
Wednesday, Oct 10 9:30am–3:00pm

Visit www.emcareercentral.org today to find the ideal position!
Words of wisdom

The opportunity of a lifetime

Entering a training program in emergency medicine today is a terrific challenge – and a time for extraordinary personal and professional growth. Engaging in the specialty that touches one-third of the citizens of the United States every year is a special opportunity and a privilege.

As you begin this stage of your life, there are several practical features of residency training and personal time management that need evaluation. The privilege of caring for others carries a significant responsibility; success in carrying out that responsibility depends most importantly on what you bring to your education, not what others do for you.

You first must develop a structured and personal plan of study, incorporating how you learn best; then, actively and assertively implement that plan. Make a commitment to invest enough time to build a solid fund of knowledge – and apply that knowledge in a way that will serve you and your patients well. Appreciate the fact that good learning requires courage and a willingness to expose your weaknesses and flaws; there are times when the best learning occurs when you’re the most uncomfortable. Remember, however, keeping yourself healthy and happy is the foundation for your success as a resident and as a practitioner.

In addition to acquiring medical knowledge and technical expertise, you must recognize the importance of communication and teamwork. The patients and families you care for expect you to have medical expertise – but you will differentiate yourself by the personal and individual connection you establish when working with others. Take the time to understand their needs. Your expression of interest and caring will be as important as the correct diagnosis you make.

We’re operating within a new and challenging paradigm. The ability to work with others to achieve the best outcome for your patients requires mastery of interaction with all members of the healthcare team. Learning to understand the complex social and medical issues that our patients struggle with will help you leverage the skills of consultants, case managers, home care experts and others to, in turn, make effective and realistic decisions.

The value of a highly qualified emergency physician cannot be overstated. As an expert in emergency medicine, your interface with the acute care interaction will often determine a patients’ outcome. Decisions about diagnostic testing, treatment, and disposition are skills you will acquire and master. The daily contributions you make can be measured by careful outpatient follow-up plans, acute admissions to the hospital when appropriate, and the many other decisions you’ll make across the continuum.

If you have the time to attend ACEP’s annual Scientific Assembly, you’ll find great opportunities to hone your skills in all areas of emergency medicine practice, education, and research. Take advantage of terrific faculty, a wide range of educational options, and the ability to interact with leaders in emergency medicine from across the country. You’ll be exposed to new technologies, new techniques, better algorithms for care, and innovative ways to help create the emergency medicine programs and departments of the future. Networking with other residents, fellows, and attendings will also provide you with educational and employment opportunities you otherwise would never imagine.

This is a great time of your life – a time when you’ll develop the habits that will serve you throughout your career. Plan on entering a career that embodies lifelong learning, managing change, and leading your team as emergency medicine continues to grow. There is no better place to start this journey than at ACEP’s Scientific Assembly with over 5,000 of your peers and partners in care.

Work with EMRA, ACEP, your program leadership, and your colleagues to make the most of your training. The residents in emergency medicine are our future. We hope this experience encourages you to engage more and contribute to the College in many ways. ACEP is always working for you.

Welcome, good luck, and enjoy Scientific Assembly! As you leave Denver, decide what you can do to make your program, the College, and our specialty better every day.
Give a shift
“Emergency physicians work hard, efficiently, around-the-clock, and often for free. That’s value.”

As a future emergency medicine attending physician, are you more concerned about memorizing Sgarbossa’s criteria, or defending yourself before a jury for not ordering a troponin test on an otherwise healthy 36-year-old male with chest wall tenderness and a normal EKG and chest x-ray? Personally, I’m more concerned about getting sued, despite providing excellent medical care. But I’m also worried about what the future holds for our specialty in general; everything in healthcare is changing, and emergency medicine has a lot to lose. The truth hurts – sometimes really bad.

A few facts
On average, emergency physicians lose $138,300 annually in bad debt, due to the Emergency Medical Treatment and Active Labor Act (EMTALA) federal mandate. (General surgeons rank second, losing $25,600 annually.) As emergency physicians we take great pride in helping people in need, regardless of their ability to pay. Nonetheless, we are legally liable for any EMTALA-related care.

Fortunately, the House of Representatives recently passed a bill (H.R. 5, with the H.R. 157 amendment) that classifies physicians as federal employees when providing EMTALA-related care. This legislation would protect emergency physicians (and our consultants) under the Federal Tort Claims Act – a distinction that requires plaintiffs to sue the government and not us.

Free clinic employees are currently protected under a similar law. The same vote on H.R. 5 included language to abolish the Independent Payment Advisory Board (IPAB). The IPAB was included as part of the Affordable Care Act; it consists of a group of unelected officials to cut healthcare costs by cutting reimbursement to providers, particularly in the first years of its existence. This legislation still faces several hurdles. Before becoming law, it needs to be passed by the Senate and signed by the President (who has threatened to veto legislation which would damage the Affordable Care Act).

Emergency physicians must understand this legislation so we can speak with our Congressional representatives about the effects it would have on our practice and our patients.

Misled beliefs
The Department of Health and Human Services states that emergency care accounts for merely 2% of the $2.4 trillion spent on healthcare annually. Two-thirds of emergency department visits occur after business hours, and on weekends and holidays. Additionally, emergency physicians donate 4 to 10 times as many hours to charity care than physicians in any other specialty. These are important facts that should be well-known throughout Congress and Washington. Emergency physicians work hard, efficiently, around-the-clock, and often for free. That’s value.

Now is the time to accelerate our advocacy efforts. We can do this in a multitude of ways. For many of us, donating our hard-earned money is the quickest and easiest way to help our patients and ourselves outside of the emergency department. One way we can do this is by donating to the National Emergency Medicine Political Action Committee (NEMPAC) and the Emergency Medicine Action Fund (EMAF). Both are non-partisan organizations that function to optimize care for emergency medicine patients.

Give a shift
NEMPAC started the “Give-a-Shift” campaign to raise funds to help emergency medicine patients and physicians. It’s a tax-deductible donation to NEMPAC ($1,000 for attending physicians and $100 for residents). You can give less or give more, but I encourage you to give something. In 2010, only 28% of ACEP-eligible emergency physicians donated an average of $203 to NEMPAC. Financially, NEMPAC ranks third among physician specialty political action committees. Orthopedics tops the list followed by radiology. There is no reason why NEMPAC shouldn’t be first.

The extent of our professional and personal responsibilities may preclude us from attending the annual ACEP Leadership and Advocacy Conference or reading the EMRA Emergency Medicine Advocacy Handbook cover to cover. But we can all write a check. Even the least tech-savvy physicians can donate online. Getting involved is as simple as writing a prescription.

The fight’s only going to get harder, the cuts deeper, and the pie smaller. Thank you for giving a shift.

References
Clinical case

One unifying cause of cranial nerve IV palsy, the real cost of medication noncompliance

Case

A 56-year-old male (patient A) presented to our emergency department with diplopia, headache, and nausea for four days. He admitted to noncompliance with his medications for hypertension and diabetes. On physical examination, his right pupil was abducted on straight gaze, however both pupils were symmetric and reactive to light (see photo). He was unable to move the right eye medially past the midline, and had no movement on upward or downward gaze. His diplopia was worsened when leaning his head towards the shoulder on the affected side. The remainder of the neurological examination was unremarkable. After a normal head CT, the ophthalmology consultant diagnosed Patient A with cranial nerve IV palsy and attributed the cause to poorly controlled diabetes, recommending outpatient follow up.

Patient A returned four days later with more cranial nerve findings, after a mechanical fall from standing. This time, patient had right eye ptosis (CN III) and a mild right-sided facial droop (CN VII), in addition to the previous CN IV palsy findings. CT head and lumbar puncture were within normal limits. The intracranial and cervical MRI/MRA were unremarkable. He was admitted and subsequently discharged home, without resolution of symptoms.

Another 56-year-old male (patient B) presented to our emergency department the next month, with right eye ptosis and diplopia for one month. Past medical history was very similar to Patient A, including poorly controlled hypertension, diabetes, and end stage renal failure. Patient B had a right pupil that was poorly reactive to light with complete ptosis (CN III), as well as inability to intort or depress the eye (CN IV). On straight gaze his right eye was abducted and superior. CT head and intracranial and cervical MRI/MRA were again, unremarkable. Patient B was admitted and upon discharge home still had cranial nerve III and IV palsies.

Discussion

The CN IV (trochlear nerve) innervates the superior oblique muscle, which controls eye intorsion (rolling toward the nose), with secondary actions of depression and abduction. Thus, on straight gaze, an eye with CN IV palsy will appear extorted and deviated upward – see figure 1. Vertical diplopia is present and is exaggerated by looking downward, as well as limitations on downward and inward gaze, such as in patient A. On presentation, patients have a head tilt toward the opposite side and downward to compensate for the diplopia. In the emergency department, one can test extraocular movements to identify limitations on downward gaze and intorsion. To confirm, the Bielschowsky test can be used: The patient leans their head towards the affected side, which should worsen the diplopia by causing more image separation. Diplopia is improved by tilting the head towards the unaffected side.

Of the cranial nerves that control eye movement (CN III, IV, VI), CN IV (trochlear) nerve palsy is the most rare, possibly due to it being the smallest of the above cranial nerves. An ophthalmology
case series from 1950-1988 identified only a small number of acquired isolated trochlear nerve palsies (657/4,278). The remainder were CN VI (1,918/4,278), CN III (1,225/4,278), or a combination of all three cranial nerves (573/4,278).

What can we tell our patients with trochlear nerve palsy about their prognosis? Unfortunately only one study in the literature examined this. Out of 34 patients with CN IV palsy, only 50% (17/34) made a complete recovery with a median time of three months and the longest recovery time of eight months.

Above, we present case reports of two similar patients unified by same age, medication noncompliance, severe vascular pathology with diabetes and hypertension. These were the two main comorbidities revealed during literature review for CN IV palsy. Per one study, a third of CN IV palsies (45/153 cases) occurred in patients with diabetes. Furthermore, most co-morbidities were attributed to vascular cases, the most common being hypertension, diabetes, and atherosclerosis.

Case conclusion
The above case reports demonstrate two dilemmas – which patient deserves hospital admission and how much work-up is immediately necessary? Besides head CT, further work-up should include lumbar puncture to rule out subarachnoid hemorrhage and meningitis. Although our literature search does not provide a clear diagnostic approach, performing an MRI (if available) is reasonable – since the nerves pass through the cavernous sinus, it’s wise to rule out cavernous sinus tumor, infection, or thrombosis.

Most emergency physicians agree that patients with cranial nerve palsies require a head CT, plus or minus LP. However, the subsequent work-up the decision to admit versus discharge varies. The literature does not provide a clear answer for this rare presentation. Finally, consider MRI to rule out cavernous sinus pathology, including tumor, thrombosis, and infection.

References

Cranial nerve III and IV palsies. Right eye ptosis and dilated pupil from CN III palsy. Right pupil extorted and directed upward from CN IV palsy. CN IV controls the superior oblique muscle which intorts the eye (rolling toward the nose), depresses (downgaze), and abducts (looking away from the nose). With CN IV palsy, the eye will extort, deviate upward, and drift inward.
As we approach fall of 2012, ACEP’s Scientific Assembly is the official start of the 2013 job-hunting season. A common theme among graduating residents is how to organize cash flow, assets, liability payments, retirement plans, education funds and everything else. The list is endless. This article attempts to make sense of it all, as concisely as possible to do the topic justice.

**Practice plans**
Your choice of practice environment is the first determinant for planning your future. Here are some things to keep in mind with each of the three most common emergency medicine practice types:

**Independent contractor**
As an independent contractor, you will have the flexibility and the challenges of being self-employed. Take time to understand self-employment income; set up a dedicated bank account and credit/debit card to separate business and personal expenses; and set up an additional account to track tax payments and plan a forward-looking budget. Plan to establish a SEP IRA or Solo 401(k) as soon as possible to begin funding retirement and reducing your tax liability. Based on your hourly rate and expected shifts, determine your gross monthly income; subtract retirement contributions; separate appropriate tax payments; and use the remainder to frame your budget.

**Private or democratic group**
Keep in mind that you commonly will have one to three years as an employee before making partner and becoming self-employed. During the employee period, you likely will have a fixed income, minimal business expenses, and a limited ability to contribute to retirement – you will not have to think like a business person. Your budget should be well-defined. As you transition into a partner role, it will be important to have an accountant and other financial advisors advise you about navigating the changes in taxation, retirement eligibility, and medical benefit limitations.

**Hospital employee**
A W-2 employment position with a hospital provides financial stability, diverse resources and, often, competitive scheduling. In exchange for security in these areas, employees typically do not earn as much as private practitioners and have less flexibility in designating money to retirement and other important programs. For many, a significant advantage of hospital work is the ability to do research, train residents and be involved in the collaborative, educational side of medicine.

If you are unsure of what type of practice you are interested in, take advantage of the EMRA Job Fair and various lectures EMRA offers at Scientific Assembly. Find opportunities to meet prospective employers, learn more about contract negotiation, and gain advice on developing a financial transition plan.

The three fundamental financial topics that need to be understood are:

- How to develop a budget that accommodates your financial goals
- How to plan for future objectives such as retirement, debt repayment, and education funding
- How to evaluate and acquire appropriate disability insurance
Allocating income
Take the time, before you graduate, to create a budget. For quantifiable objectives – such as a home down-payment, vacations and emergency savings – create a separate account at your bank for each goal and contribute a fixed monthly amount via bank draft. For retirement, education for children, debt repayment and other larger items, develop an end-goal and make contributions that are in line with those objectives.

Having a well-planned budget will allow you to maximize available income, minimize income taxes and maintain confidence in your personal financial situation.

Disability insurance for emergency residents
Currently in the field of emergency medicine there are five very competitive contracts, in most states. The competitive features to understand are:

• “Own occupation” definition of disability – These contracts will consider you totally disabled if you can not perform the substantial and material duties of your occupation, regardless of outside income or earnings. Understand that all disability claims are unique situations and are handled in a similar way by any company. All companies want to pay as much as an insured individual is eligible for, but certainly not more than what is reasonable. An “own occupation” contract does not guarantee that you will receive full benefits in every situation, but it does offer the most comprehensive, flexible level of income protection in the most diverse set of potential claim scenarios.

• Benefit limits – This is where current residents really benefit. Current guidelines allow a resident or fellow within the last six months of training to obtain up to $6,500 of tax-free monthly income protection. Do this prior to completing training, and you may be able to start in practice with greater than 100% of your net income insured. This is well above the normal industry guidelines, but the opportunity expires as soon as you complete your training.

• Out-of-pocket cost – The relative benefit cost is as low as it has been in 10 years. For the most significant price reductions, obtain disability as a group of at least three people. Males can save 10-12%; females can save 45%!

• For more detailed information on this topic, review the Disability Filter video, located at www.integratedwealthcare.com/education.

Best wishes and safe travels, if you are attending the meeting in Denver. If we cross paths at Scientific Assembly please don’t hesitate to stop me.

Thank you for all that you do.

M. Shayne Ruffing, CLU, ChFC, AEP is the creator of the Confident Transition Plan™ for medical residents, the Physician Disability Income Analyzer™ and the Physician’s Financial Navigator™. Shayne is the managing director of Integrated WealthCare, Collaborative Wealth Management for the medical community. He can be reached at 866.694.6292, or via e-mail at shayne.ruffing@integratedwealthcare.com or on the web at www.IntegratedWealthCare.com.

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The multiple bounceback – a 37-year-old man with headaches

In Bouncebacks, the authors provide the documentation of an actual patient encounter, discuss patient safety and risk management principles, and then reveal the patient’s “bounceback” diagnosis.

The cases are adapted from the book Bouncebacks! Emergency Department Cases: ED Returns (2006, Anadem Publishing – available at www.amazon.com and www.acep.org), which includes 30 case presentations with risk management commentary by Gregory L. Henry, past president of The American College of Emergency Physicians, and discussions by other nationally recognized experts.

Bouncebacks: Medical and Legal, was released in October 2011 with a novel approach to patient safety by following the stories of 10 patients from the initial visit to the attorney’s desk, including courtroom testimony and settlement decisions. It is colorful and engaging. Authors: Michael Weinstock, Kevin Klauer, and Greg Henry with forward by Mel Herbert, and commentary by many national medical experts, attorneys, and policy makers.

This month’s case is about a repeat offender; the story of a 37-year-old man with a headache who had 4 ED visits and 2 primary care visits before receiving the correct diagnosis. This wasn’t just a bounce back… It was a bounceback on steroids!

It is easy to label such a patient a “frequent flyer” or “drug-seeker.” However, a bounceback should always prompt the doctor to reevaluate the diagnostic approach and to move forward through the patient encounter with accuracy and vigilance no matter how seemingly benign the chief complaint. This case reminds us that 1) the history is the emergency physician’s greatest ally and 2) that approaching each patient and each visit with a fresh, unbiased attitude is imperative to great patient care.

This case is from Bouncebacks! Emergency Department Cases: ED Returns by Michael Weinstock and Ryan Longstreth with case commentary by Greg Henry.

Summary ED Visit 1

Chief Complaint (at 11:22): Headache

<table>
<thead>
<tr>
<th>Temp</th>
<th>Pulse</th>
<th>Resp</th>
<th>Syst</th>
<th>Diast</th>
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</thead>
<tbody>
<tr>
<td>98.9</td>
<td>104</td>
<td>18</td>
<td>112</td>
<td>68</td>
</tr>
</tbody>
</table>

History of present illness (at 11:54): Pt. is a 37-year-old male who presented with complaint of 20-year history of headaches, which occur about once per month. The patient was returning from church the day previously and had a constant pain in the frontal region associated with nausea and one episode of vomiting and was similar to past headaches, but lasted longer. No complaints of rhinorrhea, cough, sore throat, earache, dizziness, neck pain, rash, numbness, slurred speech or facial droop, chest pain, SOB, or abdominal pain.

Past medical history/triage:
PMH: Negative
PSH: Negative
Medications: None
SH: Works for Buckeye steel

Physical exam (at 12:00):
General: Alert and oriented X3, well-nourished, in no apparent distress
Head: Normocephalic; atraumatic
Eyes: PERRL, EOMI
Nose: The nose is normal in appearance without rhinorrhea
Respir.: Breath sounds clear and equal
Cephalgia secondary to sinusitis

Tube 1 = 250, tube 3 = 11

Complicated sinusitis
Change abx to Augmentin,
Change Vicodin to Percocet.

with each visit.

vigilance for life-threatening diagnosis
seeming a chief complaint, maintain
Teaching point:
toxicity).

if contacts have had headaches (CO
other immunocompromised states), or
encephalitis), weight loss (cancer or
subarachnoid hemorrhage (SAH), history of fever (meningo-
due to tumor or benign intracranial
hypertension), changes of hypertensive
retinopathy, diabetic retinopathy, or
AIDS retinopathy (toxoplasmosis or
cytomegalovirus).

Teaching point: Document a fundoscopic exam with all headache patients.

Error #2: Fundoscopic exam not documented.
Discussion: A neurologic exam for a headache is not complete without a fundoscopic exam – period. The fundoscopic exam is quick, non-invasive, and has the potential to reveal a large amount of information: blurring of the disc margins (increased intracerebral pressure due to tumor or benign intracranial hypertension), changes of hypertensive retinopathy, diabetic retinopathy, or AIDS retinopathy (toxoplasmosis or cytomegalovirus).

Teaching point: Document a fundoscopic exam with all headache patients.

Error #3: Tachycardia not addressed or repeated.
Discussion: The Bouncebacks! theme. Tachycardia is an oft-unrecognized warning sign of a more serious problem. A finding of tachycardia should be discussed in a progress note, the pulse should be rechecked, and evaluation revisited to ensure exploration of potentially serious illnesses.

Teaching point: Be wary in discharging a patient with abnormal vital signs. Reevaluate. Reassess.

Error #4: Inadequate aftercare instructions.
Discussion: The patient should have a defined time to follow up and know specifically why to return. A patient with diagnostic uncertainty should understand this fact and a notation made that this was discussed with the patient.

Teaching point: Aftercare instructions need to be time- and action-specific.

Summary of ED visit 2
• Returned 3 days later with frontal headache.
• History notes he had seen PCP 2 days previous and was diagnosed with sinusitis and prescribed Zithromax. Now complains of emesis and decreased appetite. Pain worse when bending forward. No fever, no help with Vicodin.
• Exam: No change from initial exam, except nasal mucosa edematous and erythematous with tenderness to palpation over the frontal and maxillary sinuses.
• Brain CT – Radiology reading: “Right maxillary antrum air fluid level – sinusitis?”
• Dx: Cephalgia and sinusitis

Summary of ED visit 3
• Returned 2 days later at 6AM. History included extensive synopsis of past visits and treatments. The pt. had seen the PCP again yesterday (the 5th health care visit in 6 days) but the only description of current HA was “facial pressure on the right side.”
• ED course: Demerol and Phenergan IM
• Dx: Cephalgia secondary to sinusitis
• Plan: Change abx to Augmentin, continue Vicodin and Phenergan.

Summary of ED visit 4
• Return same day at 4PM (10 hours later). History now documents demographics: “37 year male from Guinea who has been in the U.S. for 6 years.” Now complains of “fevers at home.” This is the worst HA of his life.
• PE: Normal except tenderness over frontal sinuses. Temperature is 99.0 degrees.
• ED course: LP performed to look for atypical infection.
• LP results:
  – RBC: Tube 1 = 250, tube 3 = 11
  – WBC = 5 (1 poly and 4 lymph)
  – Gram stain negative
• Dx: Complicated sinusitis
• Plan: Change Vicodin to Percocet. “Will add cryptococcal testing to CSF.” D/C to home.

continued on page 34
Note: the above physician on ED visit 4 discussed the case with ED physician 5 (below) when he arrived for the night shift at 10PM. They allowed the patient to go home as he did have reliable contact information if the cryptococcal test returned positive.

**Summary ED visit 5**

- Pt. called to return to ED a few hours later with positive India ink stain for Cryptococcus.
- Additional history: 35 lbs. weight loss in 8 mo.
- Exam: No thrush, OHL (oral hairy leukoplakia), adenopathy
- Dx: Cryptococcal meningitis
- Plan: Started on amphotericin B and admitted to Infectious Diseases. Subsequent HIV test and CD4 count confirms diagnosis of AIDS.

**Documentation, diagnosis, and patient safety issues**

**I. Why did the doctor miss the diagnosis?**

The initial doctor may have been thinking of the diagnosis of infection in an immunocompromised state, but we’ll never know because it wasn’t reflected in the thought process of the HPI, ROS, physical exam, or medical decision-making.

Our patient had cryptococcal meningitis from undiagnosed AIDS. Could this diagnosis have been made at the first visit? (or second through sixth visits?!!?) Taking social, travel and sexual histories can be time consuming in a busy ED and is not always routinely done with a likely etiology of symptoms, but with diagnostic uncertainty, can alert the provider to consider a broader differential (i.e., HIV/AIDS or tropical infections).

These doctors fell into the trap of “diagnosis momentum,” placing too much credence in previous physicians’ evaluations. Diagnosis momentum occurs when a diagnosis becomes established without adequate supporting evidence, and then gathers momentum with each subsequent provider. Our patient had a CT suggesting sinusitis, a sensitive but non-specific finding. He was started on antibiotics and when he did not improve, the Zithromax was changed to Augmentin. If the initial antibiotic does not work for sinusitis, another antibiotic may be tried, but caution should be applied due to the minimal efficacy of antibiotics for sinusitis. The number needed to treat (NNT) with antibiotics is 5-14 and number needed to harm is 17. In other words, antibiotics will only help 6% to 20% of patients and will harm 6%. If the first antibiotic does not work, the chance of the second helping is even less and the initial diagnosis should be revisited.

**II. Initial Diagnosis of HIV in Asymptomatic Patients**

White, gay men no longer represent the majority of new HIV infections in the U.S.; over a third of recently infected individuals now acquire HIV via heterosexual contact and 46% by homosexual contact. Over half of new infections are diagnosed in African-Americans, and 27% are in women.

In an undiagnosed patient, the first clue that a patient may have HIV/AIDS is assessment of risk factors: HIV-positive sexual contacts, injection drug use, hemophilia, multiple unknown sex partners, or travel in areas where HIV is endemic.

In the *history*, immunosuppression may manifest as:

1. Repeated minor mucocutaneous infections
2. Thrush
3. Recurrent herpes simplex
4. Candida vaginitis
5. Shingles

**Review of systems** may reveal:

1. Weight loss/anorexia
2. Night sweats
3. FEVERS/chills
4. Easy bruising

**Physical exam** clues to HIV diagnosis depend on the CD4 count

1. General exam – Wasting, generalized lymphadenopathy
2. Skin exam – Seborrheic dermatitis especially over the malar eminences, zoster scars, genital or perianal herpes simplex virus, and tinea
3. HEENT – Thrush, oral hairy leukoplakia (white vertically oriented lines on either side of the tongue – pathognomonic for HIV)
4. Fundoscopic exam – Cotton wool spots, papilledema from increased intracranial pressure (common with cryptococcal meningitis), toxoplasmosis, or CNS lymphoma

In November 2002, reliable, rapid testing for HIV antibodies became available, making the diagnosis of HIV quick and simple. The OraQuick Rapid HIV-1 Antibody Test (OraSure Technologies Inc., Bethlehem, Pennsylvania, US) can be performed using either a fingerstick blood sample, a tube of blood, or salivary secretions. The results are available in 20 to 30 minutes. Sensitivity and specificity are excellent and compare favorably with the routine EIA. Furthermore, these rapid assays are CLIA-waived. All positive rapid assay tests need to be confirmed with a Western blot or other confirmatory assay.

Routine laboratory studies commonly show abnormalities and can support suspicions of undiagnosed HIV infection. Leukopenia with lymphopenia is the rule; its absence argues against HIV. An abnormal white blood cell count, anemia is common but not universal. Thrombocytopenia is seen in 10% of patients. Patients are commonly co-infected with hepatitis, resulting in abnormal LFTs.

Opportunistic infections (OI) such as Cryptococcus or toxoplasmosis typically occur in the later stages of HIV infection when the CD4 count is under 200. Since the CD4 cell count falls 60 to 100 cells per year of HIV infection, it may take years after the initial viral infection for patients to present with an OI.
III. Evaluation of Headaches in Patients with AIDS

In patients with AIDS, the differential diagnosis includes CNS mass lesions, and a spinal tap should be withheld until a head CT scan is performed, confirming there is not a midline shift. While Cryptococcus would be the most common cause of subacute meningitis in an AIDS patient in the US, other OIs of the central nervous system include cytomegalovirus (CMV), herpes simplex virus (HSV), herpes zoster (VZV), progressive multifocal leukoencephalopathy (PML), tuberculosis (TB), Mycobacterium avium complex (MAC), B-cell lymphoma, toxoplasmosis, syphilis, listeria, histoplasmosis, and Coccidioides. A cerebrospinal fluid (CSF) examination and cultures of the CSF are needed to help sort out these possibilities.

IV. Symptoms and Diagnosis of Cryptococcal Meningitis

Cryptococcus is a ubiquitous organism with a portal of entry via the lungs and spreads to the CNS hematogenously. The most common symptoms of cryptococcal meningitis in HIV patients are chronic headache, fever, and malaise. Our patient’s lack of nuchal rigidity is typical in cryptococcal disease; less than half of patients have a stiff neck. Temperatures normally do not exceed 39°C and are absent in a quarter of patients.

In AIDS patients with cryptococcal meningitis, the CT scan is normal in most, but hydrocephalus and gyral enhancement can be found in some. Cortical atrophy is seen in a third of patients. An LP was performed on our patient but no opening pressure was noted. This would have been helpful and may have suggested the diagnosis, obviating his discharge and need to return. Opening pressures are elevated (>200 mm of water) in three-fourths of patients with cryptococcal meningitis and AIDS. In fact, the increased intracranial pressure may cause cranial nerve palsies and visual impairment and are the main determinant of outcome.

An easy diagnostic trick to diagnose cryptococcal meningitis is to check a serum cryptococcal antigen test, positive in about 95% of cases. This can be used to screen patients for cryptococcal disease without having to do a lumbar puncture.

V. ACEP 2008 Headache Guidelines

In June 2008, The American College of Emergency Physicians (ACEP) released new headache guidelines for the evaluation of patients with acute headache. Indications for neuroimaging include:

Level A recommendations. None specified.

Level B recommendations.
1. Patients presenting to the ED with headache and new abnormal findings in a neurologic examination (e.g., focal deficit, altered mental status, altered cognitive function) should undergo emergent* noncontrast head CT.
2. Patients presenting with new sudden-onset severe headache should undergo an emergent* head CT.
3. HIV-positive patients with a new type of headache should be considered for an emergent* neuroimaging study.

Level C recommendations. Patients who are older than 50 years and presenting with new type of headache but with a normal neurologic examination should be considered for an urgent† neuroimaging study.

Summary

1. When there is diagnostic uncertainty with a headache patient, explore additional factors such as travel history, weight loss, ethnicity – all of which could have helped make the diagnosis at one of the initial encounters.
2. Beware diagnosis momentum. Each encounter must be evaluated independently. Think: “What may I find that the previous docs haven’t found?”
3. Oh yeah, don’t forget the vital signs (tachycardia)… have we mentioned this before??

With our patient, the correct diagnosis was eventually made and the patient was appropriately treated, but his time to treatment and outcome could have been far different…

References

An emerging academic subspecialty of global importance

the simple, effective interventions are at times overlooked. Yet in remote environments, one’s history and physical exam skills must be relied upon for diagnosis. Due to space and weight restrictions, medical supplies also are limited; in its place, complete understanding of pathophysiology and pharmacology is needed to develop (often ingenious) solutions with limited resources. Thus, in many ways, wilderness medicine is a return to the fundamentals of medicine.

Paul Auerbach, often called one of the founding fathers of wilderness medicine, published the first edition of the subspecialty’s core textbook in 1983. Now in its sixth edition, the text has helped define the scope of wilderness medicine, while adapting as the field grows and changes.

Wilderness medicine patients can be found in a multitude of environments – from marine to mountainous to outer space (Figure 1). To build a differential, the physician has to consider the pathology specific to an environment as well as the everyday illnesses seen in any emergency department; that differential diagnosis can seem infinite. Similarly, the medical equipment and supplies required for treatment vary extensively.

In addition, military, travel, disaster, international relief aid, extreme/ecochallenge athletics, and an increasing active elderly population have taken more people even further into harsh environments. Now included as part of wilderness medicine by many, the intersection of environmental change and human health is of increasing importance as we experience the effects of climate change.

Physicians who gravitate to wilderness medicine have a love of the wilderness and embrace the Wilderness Medical Society’s motto of “combining your profession with your passion.” As a foundation for success – and in order to remain effective and safe – a wilderness medicine physician should have a familiarity with remote environments and have outdoor technical skills to remain effective (Figure 2).

In combination with an emerging competency in wilderness medicine fundamentals one can begin to gain clinical experience practicing in a range of ecosystems and contexts while honing their history and physical exam skills in these diverse settings. Meanwhile, the interdisciplinary nature of the subspecialty

<table>
<thead>
<tr>
<th>Table 1: ABEM’s Environmental Medicine Core Competencies</th>
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</thead>
<tbody>
<tr>
<td>1. Bites and Envenomation</td>
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<tr>
<td>2. Dysbarism</td>
</tr>
<tr>
<td>3. Electrical Injury</td>
</tr>
<tr>
<td>4. High altitude illness</td>
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<tr>
<td>5. Submersion Incidents</td>
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<tr>
<td>6. Temperature related illness</td>
</tr>
<tr>
<td>7. Radiation emergencies ABEM (I)</td>
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</table>

Table 1: ABEM 2011 Model of the Clinical Practice of Emergency Medicine Environmental Medicine Competencies (1)
guarantees overlap with other areas of medicine such as EMS, infectious disease, toxicology, and sports medicine.

Many large academic institutions and organizations have transitioned wilderness medicine into the academic realm through education and research in the form of fellowships, courses, and certifications. This has solidified its existence and reemphasizes the need for expansion as more wilderness medicine physicians are trained and the knowledge base continues to grow.

EMRA has recognized the importance of this field through its recent approval of the Wilderness Medicine Committee, with an inaugural meeting scheduled at the 2012 ACEP Scientific Assembly in Denver. Our goal is to be a key resource for medical and logistical knowledge in wilderness medicine. We will work collaboratively with other organizations, such as the ACEP and SAEM wilderness medicine sections, to further advance the field.

As Dr. Auerbach said, “Seek a niche that will sustain you professionally and philosophically. Not only will you find personal fulfillment, but your patients will reap the benefits from a physician in balance between his/her work and life.”

Please come to the EMRA Wilderness Medicine Committee inaugural meeting at the 2012 ACEP Scientific Assembly and consider running for a leadership position. Visit our homepage on the EMRA website for further information and resources.

References
EMRA gratefully acknowledges these organizations for their generous support of the many activities during *Scientific Assembly*

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TUESDAY
OCTOBER 9
## FRIDAY, OCTOBER 5

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<th>Event Description</th>
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<tr>
<td>8:00 am – 5:00 pm</td>
<td><strong>EMRA Board of Directors Meeting</strong></td>
<td>Embassy Suites Denver, Quartz Boardroom, 2nd Floor</td>
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## SATURDAY, OCTOBER 6

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<tr>
<td>1:00 pm – 5:00 pm</td>
<td><strong>EMRA Medical Student Governing Council Meeting</strong></td>
<td>Embassy Suites Denver, Quartz Boardroom, 2nd Floor</td>
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<tr>
<td>5:30 pm – 7:30 pm</td>
<td><strong>EMRA MSCG/EMIG Representative Mixer</strong></td>
<td>(offsite) Tamayo, 1400 Larimer St</td>
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<tr>
<td>7:00 pm – 10:00 pm</td>
<td><strong>EMRA Board of Directors Meeting</strong></td>
<td>Embassy Suites Denver, Quartz Boardroom, 2nd Floor</td>
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## SUNDAY, OCTOBER 7

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<tr>
<td>8:00 am – 2:00 pm</td>
<td><strong>EMRA MEDICAL STUDENT FORUM</strong></td>
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<td>8:00 am – 8:50 am</td>
<td><strong>Acls: Advance your Career Longevity and Satisfaction</strong></td>
<td>Baylor College of Medicine, Ben Taub General Hospital Colorado Convention Center, Room 405</td>
</tr>
<tr>
<td>9:00 am – 9:50 am</td>
<td><strong>Career Opportunities in Emergency Medicine Discussion Panel</strong></td>
<td>Sara Lary, DO, Lorna Linda University</td>
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<td>David Farcy, MD, Mount Sinai Medical Center</td>
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<td>Jennie Buchanan, MD, Denver Health Medical Center</td>
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<td>David Schoenfeld, MD, Beth Israel Deaconess Medical Center in Boston</td>
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<td>Colorado Convention Center, Room 405</td>
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<tr>
<td>10:00 am – 10:50 am</td>
<td><strong>Medical Student Breakout Sessions</strong></td>
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<td><strong>MSIV – Interview Day Tips</strong></td>
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<td>Janis Tupesis, MD, FACEP, University of Wisconsin</td>
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<td>Colorado Convention Center, Room 401</td>
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<td><strong>MSIII – Taming the Application, &amp; Match Ranking Process</strong></td>
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<td>Colorado Convention Center, Room 402</td>
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<td><strong>MSIII/II – Opportunities for EM During Preclinical Years</strong></td>
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<td>Denver Health and University of Colorado School of Medicine</td>
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<td>Colorado Convention Center, Room 403</td>
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<td><strong>MSIII/IV – What Osteopathic Students Need to Know</strong></td>
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<td>Colorado Convention Center, Room 404</td>
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<tr>
<td>11:00 am – 11:50 am</td>
<td><strong>Application and Interview Advice – Intern Panel Discussion</strong></td>
<td>Dan Stein, MD, Oregon Health Science University; Steven McGuire, DO, Albert Einstein; Mike Ruygrok, MD, Denver Health; Java Tunson, MD, Denver Health</td>
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<td>Colorado Convention Center, Room 405</td>
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<tr>
<td>12:00 pm – 1:00 pm</td>
<td><strong>Medical Student Networking Luncheon/Roundtable Discussion w/Program Directors</strong></td>
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<td>1:00 pm – 1:50 pm</td>
<td><strong>Managing Student Loans</strong></td>
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<td>Jason DiLorenzo, QL Advisor</td>
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<td>Colorado Convention Center, Room 405</td>
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<tr>
<td>2:00 pm – 3:00 pm</td>
<td><strong>EMRA Residency Fair Exhibitor Registration</strong></td>
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<td>Colorado Convention Center, Mile High Ballroom 2</td>
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<tr>
<td>3:00 pm – 5:00 pm</td>
<td><strong>EMRA RESIDENCY FAIR</strong></td>
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**MONDAY, OCTOBER 8**

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>7:00 am</td>
<td><strong>EMRA Resident Bloody Mary Breakfast</strong></td>
<td>Colorado Convention Center, Room 712</td>
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<tr>
<td>7:50 am</td>
<td><strong>EMRA RESIDENT FORUM</strong></td>
<td>Refreshment breaks sponsored by CEP America Colorado Convention Center, Room 607</td>
</tr>
<tr>
<td>7:50 am</td>
<td><strong>Business of EM: Contracts/Malpractice</strong></td>
<td>Todd Taylor, MD, FACEP, Microsoft Corp Health Solutions Group; Joseph Wood, MD, JD, FACEP, Mayo Clinic Medical School</td>
</tr>
<tr>
<td>9:20 am</td>
<td><strong>Mechanics of the Job Search</strong></td>
<td>Liudvikas Jagminas, MD, Yale New Haven Hospital</td>
</tr>
<tr>
<td>10:10 am</td>
<td><strong>Everyday Leadership: Secrets From Great Minds Through the Ages</strong></td>
<td>Amal Mattu, MD, FACEP, Maryland University</td>
</tr>
<tr>
<td>11:00 am</td>
<td><strong>Financial Planning for Young Physicians</strong></td>
<td>M. Shayne Ruffing, CLU, ChFC, AEP, Integrated WealthCare</td>
</tr>
<tr>
<td>11:50 am</td>
<td><strong>Resident Networking Luncheon</strong></td>
<td>Mark Mitchell, DO, FACOEP Colorado Convention Center, Mile High Ballroom 4A</td>
</tr>
<tr>
<td>1:10 pm</td>
<td><strong>RESIDENT BREAKOUTS</strong></td>
<td><strong>Resident as Educator</strong> Elise Lovell, MD Todd Guth, MD Sneha Sha, MD Colorado Convention Center, Room 605 <strong>Research During Residency</strong> Richard Rothman, MD, FACEP Gregory Moran, MD, FACEP Breena Taira, MD, MPH Melinda Morton, MD Colorado Convention Center, Room 201 <strong>Board Exam Preparation Discussion Panel</strong> Mary Jo Wagner, MD, FACEP Amal Mattu, MD, FACEP Hamad Husainy, DO Jonathan Heidt, MD Carson Penkava, MD Colorado Convention Center, Room 201 <strong>Advocacy 101</strong> Sara Hoper, MD Will Fleishman, MD Colorado Convention Center, Room 612</td>
</tr>
</tbody>
</table>

**TUESDAY, OCTOBER 9**

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>7:30 am</td>
<td><strong>Representative Council Welcome Breakfast &amp; Candidate’s Forum</strong></td>
<td>Embassy Suites Denver, Crestone Salon B, 3rd Floor</td>
</tr>
<tr>
<td>7:30 am</td>
<td><strong>EMRA Representative Council Registration</strong></td>
<td>Embassy Suites Denver, Crystal Foyer, 3rd Floor</td>
</tr>
<tr>
<td>8:00 am</td>
<td><strong>EMRA Representative Council Meeting and Town Hall</strong></td>
<td>Embassy Suites Denver, Crystal Salon B-C, 3rd Floor</td>
</tr>
<tr>
<td>12:00 pm</td>
<td><strong>Representative Council Luncheon</strong></td>
<td>Sponsored by Vidacare Embassy Suites Denver, Silverton Salon 2, 2nd Floor</td>
</tr>
<tr>
<td>1:00 pm</td>
<td><strong>EMRA EMS Committee Meeting</strong></td>
<td>Embassy Suites Denver, Crestone Salon A, 3rd Floor</td>
</tr>
<tr>
<td>1:30 pm</td>
<td><strong>EMRA New Board of Directors Orientation</strong></td>
<td>Embassy Suites Denver, Silverton Salon 1, 2nd Floor</td>
</tr>
<tr>
<td>3:00 pm</td>
<td><strong>EMRA Representative to ACEP Committee Meeting</strong></td>
<td><strong>EMRA Board Alumni Reception</strong> Embassy Suites Denver, Crestone Salon A, 3rd Floor</td>
</tr>
<tr>
<td>10:00 pm</td>
<td><strong>EMRA Fall Award Reception</strong></td>
<td><strong>EMRA Party</strong> Sponsored by Emergency Medical Associates Beta Nightclub, 1909 Blake Street</td>
</tr>
</tbody>
</table>

**WEDNESDAY, OCTOBER 10**

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>9:30 am</td>
<td><strong>EMRA Board of Directors Meeting</strong></td>
<td><strong>EMRA Board of Directors Meeting</strong> Embassy Suites Denver, Quartz Boardroom, 2nd Floor</td>
</tr>
<tr>
<td>12:00 pm</td>
<td><strong>EMRA Resident Sim Wars Competition</strong></td>
<td><strong>EMRA Board of Directors Meeting</strong> Embassy Suites Denver, Silverton Salon 1-3, 2nd Floor</td>
</tr>
<tr>
<td>2:00 pm</td>
<td><strong>EMRA Technology Committee Meeting</strong></td>
<td><strong>EMRA Board of Directors Meeting</strong> Embassy Suites Denver, Silverton Salon A, 3rd Floor</td>
</tr>
<tr>
<td>4:00 pm</td>
<td><strong>EMRA Health Policy Committee Meeting</strong></td>
<td><strong>EMRA Board of Directors Meeting</strong> Embassy Suites Denver, Silverton Salon 1-3, 2nd Floor</td>
</tr>
<tr>
<td>5:00 pm</td>
<td><strong>EMRA International Health Committee Meeting</strong></td>
<td><strong>EMRA Board of Directors Meeting</strong> Embassy Suites Denver, Silverton Salon A, 3rd Floor</td>
</tr>
<tr>
<td>6:00 pm</td>
<td><strong>EMRA Critical Care Committee Meeting</strong></td>
<td><strong>EMRA Board of Directors Meeting</strong> Embassy Suites Denver, Silverton Salon 1-3, 2nd Floor</td>
</tr>
<tr>
<td>7:00 pm</td>
<td><strong>EMRA Research Committee Meeting</strong></td>
<td><strong>EMRA Board of Directors Meeting</strong> Embassy Suites Denver, Silverton Salon A, 3rd Floor</td>
</tr>
<tr>
<td>8:00 pm</td>
<td><strong>EMRA Education Committee Meeting</strong></td>
<td><strong>EMRA Board of Directors Meeting</strong> Embassy Suites Denver, Silverton Salon B, 3rd Floor</td>
</tr>
<tr>
<td>4:00 pm</td>
<td><strong>EMRA Wilderness Medicine Committee Meeting</strong></td>
<td><strong>EMRA Board of Directors Meeting</strong> Embassy Suites Denver, Silverton Salon C, 3rd Floor</td>
</tr>
<tr>
<td>5:00 pm</td>
<td><strong>EMRA Board of Directors &amp; Committee Updates Meeting</strong></td>
<td><strong>EMRA Board of Directors Meeting</strong> Embassy Suites Denver, Quartz Boardroom, 2nd Floor</td>
</tr>
</tbody>
</table>
Academic Opportunities

Baylor College of Medicine
Cleveland Clinic
Emergent Medical Associates
MedStar Georgetown University Hospital
/ Washington Hospital Center
Emergency Medicine Residency Program.
Mount Sinai Hospital
Ohio State University Wexner Medical Center
St. John’s Riverside Health
Staten Island University Hospital
Steward Health Care
SUNY Downstate
Teed & Company
Texas A&M / Christus Spohn
Texas Tech University Health Sciences Center
University of California San Francisco
University of New Mexico
University of Virginia Dept of EM

Fellowship Opportunities

Baylor College of Medicine
CAL/ACEP Legislative Fellowship
Christiana Care Health System
International Emergency Medicine Fellowship, Brigham and Women’s Hospital / Harvard University
Jacobi / Montefiore / Einstein
Johns Hopkins University Program
Maimonides Medical Center
MedStar Georgetown University Hospital / Washington Hospital Center Fellowship
NY Hospital Medical Center of Queens
NYU/Bellevue Emergency Ultrasound Fellowship
Ohio State University Wexner Medical Center
Oregon Health and Sciences University
Resurrection EM Ultrasound Fellowship
Staten Island University Hospital
UC Davis
UCSF - Fresno Emergency Medicine
UMDNJ – RWJMS Emergency Ultrasound Fellowship
University of Arizona – Dept of EM
University of Maryland
University of Pittsburgh
University of Texas Houston
UT Health Science Center San Antonio / SAFD EMS Fellowship
Yale University Department of EM

International Opportunities

CHSI Middle East
Global Medical Staffing
MedRecruit
Sidra Medical and Research Center
Triple0 Medical Recruitment
VISTA Staffing Solutions

North Central Region

4M Emergency Systems, Inc.
Acute Care, Inc
Alegent Creighton Health
ApolloMD
Aurora Health Care
Baycare
Best Practices
CEP America
ComHealth
ECI Healthcare Partners
Elkhart Emergency Physicians, Inc
EmCare
Emergency Care Specialists (ECS)
Emergency Medicine Physicians
EMPact Emergency Physicians
EPMG
Essentia Health
Faith Regional Health Services
Henry Ford Health System
Hospital Physician Partners
Great River Medical
Indiana Emergency Care
Infinity Healthcare
Marshfield Clinic
MEDS
Ministry Health Care
OSF Healthcare
Phoenix Physicians, LLC
Premier Physicians Services
Quest Healthcare Solutions
Sanford Health
Schumacher Group
TeamHealth
Trinity Health
VISTA Staffing Solutions
Weatherby Healthcare

North East Region

ApolloMD
Bassett Healthcare Network
Baystate Health
Best Practices
CompHealth
Doctors for Emergency Service
Eastern Maine Medical Center
ECI Healthcare Partners
EmCare
Emergency Medical Associates
Emergency Medicine Associates (EMA)
Emergency Medicine Physicians
Emergency Service Associates, PA
EPMG
Geisinger Health System
Health Quest/Vassar Brothers Medical Center
Howard University Hospital
Kaiser Permanente – Mid Atlantic Permanente Medical Group
Keystone Healthcare Management
MDLinx Career Center
MedExcel USA, Inc
Medical Emergency Professionals (MEP)
Medicus Healthcare Solutions
MedStar Emergency Physicians
Mercy Hospital
North Shore LIJ
Penn State Hershey Medical Center – Emergency Medicine
Phoenix Physicians, LLC
Physicians’ Practice Enhancement
Pinnacle Health
Qualified Emergency Specialists, Inc
Schumacher Group
Sheridan Healthcare
South Jersey Healthcare
Special thanks to Florida Emergency Physicians and Team Health for sponsoring the refreshments at the Job Fair!
R.T. is a 67-year-old male who was diagnosed with Stage IV lung cancer one year ago. Chemotherapy and radiation were unsuccessful. He presents to the emergency department today with family members after becoming progressively short of breath throughout the day.

You are the resident assigned to this patient. Your evaluation reveals a frail man in moderate respiratory distress. Auscultation reveals markedly diminished breath sounds over the entire right lung and left base. A stat chest X-ray is ordered and shows complete opacification of the right lung, and a moderate left pleural effusion.

During your evaluation, you notice R.T. is worsening despite supplemental oxygen. You meet with family members to discuss the patient’s plan for end-of-life care, only to learn that he does not have any signed documents, nor has the family ever met to discuss options. You attempt to establish DNR status with family members at bedside, but meet resistance from his daughter, the power of attorney. She sobs, “I can’t make the decision; I feel like I am killing him!”

You are uncomfortable with her response and tell her that someone will speak with her after the patient is admitted to the ICU. During your discussion with the family, a nurse notifies you that the patient is in respiratory failure and will need to be intubated. Unsure of what to do, you decide to tube the patient and admit him to the ICU for further management.

Caring for the terminally ill or dying patient is a common occurrence in the emergency department. However, many emergency medicine residents and attendings are uncomfortable dealing with those facing the end of life. The scope of palliative care is broad – it encompasses everything from symptom management to the discussion of code status, delivering bad news, hospice referrals, and withdrawal of life support. Palliative care discussions require skill, as do central line placement and intubation. Caring for dying patients – and their families – requires training, competence, and sensitivities that most of us weren’t taught.

How do you discuss death with a dying patient or a grieving family? What are the words you use, the settings in which you do it, the team members you have present?

Palliative care is whole person care. It refocuses the direction of clinical care so that it is consistent with the wishes and needs of the patient and family as they confront end-of-life decisions. Time constraints, lack of a prior relationship with the family, and the often unexpected nature of the terminal event add to the complexity of managing these patients.

As emergency medicine physicians, our primary goal has always been to resuscitate and stabilize the unstable patient; as a result, many with terminal illnesses are funneled to the ICU or medical floor, where they will make their first contact with a palliative care team. There, the decision changes from “How do we want to proceed?” to the even more difficult question of “How and when do we withdraw care?” Although most people believe that palliative care means withdrawing care or doing nothing at all, this is not the case.

Palliative care can and should be implemented while aggressive resuscitation modalities are being applied. Equally aggressive symptom management, prognostication, and end-of-life decisions should all be initiated at the same time. Each visit to the emergency department is an opportunity for conversation about these issues.
even if the patient is still undergoing active treatment.

Many emergency medicine physicians have difficulty integrating the role of palliative care into their practice. The hallmark of this struggle is the perception that discussing goals of care simply requires too much time. As physicians, death has always been the enemy, so we are faced with our own fear of failure when treating the terminally ill. We also are faced with our own mortality, which often makes it emotionally easier to intubate, stabilize, and hand off the patient for admission.

Initiation of palliative care in the emergency department may prove to be beneficial for all of us – the physician, the patient, and family members. The integration of palliative care concepts and consultation teams into emergency care may help avoid unnecessary treatments, tests and procedures that are not aligned with patients’ goals of care. In the hospital setting, palliative care has been shown to decrease symptoms, improve quality of life, increase patient and family member satisfaction, and decrease costs.1

As emergency physicians, we man the frontlines of healthcare. Our training should include competency in palliative care skills. Incorporating such training into resident education would dissolve the discomfort many of us face when taking care of the dying patient. Just as a growing emergency medicine curriculum has embraced other skill sets – such as ultrasound – trainees in our specialty need the skills to adapt their management strategies from a curative to a palliative approach, when appropriate.1 It is not enough to learn these skills on medicine or ICU rotations, as many of us have; we must train specifically to manage these patients in the emergency department.

Let us revisit our patient, R.T., using the palliative care approach. You meet with the family members and ask about their father’s wishes for end-of-life care. You place the patient on BiPAP and administer Ativan to make him more comfortable, and also consider a palliative thoracentesis to relieve his dyspnea.

During the family meeting, you inform them of R.T.’s prognosis and elicit their goals: Performing the thoracentesis to allow for temporary symptom relief vs. intubation; hospice vs. home care. Emphasis is placed on what the patient would want if he had the opportunity to make these decisions. It is important that the family understand R.T.’s quality of life.

As I face my final year of residency, I increasingly recognize the importance of communication in our practice. While discussing death on a daily basis can take a toll on one’s psyche, we chose this profession to advocate and care for those who are unable to do so for themselves. As we move forward in our careers, these important encounters will not seem unfamiliar or terrifying if we have the tools with which to handle them. ■

References
Thousands of North Americans are bitten every year by snakes. While bites from most species are not life threatening, medical intervention is critical for identifying serious – and often delayed – complications and preventing morbidity associated with the most toxic envenomations.

**Epidemiology**

Between 5,000 and 8,000 poisonous snakebites are reported to poison control centers in the U.S. every year; however, only a handful of deaths result from these bites. In this country, there are two major families of native venomous snakes: Elapidae (coral snakes) and Viperidae/Crotalidae (rattlesnakes, copperheads, cottonmouths).

Approximately 25% of viper and 50% of elapid bites are considered “dry” with no envenomation. Nearly all bites in the U.S. from snakes in the wild occur between April and October, when snakes are most active. A bite from an exotic snake species is more likely during other months of the year.

Young males, often under the influence of alcohol, constitute an overwhelming majority of victims. Bites in adults are primarily located on the upper extremities, while bites in children primarily occur on the lower extremities and are less likely to be the result of deliberate handling of snakes.

Bites in adults are primarily located on the upper extremities, while bites in children primarily occur on the lower extremities and are less likely to be the result of deliberate handling of snakes. There are also reports of pediatric envenomations caused by contact with the fangs of a recently deceased snake.

While mortality from snake bites remains low, the specter of significant morbidity is real. Complications vary widely – from disfiguring soft tissue injuries, to severe coagulopathies and defibrination, to shock. Respiratory compromise following envenomation is rare; local tissue damage is the most common complication. Localized ecchymosis with hemorrhagic blebs is a frequent finding. Proximal lymphadenopathy and/or lymphangitis on the affected extremity can reflect migration of the venom.

**Evaluation**

As with any patient in the emergency department, stabilization of the ABCs, history, and physical exam are central to management of the snakebite victim. Identification of the snake is helpful, when possible, although patients and their families should be discouraged from bringing the snake into the emergency department.

In addition to local pain and swelling, many patients present with anxiety, nausea, vomiting, diarrhea, fainting, tachycardia, or other autonomic symptoms. The typical diagnostic evaluation for snakebites includes CBC, PT/INR, fibrin split products, fibrinogen, D-dimer, CK, and urine dipstick for occult blood. Some authors recommend evaluating serum coagulation markers in all snakebite victims due to the difficulty of identifying patients at risk for significant coagulopathy.

Envenomation presents with a spectrum of clinical severity. A minimal-moderate-severe rubric and a Grade I-IV scoring method are widely used for characterization and reassessment of the patient with a snake bite. Dart and colleagues have validated the snakebite severity score (SSS) as an objective instrument for the classification and management of patients.

**Management**

Most patients with confirmed or suspected snakebites can be managed conservatively with observation and supportive care. A consensus panel recommends an in-hospital, 18- to 24- hour monitored observation period, which includes clinical reevaluation every 6 hours. Labs should be drawn at 6 to 12 hours after presentation and again prior to discharge. Most pediatric patients also can be managed conservatively.

In some institutions snakebites are managed using an interdisciplinary approach, by including a surgical or burn service and a toxicologist in patient care. Consultation with a toxicologist or poison control is recommended in patient care.
management. Your regional poison control center can be contacted by calling 1-800-222-1222.

The envenomation site and surrounding area should be monitored closely with frequent checks for increasing swelling or ecchymosis, changes in skin color and texture, evidence of compartment syndrome, or other signs or symptoms of neurovascular compromise. Routine wound care is suggested. Pre-hospital pressure bandaging and immobilization following North American snakebites is not recommended.14,15

Tetanus prophylaxis should be administered, if needed. Empiric antibiotic therapy is not warranted.16 Recent evidence questions the benefit of fasciotomy/dermotomy for increased compartment pressure when tissues are still perfusing well. Nonetheless, surgical intervention may be required in extreme cases of limb swelling or neurovascular compromise.17 Overall, surgical intervention is rarely required in patients with snakebites.18

CroFab, the brand name for crotalidae polyvalent immune fab (Ovine), has been the mainstay of antivenom treatment for poisonous snakebites. It has been shown to be effective for bites from pit vipers by preventing the extension of local tissue effects.19 CroFab is exceptionally expensive and is not readily available in all hospitals. It has a low incidence of serious adverse or immunologic reactions; most side effects are minor and do not prevent additional doses.19,20 In a very small sample of pregnant women with snakebites, antivenom had no adverse outcomes.21

Snakebite remains a commonly encountered condition in the emergency department. The rapid and appropriate evaluation and treatment of these patients, as well as consultation with appropriate experts, can minimize the morbidity associated with these potentially severe injuries. ■

References
Introduction

This is a case of a previously healthy young male who presented to the emergency department with severe back pain after sneezing. Evaluation revealed advanced stage metastatic gastric cancer with a pathologic vertebral body fracture.

Case Description

The patient was a 34-year-old Hispanic male with no medical history other than mild intermittent back pain, which he’d had for six months. On the day of admission, his back pain acutely worsened after he sneezed. The degree of discomfort alerted him enough to come to the emergency department. The patient described the pain as sharp, in the mid-back region, 7/10, and worse with movement. He denied other symptoms, and had some relief with cyclobenzaprine.

On exam, the patient had no neurologic deficits and was found to have mild left paraspinal lumbar tenderness. He was given analgesics with some pain relief. Blood work was normal but, because his pain was out of proportion to his exam, a non-contrast CT of the abdomen and pelvis was performed. CT showed multiple lytic lesions throughout the spine and other visualized bony structures, a right pleural effusion, and a small amount of ascites.

After admission to the hospital, a final diagnosis of gastric adenocarcinoma was confirmed by endoscopy and biopsy. During his hospital course, he developed a fever and the right pleural effusion was drained. Cytology of the pleural fluid also was positive for malignant cells consistent with gastric adenocarcinoma. He received radiotherapy to the spine, which helped relieve the pain.

A nuclear bone scan prior to discharge showed innumerable foci of abnormally increased uptake throughout the osseous structures. Uptake predominated in the axial skeleton – cervical, thoracic, and lumbar spine; sacrum; ribs; sternum; proximal humerus; proximal femurs; and pelvis.

The patient was discharged to home with a follow-up appointment for chemotherapy. There, he was evaluated for an experimental trial for advanced gastric cancer.
“After our patient’s curious case, we conducted a literature review on gastric cancer – it showed only one other case of a patient presenting with back pain at the time of a gastric cancer diagnosis.”

Discussion
This remarkable case is due to the underlying pathology of gastric cancer – it’s the 14th most common cancer in the U.S., though the rate has dramatically declined over the past half century. In the U.S., the median age at the time of gastric cancer diagnosis is 69 years in males and 72 years in females.

At the time of advanced disease, most patients present with a history of weight loss, indigestion, and dysphagia. In our patient’s case, after the CT resulted, we inquired again about recent symptoms. With more pointed questioning, he revealed that he’d lost weight over the past few months. He’d also been having some dysphagia, which he attributed to possible gastric reflux.

After our patient’s curious case, we conducted a literature review on gastric cancer – it showed only one other case of a patient presenting with back pain at the time of a gastric cancer diagnosis. This other case report was that of a 46-year-old female, who was seen by her general practitioner for worsening severe back pain. Outpatient workup revealed not only vertebral fracture, but also a profound normocytic anemia.

She was sent to the emergency department for admission and further investigation. The hospital physicians found isolated metastases to the spine had caused her vertebral fracture and ensuing back pain. While searching for the cause of anemia, upper endoscopy revealed the cause of both the back pain and the anemia as gastric carcinoma.

Metastases to the bony skeleton from gastric carcinoma are uncommon, with an incidence of 14% found in autopsy specimens. It is particularly rare for the primary presentation of a gastric carcinoma to be metastases to the bone. This case is notable for these two reasons as well as a third: No other report reveals a patient as young as this gentleman. Our case illustrates the importance of clinical suspicion in evaluating a common chief complaint.

References
1. Bryan J. Dicken, MD, David L. Bigam, MD, FRCS, Carol Cass, PhD, John R. Mackey, MD, FRCP, Anil A. Joy, MD, FRCP, and Stewart M. Hamilton, MD, FRCS; Gastric
Congratulations to the
2012 EMRA Fall Award Recipients

Clinical Excellence Award
Nicole Seleno, MD – Denver Health Medical Center

Augustine D’Orta Award
Beth M Ranney, MD – Maricopa Medical Center

Excellence in Teaching Award
Christopher Doty, MD, FACEP – SUNY Downstate

Joseph F Waeckerle Founder’s Award
Gus Michael Garmel, MD, FACEP – Stanford University

Mentorship Award
Pratik B Doshi, MD – University of Texas Houston

Local Action Grant
Dennis Hsieh, MD – Alameda County Medical Center

SA Travel Scholarship
Jeremy Brudevold, MD – University of Kansas SOM
Jessica Ann Best, MD – UT Southwestern – Austin
Nicholas Hartman, MD, MPH – Northwestern

Don’t Miss the EMRA Resident SimWars Competition

Wednesday, October 10, 2012
12:00pm – 5:00pm at the Embassy Suites Denver, Silverton Salon 1-3, 2nd floor

Defending Champions
Alameda County Medical Center
Program Director: Herbert Eugene Hern, MD, FACEP

NYC SimWars Champions
Beth Israel Medical Center
Program Director: Saadia Akhtar, MD

The Ohio State University
Program Director: Diane L. Gorgas, MD

UMDNJ – Robert Wood Johnson
Program Director: Amy Church, MD, FACEP

University of Maryland
Program Director: Michael C. Bond, MD, FACEP

University of Texas – Houston
Program Director: Samuel D. Luber, MD, MPH, FACEP

University of Florida – Jacksonville
Program Director: David A. Caro, MD, FACEP

Oregon Health Science University
Program Director: Lalena M. Yarris, MD

Sincere appreciation to the following sponsors for their support with the EMRA Resident SimWars Competition

As usual, many more teams applied than we have space for in a single competition but we hope those names that weren’t drawn from the lottery will still join us for an exciting, entertaining, educational experience, and of course, please apply next time! Send inquiries to simwars@gmail.com.
1. A 15-year-old girl presents with a sore throat and fever. Physical examination reveals tender anterior cervical adenopathy. She has not had a cough. Which of the following additional findings helps confirm the diagnosis of group A beta-hemolytic Streptococcus infection?
   A. Displaced uvula
   B. Muffled voice
   C. Palatal petechiae
   D. Tender hyoid

2. A 40-year-old woman presents with fever, right upper quadrant pain, jaundice, hypotension, and altered mental status. Laboratory tests reveal elevated WBCs, bilirubin, and alkaline phosphatase levels; lipase level is normal. Ultrasound examination demonstrates cholelithiasis with a 10-mm common bile duct. What is the appropriate next step in management?
   A. CT scanning
   B. Emergency surgery
   C. Endoscopic retrograde cholangiopancreatography
   D. Hepatobiliary imino-diacetic acid scan

3. A 17-year-old boy presents with severe pain in his left eye after being hit by a hockey puck the night before. Physical examination reveals periorbital ecchymosis, intact extraocular movements, and no orbital tenderness. Ophthalmoscopic examination of the disc is normal. The left pupil is sluggish. He has decreased visual acuity in the left eye, injection of the left limbus, and photophobia when light is shined into the right eye. What is the most likely diagnosis?
   A. Endophthalmitis
   B. Hyphema
   C. Scleritis
   D. Traumatic iritis

4. A 58-year-old woman presents with shortness of breath and chest discomfort that began 1 hour earlier while she was working in her yard. She denies other associated symptoms and is currently asymptomatic. Vital signs include blood pressure 115/85, pulse 79, respirations 16, and oxygen saturation 99% on room air. Physical examination and ECG findings are normal. Her troponin level is below the lower limit of detection. Which of the following statements about risk stratifying this patient is correct?
   A. If a GI cocktail relieves her discomfort, she likely has a noncardiac condition
   B. If sublingual nitroglycerin relieves her discomfort, she likely has cardiac ischemia
   C. She can be safely discharged if she has no risk factors for coronary artery disease
   D. She should undergo repeat ECG and biomarker testing

5. Which of the following medications is most effective in the treatment of an acute asthma exacerbation?
   A. Inhaled steroids
   B. Intravenous ketamine
   C. Intravenous magnesium
   D. Nebulized albuterol
Emergency Medicine Research Handbook for Residents and Medical Students

Brian C. Geyer, MD, PhD, MHP and Elizabeth Goldberg, MD

This handbook is a result of over two years of discussion within the EMRA Research Committee about how to assist emergency medicine residents and medical students who are just getting started in research. The scholarship project that all emergency medicine residents are obligated to complete during residency is an opportunity to get your feet wet in research and discover answers to clinical questions you may encounter.

List Price $25.95 • ACEP Member Price $12.35
EMRA Member Price $11.95
900197; Published 2012; 104 pages; Soft Cover 6 x 9


Nathanial R. Schlicher, MD, JD

In this expanded 2nd edition of the handbook, Dr. Schlicher and the chapter authors outline the essential and advocacy issues surrounding emergency medicine today. Not just for the politically-minded, this resource is useful for the student, resident, physician, patient or concerned citizen to help understand the important issues affecting all aspects of emergency care.

List Price $25.95 • ACEP Member Price $12.35
EMRA Member Price $11.95
900197; Published 2012; 104 pages; Soft Cover 6 x 9

The Basics of Emergency Medicine, A Chief Complaint Based Guide

Joseph Habbouroue, MD, MBA

This new pocket reference creates a framework to learn from and provides an easy-to-use resource to make sure the basics aren’t overlooked. Dr. Habbouroue compiled patient’s 20 most common chief complaints from head to toe! This practical tool is for internists, medical students, off-service rotating residents, NPs, RPs, and nurses to use on the fly!

List Price $12.00 • ACEP Member Price $6.80
EMRA Member Price $7.00
900330; Published 2011; 136 pages; Soft Cover 5.5 x 8.5


Joseph P. Wood, MD, JD

Invaluable for any emergency physician entering into an employment or independent contract agreement to provide medical services on behalf of a hospital or group. What you don’t know can really hurt you!


List Price $49.95 • ACEP Member Price $44.95
EMRA Member Price $29.95
900110; Published 2007; 92 pages; Soft Cover 5 x 8.5

Emergency Medicine’s Top Clinical Problems, 2nd Edition

Gary Katz, MD, MBA and Mark Mosteyl, MD, MHA

A new and improved pocket reference and quick tool. Each chapter starts with critical actions and then logically expands with disease-specific information. The design simulates the format of an emergency medicine oral or written board exam.

List Price $25.95 • ACEP Member Price $12.35
EMRA Member Price $11.95
900100; Published 2008; 218 pages; Soft Cover 4 x 6


Kristen E. Harken, MD and Jeremy T. Cushman, MD, MS

The most comprehensive guide to the specialty of emergency medicine written specifically for medical students. Familiarize yourself with all aspects of emergency medicine including lifestyle and wellness, careers, training, research, fellowships, subspecialties and much more.


List Price $25.95 • ACEP Member Price $12.35
EMRA Member Price $11.95
900320; Published 2007; 280 pages; Soft Cover 5 x 9

Emergency Medicine’s Top Pediatric Clinical Problems, 1st Edition

Dale Woolridge, MD, PhD

The pediatric version of top clinical problems features the same design and format as its cousin. It is a must-have pocket reference and teaching tool for all EM physicians, especially during pediatric rotations.

List Price $25.95 • ACEP Member Price $12.35
EMRA Member Price $11.95
900320; Published 2008; 386 pages; Soft Cover 4 x 6


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Pitfalls to avoid

Risk management pitfalls for adult pain management

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1. “I thought the patient was just seeking pain medication to get high.” Drug-seeking behavior is a difficult problem in the emergency department, and it is one to which there is not a simple answer. If serious concern exists, an attempt may be made to validate the patient’s claims (e.g., calling the primary provider, reviewing pharmacy dispensing records, etc.), but this is often unsuccessful, and the individual solution may rest with the clinician’s judgment or departmental policy.

2. “I didn’t want to give pain medication because I didn’t want to mask the examination findings.” Appropriate analgesia does not compromise physical examination findings for serious injury and may, in fact, improve the ability to localize painful stimuli. This has been demonstrated reproducibly in the emergency department setting.

3. “The patient felt better with pain medication, so I didn’t pursue further diagnostic testing.” While analgesia may improve comfort, careful attention must still be paid to historical elements (e.g., high-energy motor vehicle collision) or examination findings (e.g., abdominal tenderness) that may be concerning for serious pathology. A focused examination after analgesia may reveal whether abnormal findings can be evoked in an otherwise comfortable patient.

4. “There was no radiographic abnormality, so I didn’t think the patient needed pain medication.” Pain is a subjective experience, and many causes of pain (particularly neuropathic pain) may not provide objective evidence of the level of discomfort.

5. “I didn’t consider regional anesthesia.” Regional anesthesia is an increasingly popular means of achieving analgesia and decreasing the amount of systemic analgesia required. It is useful to have a repertoire of familiar and useful techniques to augment some scenarios (e.g., dental blocks for dental injuries, digital blocks for finger injuries, etc.).

6. “The patient was agitated, and I didn’t consider pain as the etiology.” Many times patients are unable to communicate their discomfort adequately (e.g., intubated or demented patients). Painful conditions should be considered as a cause of increased agitation or delirium.

7. “The vital signs were normal, so I decided the patient was not in pain.” Vital sign abnormalities are not a reliable indicator of pain. In addition to medications that may blunt a response (e.g., beta-blockers), each patient’s experience and physiologic response may be different, and some patients may experience significant pain without producing abnormal vital signs.

8. “The patient had opioid dependence, so I used an agonist-antagonist.” Some partial agonists (e.g., buprenorphine) bind with more affinity than complete agonists. In a patient on a chronic long-acting opioid agonist (e.g., methadone), introduction of a partial agonist may displace complete agonists at the receptor site and precipitate a relative withdrawal.

9. “I had to keep giving him pain medication because he wouldn’t calm down.” Anxiolysis is an important part of pain control and limiting “wind-up” phenomenon. Often, this can be accomplished by nonpharmacologic means (e.g., discussing the patient’s concern, covering a wound, distracting a child, or immobilizing a limb).

10. “The patient was fine when she left for x-ray, but when she returned, she was screaming in pain.” Splinting with radiolucent materials prior to transport or manipulation for imaging helps decrease the pain precipitated by mobilization. In addition, it is reasonable to provide additional analgesia in anticipation of painful procedures or transport.
1. **“There is no reason to call a child life specialist. We are going to have to sedate this child.”**
   A child life specialist can be extremely helpful in calming the child and alleviating the anxiety of the parent. Sedation may still be necessary in certain cases, but a child life specialist should always be involved to help aid in the process.

2. **“The emergency department is too busy to wait for the LET to work.”**
   Waiting for the LET to take effect can diminish the need for local infiltration of lidocaine, especially for smaller lacerations, and can significantly diminish the pain and anxiety associated with laceration repair.

3. **“I have done many sedations. I can handle doing the sedation and the procedure itself.”**
   There should be a separate, dedicated provider (medical doctor or certified registered nurse anesthetist) for the procedural sedation, along with a nurse or a respiratory therapist to properly record vitals and administer the medication.

4. **“The nurse cannot find an ETCO2, so we’ll just use the pulse oximeter.”**
   ETCO2 has been shown to be more effective at demonstrating decrease in ventilation and should be used during sedations. The room should also be prepared with other equipment in case resuscitation or an advanced airway is necessary.

5. **“NPO status is very important and cannot be ignored, even if the procedure is emergent.”**
   When evaluating a patient for an emergent sedation, NPO status needs to be address in the following manner: First, assess the patient’s baseline risk factors. Second, access the timing and nature of recent oral intake. Third, access the urgency of the procedure. Fourth, determine the prudent limit of targeted depth and length of procedural sedation and analgesia. When it is necessary to perform an emergent procedure, one should proceed regardless of the patient’s NPO status.

6. **“This patient previously received analgesics and makes a poor candidate for sedation.”**
   Previously receiving analgesics is not a contraindication to procedural sedation as long as proper monitoring, equipment, and drug doses are used.

7. **“I used propofol, but I didn’t know this child had an egg allergy.”**
   Propofol is contraindicated in any patient with known or suspected allergy to propofol, eggs, or soy products. Proper history and physical examination should be obtained in all patients prior to proceeding with the procedural sedation. An allergy history is especially important.

8. **“This child needs a CT scan. I’m going to use ketamine since I’m very comfortable with that medication.”**
   Ketamine is not an ideal medication for radiographic imaging since the child may still move quite a lot. Pentobarbital may be a more preferable choice, since its onset of action is quick and the duration of sedation is short.

9. **“The child’s initial IM ketamine dose wore off prior to the orthopedic surgeon being done with the procedure.”**
   Although an IV catheter is not necessary with all procedural sedations, it must be anticipated if more than 1 dose will need to be administered or if the case may present other difficulties. If more sedation is required, an IV can be placed after the initial sedation, although it is preferable before.

10. **“It’s the middle of the night. Since this child is now sleeping, I’m fairly certain there is no need to wait for the sedation medication to wear off.”**
    Although it can be difficult to assess, the patient should always be observed to return to baseline status. The parents should be encouraged to wake the child up for an evaluation prior to being discharged from the emergency department.
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Emergency Medicine Physicians Needed. NES Healthcare Group is seeking emergency medicine physicians for Lutheran Medical Center (LMC), Brooklyn, NY. LMC is a Level I Trauma Center and a designated stroke center. Candidates must be BC/BP EM and have current EM experience. Competitive compensation, incentive program, CME allowance and malpractice coverage provided. Contact: Megan Evans, Physician Recruiter, 800.394.6376, fax 631.265.8875, mevans@neshold.com.

New York, Long Island, Albany and Cortland: Brookhaven Memorial Hospital is in East Patchogue on the southern shore of Long Island and sees 70,000 ED pts./yr. Cortland Memorial Hospital is a modern, full-service facility situated in the Finger Lakes Region between Syracuse and Ithaca (35,000 ED pts./yr.). Albany Memorial Hospital has a new ED (45,000 pts./yr.) and hosts EM resident rotations, while Samaritan Hospital in Troy is a respected community hospital, minutes from Albany, seeing 46,000 ED pts./yr. Outstanding partnership opportunity includes equal profit sharing, equity ownership, funded pension, open books, full benefits and more. Contact Ann Benson (careers@emp.com), Emergency Medicine Physicians, 4535 Dressler Rd, NW, Canton, OH 44718. Phone 800-828-0898 or fax 330-493-8677.

New York, Brooklyn: Emergency Medicine Physicians Needed. NES Healthcare Group is seeking emergency medicine physicians for Lutheran Medical Center (LMC), Brooklyn, NY. LMC is a Level I Trauma Center and a designated stroke center. Candidates must be BC/BP EM and have current EM experience. Competitive compensation, incentive program, CME allowance and malpractice coverage provided. Contact: Megan Evans, Physician Recruiter, 800.394.6376, fax 631.265.8875, mevans@neshold.com.

New York, Long Island, Albany and Cortland: Brookhaven Memorial Hospital is in East Patchogue on the southern shore of Long Island and sees 70,000 ED pts./yr. Cortland Memorial Hospital is a modern, full-service facility situated in the Finger Lakes Region between Syracuse and Ithaca (35,000 ED pts./yr.). Albany Memorial Hospital has a new ED (45,000 pts./yr.) and hosts EM resident rotations, while Samaritan Hospital in Troy is a respected community hospital, minutes from Albany, seeing 46,000 ED pts./yr. Outstanding partnership opportunity includes equal profit sharing, equity ownership, funded pension, open books, full benefits and more. Contact Ann Benson (careers@emp.com), Emergency Medicine Physicians, 4535 Dressler Rd, NW, Canton, OH 44718. Phone 800-828-0898 or fax 330-493-8677.

North Carolina, Charlotte: EMP is partnered with eight community hospitals and free-standing EDs in Charlotte, Gastonia, Lincolnton, Pineville and Statesville. A variety of opportunities are available in urban, suburban and smaller town settings with EDs seeing 22,000-104,000+ pts./yr. EMP is an exclusively physician-owned/managed group with open books, equal voting, equal profit sharing, equity ownership, funded pension, full benefits and more. Contact Ann Benson (careers@emp.com), Emergency Medicine Physicians, 4535 Dressler Rd, NW, Canton, OH 44718. Phone 800-828-0898 or fax 330-493-8677.

North Carolina, New Bern: Respected 313-bed regional medical center located at the intersection of the Trent and Neuse Rivers just off the central coast, with 72,000 ED pts./yr. Outstanding partnership opportunity includes equal profit sharing, equity ownership, funded pension, open

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The Department of Emergency Medicine at East Carolina University Brody School of Medicine seeks BC/BP emergency physicians and pediatric emergency physicians for tenure or clinical track positions at the rank of assistant professor or above, depending on qualifications. We are expanding our faculty to increase our cadre of clinician-educators and further develop programs in pediatric EM, ultrasound, and clinical research. Our current faculty members possess diverse interests and expertise leading to extensive state and national-level involvement. The emergency medicine residency is well-established and includes 12 EM and 2 EM/JM residents per year. We treat more than 110,000 patients per year in a state-of-the-art ED at Vidant Medical Center. VMIC is an 860 bed level I trauma, cardiac, and regional stroke center. Our tertiary care catchment area includes more than 1.5 million people in eastern North Carolina, many of whom arrive via our integrated mobile critical care and air medical service. The ED expanded into a new children’s ED in July 2012, and a new children’s hospital is also under construction. Greenville, NC is a fast-growing university community located near beautiful North Carolina beaches. Cultural and recreational opportunities are abundant. Compensation is competitive and commensurate with qualifications; excellent fringe benefits are provided. Successful applicants will possess outstanding clinical and teaching skills and qualify for appropriate privileges from ECU Physicians and VMIC.

Confidential inquiry may be made to Theodore Delbridge, MD, MPH, Chair, Department of Emergency Medicine (delbridget@ecu.edu).

ECU is an EEO/AA employer and accommodates individuals with disabilities. Applicants must comply with the Immigration Reform and Control Act. Proper documentation of identity and employability required at the time of employment. Current references must be provided upon request www.ecu.edu/ecuem
books, full benefits and more. Contact Ann Benson (careers@emp.com), Emergency Medicine Physicians, 4535 Dressler Rd. NW, Canton, OH 44718. Phone 800-828-0898 or fax 330-493-8677.

**Ohio, Cincinnati:** Excellent opportunity with established equity-ownership group north of Cincinnati. BP/BC EM physicians are sought for newer hospital with state-of-the-art ED seeing approximately 63,000 patients annually. Very good coverage of 61 physician and 44 MLP hours daily. Generous package includes family medical plan, employer-funded pension, CME/expense account, malpractice, guaranteed hourly plus incentive income, plus shareholder opportunity at one year with no buy-in. This location is convenient to Cincinnati, Dayton or suburban living. Due to recent expansion, Premier also has additional Cincinnati opportunities available. Contact Kim Rooney, Premier Physician Services, (800) 726-3627, ext. 3674; krooney@premierdocs.com.

**Ohio, Cincinnati:** Situated in desirable Anderson Township, Mercy Hospital – Anderson sees 48,000 patients per year. Outstanding partnership opportunity includes equal profit sharing, equity ownership, funded pension, open books, full benefits and more. Contact Ann Benson (careers@emp.com), Emergency Medicine Physicians, 4535 Dressler Rd. NW, Canton, OH 44718. Phone 800-828-0898 or fax 330-493-8677.

**Ohio, Cincinnati:** Qualified Emergency Specialists Incorporated, (QESI) is pleased to announce an Emergency Medicine opportunity in the thriving community of beautiful Cincinnati. **Total Package Worth Over $400,000 Annually:** Private, Democratic, Physician Owned Group; Complete Benefits Package - Self Directed Retirement; Extensive Mid-Level Provider Support; **Opportunity for Full Equity Partnership and Dividend in One Year:** Most Shifts with Double and Triple Physician Coverage; Expanding into our Regional Market. We are in the process of accepting CV’s and scheduling confidential interviews. Please contact me, Sean Larkin at (800) 346-0747 or email your CV to info@psrinc.net or visit our website at www.psrinc.net.

**Ohio, Columbus:** Appealing opportunity for BP/BC EM physician in North Columbus suburb. Desirable facility has 28,000 annual visits. Terrific college town offers cultural appeal within 30 minutes of Columbus. Physician led group provides equity-ownership, guaranteed hourly plus additional incentive, family medical plan, employer-funded pension, expense account and more. Contact Amy Spegal, Premier Physician Services, (800)726-3627, ext 3682, aspegal@premierdocs.com, fax (937)312-3683.

**Ohio, Dayton:** BP/BC EM physician sought to join solidly established, democratic group at 42,000 volume ED in northern suburb. Enjoy working in a collegial environment and outstanding physical plant. Excellent package includes guaranteed hourly plus incentive, malpractice, employer-funded pension, family medical plan, CME, and more. Contact Greg Felder, Premier Physician
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Ohio, Lima: Meet your financial and practice goals. Named among Top 100 Hospitals, 57,000 volume, level II ED will complete expansive, state-of-the-art renovation in 2012. Excellent coverage and terrific package including guaranteed hourly plus RVU and additional incentives, malpractice, employer-funded pension, family medical, CME, shareholder opportunity. Contact Kim Rooney, Premier Physician Services, (800)726-3627, ext. 3674, krooney@premierdocs.com, fax (937)312-3675.

Ohio, Medina and Wadsworth: Combined two-site position at a brand new free-standing ED (10,000 pts./yr.) and established community hospital (20,000 pts./yr.). Nice communities are near Akron and the area’s most desirable residential communities. Outstanding partnership opportunity includes equal profit sharing, equity ownership, funded pension, open books, full benefits and more. Contact Ann Benson (careers@emp.com), Emergency Medicine Physicians, 4535 Dressler Rd. NW, Canton, OH 44718. Phone 800-828-0898 or fax 330-493-8677.

Ohio, Parma: Parma Community General Hospital is situated in the SW Cleveland suburbs, state of the art physical plant and equipment, serves 48,000 patients per year. Outstanding partnership opportunity includes equal profit sharing, equity ownership, equal voting, funded pension, open books, comprehensive benefits and more. Contact Ann Benson (careers@emp.com), Emergency Medicine Physicians, 4535 Dressler Rd. NW, Canton, OH 44718. Phone 800-828-0898 or fax 330-493-8677.

Oklahoma, Tulsa: Modern 971-bed regional tertiary care center sees 87,000 ED patients per year, with broad pathology, high acuity, modern facilities and supportive environment. Outstanding partnership opportunity includes equal profit sharing, equity ownership, funded pension, open books, full benefits and more. Contact Ann Benson (careers@emp.com), Emergency Medicine Physicians, 4535 Dressler Rd. NW, Canton, OH 44718. Phone 800-828-0898 or fax 330-493-8677.

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**Pennsylvania, Pittsburgh:** Allegheny Valley Hospital in Natrona Heights boasts a brand new ED seeing 37,000 emergency pts./yr. Forbes Regional Hospital is a respected facility in Monroeville seeing 48,000 ED pts./yr. Both sites are proximate to Pittsburgh’s most desirable residential communities; areas afford easy access to abundant outdoor recreation and nationally ranked schools. Outstanding partnership opportunity includes equal profit sharing, equity ownership, funded pension, open books, full benefits and more. Contact Ann Benson (careers@emp.com), Emergency Medicine Physicians, 4535 Dressler Rd. NW, Canton, OH 44718. Phone 800-828-0898 or fax 330-493-8677.

**Pennsylvania, Sharon:** Sharon Regional Health System has an extremely supportive administration/medical staff, newer ED, and full service capabilities making this a great place to work, with 35,000 patients treated annually. Small city setting offers beautiful housing and abundant recreation less than an hour from Pittsburgh and Cleveland. Outstanding partnership opportunity includes equal profit sharing, equity ownership, funded pension, open books, full benefits and more. Contact Ann Benson (careers@emp.com), Emergency Medicine Physicians, 4535 Dressler Rd. NW, Canton, OH 44718. Phone 800-828-0898 or fax 330-493-8677.

**Pennsylvania, York:** Staff and Assistant Director/Assistant Residency Director positions at Memorial Hospital. Site has new ED, respected osteopathic EM residency, and sees approximately 42,000 ED pts./yr. Outstanding partnership opportunity includes equal profit sharing, equity ownership, funded pension, open books, full benefits and more. Contact Ann Benson (careers@emp.com), Emergency Medicine Physicians, 4535 Dressler Rd. NW, Canton, OH 44718. Phone 800-828-0898 or fax 330-493-8677.

**Texas, San Antonio:** ACADEMIC EMERGENCY PHYSICIAN, UNIVERSITY OF TEXAS HEALTH SCIENCE CENTER AT SAN ANTONIO. The University of Texas Health Science Center at San Antonio, School of Medicine.
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Emergency Medicine, is recruiting for full-time residency trained academic emergency medicine physicians. Optimal candidates will have an established track record of peer-reviewed research, excellence in education and outstanding clinical service. Our initial class of emergency medicine residents is expected to start in July 2013. University Hospital, the primary affiliated teaching hospital of the University of Texas Health Science Center at San Antonio, is a 498 bed, Level 1 trauma center which treats 70,000 emergency patients annually. University Hospital is recognized by US News and World report as #1 in the metro San Antonio area as well as regionally and nationally in multiple specialties. The University Hospital Emergency Department serves as the primary source for uncompensated and indigent care as well as the major regional tertiary referral center with a focus on transplant, neurologic, cardiac, diabetes and cancer care. A new, state of the art $787 million Emergency Department and trauma tower with 75 beds will open in early 2014. The successful candidate will join a young, vibrant and enthusiastic group of seventeen academic emergency physicians committed to a common goal of starting an extremely competitive emergency medicine residency program. Academic emergency physicians with expertise in EMS, Ultrasound, Toxicology, and multiple dual board certified EM / IM physicians currently round out the faculty. Department status within the School of Medicine is anticipated within 12-18 months. San Antonio is the third fastest growing and seventh largest city in the United States and features excellent weather year round with over 300 days of sunshine and an average temperature of 70 degrees. San Antonio is one of the most affordable cities in the nation and is home to multiple adventure parks including SeaWorld®, Schlitterbahn.
Water Park, and Six Flags® Fiesta Texas®. Furthermore, San Antonio offers cultural adventures such as The Witte Museum, San Antonio Symphony, San Antonio Botanical Garden, and multiple golf courses. The University of Texas Health Science Center at San Antonio offers an extremely competitive salary, comprehensive insurance package, and generous retirement plan. Academic appointment and salary will be commensurate with experience. Candidates are invited to send their curriculum vitae to: Justin Williams, M.D., FACEP, Interim Chief of Emergency Medicine, 7703 Floyd Curl Drive, MC 7840, San Antonio, TX 78229-3900. Telephone: (210)567-4294, FAX: (210)567-0757. All faculty appointments are designated as security sensitive positions. The University of Texas Health Science Center at San Antonio is an Equal Employment Opportunity / Affirmative Action Employer.

Washington, Tacoma: We need excellent Emergency Physicians (BC/BP) to join our group in the beautiful Northwest! We offer the opportunity to practice challenging, high acuity emergency medicine in a supportive environment with highly competitive compensation and a quick transition to full partnership status. Full time contract at 1200 hrs/year (~12 shifts/mo) 8 hour shifts. Leadership opportunities – Contact Sara Harris @ sara.harris@multicare.org.

West Virginia, Wheeling: Ohio Valley Medical Center is a 250-bed community teaching hospital with a brand new ED under construction. AOA approved Osteopathic EM and EM/IM residency program. Enjoy teaching opportunities, full-specialty back up, active EMS, and two campuses seeing 30,000 and 25,000 visits a year through the Emergency Department.

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We are seeking physicians who will participate in our clinical and educational programs and contribute to the Department’s research and consulting agenda. Rank and salary are commensurate with experience.

**Basic Qualifications:** Physicians should be residency trained in Emergency Medicine. University faculty rank will be commensurate with experience.

**Application Procedure:** A CV is considered a completed application. Review of applications will begin on October 10, 2012 and continue until all positions are filled. Please submit CV by mail to Robert Shesser MD, Chair, Department of Emergency Medicine, George Washington University, 2150 Pennsylvania Avenue NW, Suite 2B-417, Washington DC 20037 or by email at: rshesser@mfa.gwu.edu.

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West Virginia, Fringe Suburb Washington, DC: Staff Physician Opportunity. A private independent group of 10 at WVU Hospitals-East (City Hospital) since 1995 seeks a BC/BP full time EM physician to work 16 9-hour shifts per month. Very stable group with 90 years of combined local experience offers: A competitive financial/benefit package. A-rated malpractice with tail included: Tort reform recently withstood the constitutionality test at Supreme Court level. 50,000 annual visits, Level III facility. Flexible scheduling; 45 hrs/day physician coverage. New 40-bed ED with leading-edge technologies, Epic EMR. Perfect location in West Virginia’s Eastern Panhandle, fringe-suburb of Baltimore, MD/Washington DC, on the I-81 corridor with virtually no traffic! Great schools, affordable housing, healthy economy, outstanding opportunities for relaxation and outdoor adventure. Contact Daryl LaRusso, MD, MPH, FACEP, phone (304-264-1287 x1701), E-mail (dlarusso@cityhospital.org).

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The Department of Emergency Medicine at The Ohio State University Wexner Medical Center is seeking physicians for clinical and academic faculty positions (rank based on credentials). Teaching opportunities for medical students, residents, fellows and others are abundant as are research and scholarship opportunities. Clinical responsibilities include patient care activity in an Emergency Department (71k annual visits) designated as a Level 1 Trauma Center, Burn Center, Cardiac Center and Stroke Center and/or a Community-based Emergency Department (50k annual visits).

The Ohio State University Wexner Medical Center is one of the largest and most diverse academic medical centers in the country and the only academic medical center in central Ohio. We’re internationally known for our superior quality, depth of expertise and leadership in personalized health care. A new Cancer Hospital and Critical Care Tower which includes a new Emergency Department will be completed in 2014 (phase 1) and in 2016 (phase 2). We offer a competitive salary with full university benefits including generous health insurance options, multiple retirement plan options, tuition assistance, group paid malpractice coverage, and CME allowance just to name a few.

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