

# EMM Resident

Official Publication of the **Emergency Medicine Residents' Association**

February/March 2017

VOL 44 / ISSUE 1

## Health Policy Checkup

*pg 8*

## Updates on Single Accreditation System

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# Letter from the Editor



**Abby Cosgrove, MD**  
Editor-in-Chief, EM Resident  
Washington University in St. Louis  
St. Louis, MO

Dealey Plaza, site of Kennedy assassination

I couldn't stop staring at the eerie photo I had just taken from the 7<sup>th</sup> floor of the Texas School Book Depository, peering out over the intersection of Elm and Houston. I was standing in almost the exact location from where President John F. Kennedy had been assassinated on Nov. 22, 1963. I could almost see the black car speeding away to Parkland Hospital, Jackie Kennedy, in her blood-stained pink suit, crawling desperately over the back seat.

One visit to the Sixth Floor Museum in Dallas this past December, and I was hooked. Hooked on the gruesome Zapruder film, the conspiracy theories, the fears and hopes played out by the American people, and the steaming pot of current affairs that boiled over into one of the most notorious crimes of the 20<sup>th</sup> century. It was all-consuming.

Of course I couldn't help but think about what the scene must have been like in Trauma Room 1 shortly after that fatal shot. The account of the hospital operator frantically overhead paging any available doctor to the emergency room (to which two general surgeons in the cafeteria decided to respond) is almost ludicrous compared to the automatic trauma team activations of present day, not to mention the automatic presence of board-certified emergency medicine physicians. *It could not have been more different.*

Then I read an interview with Dr. Ronald Jones, a chief surgical resident at the time, who recounted the details of the event he still remembers so vividly: the President's lifeless stare, the restrictive back brace they struggled to remove, the wedding ring that Jackie Kennedy slipped

off his left ring finger. The memories, even to this day, are exhausting to relive. *Maybe it wasn't so different after all.*

While we continue to suffer through tragedy, loss, and enormous grief within the walls of our own trauma bays today, we are blessed with countless life-saving pharmaceuticals, medical devices, and technologies that were completely unheard of just 50 years ago. But we are also burdened by administrative and systemic nuances that have attributed to alarming rates of physician burnout and fatigue. Surely Dr. Jones did not encounter issues of intense overcrowding, boarding psychiatric patients, battles over fair reimbursement rates, intense fears of litigation, or feelings of exploitation and loss of professional autonomy.

As emergency medicine physicians in training, we spend every day trying to master the knowledge and skillset required to become excellent clinicians capable of caring for any patient (or God forbid President of the United States) who enters the doors of our emergency department. But as in politics, every day we are also trying to learn within a practice environment that is increasingly driven by money, policy, and power. And sometimes these two worlds collide.

This is exactly what happened to the the emergency medicine residents at Summa Akron City Hospital in Akron, Ohio, this past January, who found out with 4 days' notice that their entire faculty and program director were being replaced after a failed contract negotiation. Unfortunately, this transition of contracts led by hospital administrators did not

account for the needs of its residents, initially leaving them without any dedicated educators, causing them to halt their interview season and placing them at risk of losing their GME funding.

Your EMRA Board of Directors was deeply distressed by this situation and wrote an open letter expressing our concerns. Excerpts from this letter, along with a Q&A with Summa's new program director, can be found on page 6 of this issue. This is not the first time EMRA has gone to bat for the residents and medical students it represents, and it certainly will not be the last. After all, advocating for your needs is one of the three pillars upon which this organization stands.

Especially during the presidential transition, and at a time when the future of the American health care system is as unclear as ever, we will continue to fight for what is right and just. I would thus encourage you to become involved with EMRA's advocacy initiatives (see p. 4, 9) and to attend ACEP's Leadership & Advocacy Conference, March 12-15 in Washington, D.C.

After all...

*"It is not the critic who counts; not the man who points out how the strong man stumbles, or where the doer of deeds could have done them better. The credit belongs to the man who is actually in the arena, whose face is marred by dust and sweat and blood; who strives valiantly; who errs, who comes short again and again... who spends himself in a worthy cause; who at the best knows in the end the triumph of high achievement, and who at the worst, if he fails, at least fails while daring greatly, so that his place shall never be with those cold and timid souls who neither know victory nor defeat."*

Stay strong out there, my friends.

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*EM Resident* (ISSN 2377-438X) is the bi-monthly magazine of the Emergency Medicine Residents' Association (EMRA). The opinions herein are those of the authors and not 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 edit all material and does not guarantee publication.

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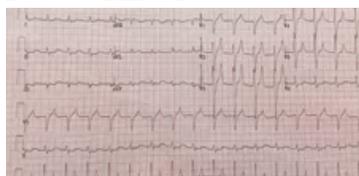
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### February 15

EMRA Committee & Division Vice-Chair Applications Due  
EMRA Medical Student Council Applications Due

### February 22

In-Training Exam  
NRMP Rank Order List deadline

### March 1

Emergency Medicine Residents' Appreciation Day

### March 3

SIMWars Team Registration Deadline for Competition at SAEM Annual Meeting

### March 12-15

ACEP Leadership & Advocacy Conference

### March 17

Match Day

### April 3

Deadline for EMRA Resolutions @ SAEM

### April 27

Chief Resident Symposium @ CORD Academic Assembly

### April 27-30

CORD Academic Assembly, Nashville

### April 29-May 2

ABEM Spring Oral Certification Exam

### May 16-18

Essentials of Emergency Medicine, Las Vegas

### May 16-19

SAEM Annual Meeting, Orlando, Florida

### October 14-17

ABEM Fall Oral Certification Exam

### October 29-November 1

ACEP *Scientific Assembly*, Washington, D.C.

### November 6-11

ABEM Qualifying Exam

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# CALL TO ACTION

## USE YOUR VOICE!



**Alicia Kurtz, MD**  
EMRA President  
Chief Resident, UCSF Fresno  
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**We, as EM residents,  
are the future of  
emergency care in  
our country...**

### Hello there, EMRA!

**W**hat a few months it has been! On the national level, we've had a presidential election and inauguration causing the politics in our capital to take a palpable pivot, with health care once again in the spotlight in a big way. With the hustle and bustle of the holidays and so many of our departments bursting at the seams in the thick of another virus-filled winter, it's easy to get caught up in our own day-to-day lives and watch casually from the sidelines as Congress starts to address issues like balanced billing, repeal and replacement of the Patient Protection and Affordable Care Act (a.k.a. ACA or Obamacare), Medicare and Medicaid policy and funding, and so much more.

While understandable, there's a fundamental problem with this approach: **Politics is not meant to be a spectator sport. If we sit on the sidelines, we lose. And if we lose, that means our patients lose.** We are the best equipped to truly speak on the struggles and challenges we face every day as we do our best to provide timely, quality care to people from every walk of life. *We*, as EM residents, are the future of emergency care in our country and are the ones who will be tasked with working shifts, running departments, and educating the next wave of trainees in the very near future. So we have to pay attention and stay engaged.

But wait — **what does this mean for EMRA?** I'm so glad you asked!

EMRA is an independent organization that operates under the guidance of two documents:

1. Our **Bylaws** tell us how to run our organization — the board structure, how our Representative Council is run, how we make changes to policy, etc.
2. Our **Policy Compendium** contains more detail on how parts of EMRA work and are funded (like our Committees & Divisions for example) as well as **all of EMRA's positions on issues relevant to EM residents and emergency care in general.** These policies are considered the official stance of the association. Surprisingly, other than GME funding, access to EM care for all, and saying we support car seat laws, **EMRA does not currently have any official policies regarding hot-button health care policy or advocacy related issues!**

To address this gap in our policy and help our EMRA board more accurately represent your views during what is sure to be a heated political year, I have tasked Legislative Advisor Rachel Solnick, MD, with forming a **Health Policy Advocacy Task Force.** This task force will submit a set of new policies to our Representative Council at our SAEM meeting in May to be discussed and voted on. Once adopted, we will use these new policies to come up with our advocacy strategy, inclusive of a plan to better engage YOU, our members, in the political process. It is our priority to keep your voices heard — certainly for each other as physicians, but more importantly for our patients who depend on us to advocate for them in a very broken and convoluted health care system.

**Want to get involved in the Task Force?** Contact Dr. Solnick at [legislativeadvisor@emra.org](mailto:legislativeadvisor@emra.org). **Have other ideas, thoughts, opinions?** Please reach out to me at [president@emra.org](mailto:president@emra.org)!

We're excited to see where this year takes us and promise to keep fighting for you and our patients. Like that old adage asks, **"If not us, who? If not now, when?"**

Always forward,  
Alicia ★

## AN UPDATE

# The Single Accreditation System

## How It Is Affecting AOA Residencies and Fellowships

We are 18 months into the American Osteopathic Association (AOA) and the Accreditation Council for Graduate Medical Education (ACGME) merger to the Single Accreditation System (SAS). The date for completion of the SAS is June 30, 2020, so **if a program is not ACGME accredited by that time, the program will no longer be an accredited emergency medicine program.** A lot has changed and many things are still in flux.

The ACGME Review Committee for Emergency Medicine (RC-EM) is accepting and reviewing applications from AOA programs. To date, 61 AOA emergency medicine programs exist, of which 34 have applied for ACGME accreditation and are in various stages of accreditation.

Programs that have applied for accreditation but have not yet heard back from the RC-EM are considered **pre-accredited**. Programs that have applied to the ACGME for accreditation but require further changes prior to achieving accreditation are in **continued pre-accreditation** status. It takes 4-12 months for the RC-EM to review the application, depending on the timing of the submission.

The next tier of accreditation is **initial accreditation**, which allows graduates to sit for ABEM certification even if accreditation is granted on the last day of residency. Newly accredited residencies will, however, have a review in 2 years that includes a site visit to check on the program. If the program is deemed to be in compliance, it will receive continued accreditation. As of September 2016, 13 programs have obtained initial ACGME accreditation with a 2-year accreditation cycle.

If you are applying to any of these programs and wish to see its accreditation progress, check the AOA Osteopathic Medical Internships and Residencies website at <http://opportunities.osteopathic.org/index.htm> or contact the program directly.<sup>1</sup>



[osteopathic.org/index.htm](http://opportunities.osteopathic.org/index.htm) or contact the program directly.<sup>1</sup>

### What Are the Implications?

Many people want to know the implications of the different designations, especially for board certification. AOA program graduates may take the American Osteopathic Board of Emergency Medicine (AOBEM) Certification test while their residency program is AOA approved. **Once the AOA program achieves ACGME initial accreditation, even if it is the last day of residency, the resident may also take the American Board of Emergency Medicine (ABEM) certification test.**<sup>2</sup>

As for 3- versus 4-year training programs, all AOA-approved emergency medicine programs are required to be four-year programs. Under the SAS, many AOA programs applying for ACGME accreditation are contemplating whether they should stay a 4-year program or switch to a 3-year program. How will this affect students and residents? The matter is very simple: if you have not yet started residency and your program changes to a 3-year program, you will complete 3 years of residency.



**Ashley Guthrie, DO**  
EMRA Member-at-Large  
St Joseph's Regional  
Medical Center  
Paterson, NJ

For those who have already started residency, this can be confusing in terms of board eligibility. If you start your residency in a 4-year residency and it changes to a 3-year program, you must complete 24 months of training under the new ACGME accreditation. This effectively means that, if you are a PGY2 or greater, you will have to complete your program as a 4-year program in order to be board-eligible. Therefore, only the PGY1 class and future incoming classes would be able to graduate in 3 years.<sup>3</sup>

**When it comes to transferring, if an AOA EM resident decides to transfer to a separate/different established ACGME EM program, s/he can receive partial credit for prior training.** The program director of the resident's new program can award up to 6 months of credit for 12 months of completed AOA EM training. For 24 or more months of completed AOA EM training, a resident can be awarded up to, but no more than, 12 months of credit.

AOA fellowships are eligible to apply for accreditation once their core program has achieved initial accreditation. As of July 2015, any AOBEM-certified physician who enters and successfully completes an ACGME fellowship in a subspecialty that ABEM sponsors may apply to ABEM to take the subspecialty examination.

As the SAS process continues, there may be unforeseen situations requiring further changes. Rest assured the AOA, ACGME, AOBEM, and ABEM are working together to keep the best interests of students, residents, and fellows in mind and will continue to tackle problems as they arise. **EMRA will keep you informed of these changes.** Good luck to the students in the coming match! ★

## Q &amp; A



**Zach Jarou, MD**  
 President-Elect  
 Denver Health/University of Colorado  
 Denver, CO  
 @zachjarou

## Blending the Business of Health Care with the Practice of Medicine

Every day, in every hospital in America, the practice of medicine is carried out faithfully by dedicated providers intent on caring for their patients and educating tomorrow's workforce. But that practice takes place amidst the business of health care – and sometimes the two collide. Policies change, contracts end, administrations turn over. It can create uncertainty, especially for residency programs.

Such was the case for Summa Health System of Ohio, which underwent an unforeseen shift in emergency department contract providers during December. The abruptness of the change — a turnover on just 4 days' notice — prompted the EMRA Board of Directors to send **an open letter to the EM community**. Primary concerns included the departure of all EM residency program faculty, including the program director, with no transition plan initially in place for the program or its 30 residents. The EMRA Board wrote:

*“Following our conversations with our fellow members in Akron, we became gravely concerned the current situation at Summa falls short of meeting [ACGME] requirements. While the new contract at Summa employs board certified emergency physicians, as of January 1st, there were no named core faculty on staff in the ED, suggesting the transition of contracts was done without ensuring the presence of ACGME certified educators for the residency.*

*“As a result, the current interview and Match season has become tenuous, risking the loss of federal GME funding to the program as well as quality residency positions — an unacceptable possibility in a time when our country already faces a shortage of EM physicians and is in desperate need of the high caliber emergency doctors that Summa Akron is known for producing.*

*“As the voice of emergency medicine physicians-in-training, EMRA stands firmly with the Summa residents. Moving forward, it is imperative that any major transitions in an emergency department that hosts an EM residency prioritize the education and well-being of their residents and remain compliant with ACGME policy. While this serves to fulfill hospitals' contractual and ethical obligations to trainees, far more importantly it ensures the safest and highest quality patient care for the communities we serve.”*

Into that gap stepped EMRA alumni member Scott Felten, MD, FACEP, who was quickly named interim program director by US Acute Care Solutions, which took over Summa Health System's contract.

Dr. Felten has worked at all nine USACS graduate medical education facilities. He spoke with EMRA about his new undertaking in Ohio.

### Q: What's your priority as the interim program director?

A: My top priorities are:

1. To make sure that the residents' education is not compromised in any way and to actually improve upon their educational experience.
2. To maintain the long-term health of the program by optimizing our residency match this year.
3. To ensure that the residents have the ability, space and support to get through what is obviously an unexpectedly rapid transition.

I'm confident we will be able to get through these tough initial stages to emerge as an even better residency.

### Q: How is the change in staffing affecting current residents?

A: It is impossible to say that this change hasn't affected every resident in some way. Strong, positive relationships have been built over the past several years. We at USACS acknowledge this, and most of my time is dedicated to making new connections with the residents, providing guidance and mentorship, and forging ahead in this constantly changing environment. We are excited about building new relationships with the residents — we have a lot to offer, but we also have a lot to learn from them. Our shared goal is to take care of patients, and we will all continue to do that.

**Q: What's the status of your program for this year's match?**

**A:** We are very much in the match and are expecting to fill our program as usual. This has been and continues to be an excellent program, and we are building an outstanding new core faculty. We encourage all medical students to continue their plans to rank us highly. For some reason, medical students who had interviews scheduled, but had not yet interviewed, had their interviews cancelled before USACS arrived. I have contacted those students personally and reestablished their interviews. I expect us to fill with the same caliber of residents we always have. I inherited a great program, and I don't expect this to slide.

**Q: Moving forward, what are your goals for the program?**

**A:** Our goals are to establish a new core faculty (including residency leadership), to maintain and improve upon the education of the residents, and to ensure that the residents are well-supported and mentored. We are well on our way to doing this — I have already hired an assistant program director (EMRA alumni member Christopher Lloyd, DO, FACEP) who is an incredible resident advocate and educator, and named interim core faculty.

**Q: How will you accomplish these objectives?**

**A:** Summa Akron City Hospital is an excellent environment for energetic faculty who are eager to work with outstanding residents and build the best clinical emergency medicine residency in the country. Change always creates opportunity, and the best way to seize this opportunity is to throw your hat into the ring. We already have several excellent new core faculty and we are building an outstanding department. If anyone reading wants to be a clinician educator in a well-established EM residency program with the resources of a national EM physician group (and without the strong pressure of research grant submissions), drop me a line at [feltens@summahealth.org](mailto:feltens@summahealth.org)!

Because we are a national group with ties to 9 other residency programs and multiple national EM experts, we are able to draw upon our colleagues to participate in the education of our residents. Our physicians are experts in the areas of education, EMS, ethics, research, geriatric EM, administration, career planning, risk management, evidence-based medicine, and more. These physicians can help participate in the training of the Summa residents to provide a truly well-rounded educational experience.

The mentorship and guidance piece starts locally with me and involves all the core faculty at the site with national level support. I'm honored to be in the position to move the residency forward, and my passion is the achievement of success for our residents during residency and beyond.

**Q: What would you like the EM community, especially the residents and medical students EMRA serves, to know?**

**A:** USACS manages 10 outstanding residencies in places like Chicago, Pittsburgh, Las Vegas, and this one in Akron. Our support for GME is thorough and unwavering. The situation in Akron is unique, but manageable for a company like USACS. We will not let these young physicians down, and we are excited to participate in their education. ★

**More about Scott Felten**



Most recently, Dr. Felten worked clinically at St. Francis Hospital in Tulsa, Oklahoma, and in the Mercy Health System in Cincinnati. Previously, he served as an assistant professor of emergency medicine at the University of Oklahoma in Tulsa. Before that, he was a member of the ED staff at Akron General Medical Center and later served as the medical clerkship director, associate program director, and medical director of the Akron General Medical Center Emergency Department in Stow, Ohio.

Dr. Felten graduated from the University of Nebraska with a bachelor's in biology in 1993. He completed medical school training at the University of Nebraska Medical Center in 1997. He served as the chief resident of Emergency Medicine at Akron General Medical Center in Akron, Ohio and completed the program in 2000.

# Preserving the Safety Net



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## What is the True Cost of the Uninsured?

President Donald J. Trump has sparked emotional debate across the country with bold promises on important public health issues like Medicaid expansion. He has said the Affordable Care Act (ACA) will be repealed and replaced with a more cost-efficient system.<sup>1</sup> As rumors grow, uncertainty mounts about the future of our country's health care safety net, particularly for the uninsured. As emergency physicians, we take care of millions of patients without health insurance each year. **What are the true costs of these uninsured? What is our duty to this population?**

On a recent shift, a patient came to the emergency department in tears with thoughts of hurting himself. He had poorly controlled hypertension and little financial support. Without insurance and barely enough income to sustain himself, he could not afford medications to keep his blood pressure controlled, much less the out-of-pocket costs required to see a mental health specialist. Like so many of our fellow Americans, he sought the ED when he had nowhere else to turn.

### Who Are the Uninsured?

Despite implementation of the ACA in 2015, there were still an estimated 28.5 million uninsured individuals that

year.<sup>2</sup> Although financial assistance remains available from the government to help purchase a health care plan, many uninsured adults are deterred by high costs and ultimately remain uninsured. This group includes a growing share of Latinos (from 29% to 40% from 2013-2016) and those with incomes below the federal poverty line (39% of the uninsured in 2016), with the majority pointing to “affordability” as a major reason for remaining uninsured.<sup>3</sup> The highest rates of uninsured adults reside in the Southern states. Sometimes, adults may fall into a “coverage gap” where they earn too much to qualify for Medicaid but don't make enough to receive premium tax credits for purchasing insurance. Nearly 3 million people are estimated to be in this “coverage gap.”<sup>3</sup>

### Why Does this Matter?

The literal and metaphorical costs are high. The uninsured receive lower quality care and at a high economic burden to them. Their personal health suffers, and the cost to our health care system is great. The uninsured are less likely to seek follow-up care, more likely to be hospitalized for preventable medical conditions, and are prone to receive fewer diagnostic/treatment services than the insured.<sup>4</sup> This leads to enormous

hardship on families who become overwhelmed with excessive medical bills.

The evidence also supports that being uninsured leads to worsened health care outcomes. The Oregon Experiment, a lone study in Oregon, showed notably improved health outcomes with Medicaid enrollment compared to those who had no insurance.<sup>5</sup> This included a 30% reduction in observed rates of depression between the two groups.<sup>6</sup> **Other studies have shown that insurance status leads to improved affordability, less medical debt, and less societal burden of poor health outcomes relative to the uninsured.**

Finally, our greater health care system continues to be jolted. Lack of insurance burdens society, which must absorb debt and fund uncompensated medical care. This drain especially weighs on the shoulders of nonprofit hospitals, where each additional uninsured person can cost up to \$900 per year.<sup>1</sup> As insurance plans remain expensive, companies raise their premium rates and local governments struggle to provide tax subsidies to the poor — making our public health system strain at the edges.

### What Does the Future Hold?

Most recently, the success of the ACA has been called into question. How will

a potential repeal of the ACA affect the uninsured? The simple answer is that nobody knows. What is certain is that change has already begun.

**In November, Rep. Tom Price (an orthopedic surgeon) was selected as secretary of Health and Human Services.** This nomination was controversial, especially among physicians. Critics point to his radical positions on health care. In 2015, he proposed an alternative to the ACA that would strip 14 million poor people of health insurance by rolling back federally-funded Medicaid expansion in 31 states and the District of Columbia. His proposal would also exempt insurers from covering addiction treatment or birth control services. Others advocate that the administration is taking a badly needed “outsider” approach to fixing our imperfect health care system.

### How Can You Get involved?

As emergency medicine residents, we have enormous power to enact change and help reduce health disparities. Politically, EMRA serves as a great launching pad for getting involved in health policy and advocacy. **Getting involved is easy!**

- ✓ Join the Health Policy Committee.
- ✓ Sign up for the ACEP 911 Network.
- ✓ Attend ACEP’s Leadership & Advocacy Conference, which will take place March 12-15 in Washington, D.C.

Even a simple phone call has the potential to change the opinion of a key health advisor or a member of Congress.

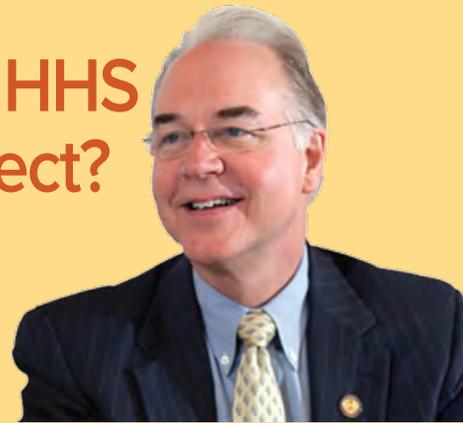
As physicians, it may appear daunting to confront the most entrenched and debilitating forms of poverty. Yet we cannot sit silently. **We must rise to the occasion and work together to create novel solutions to some of the most complicated problems of our time.** Our health care system, and our patients, depend on it. ★

**As rumors grow, uncertainty mounts about the future of our country’s health care safety net, particularly for the uninsured.**

# Tom Price to Lead HHS What Can We Expect?



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EMRA Legislative Advisor  
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New Haven, CT  
@RachelSolnickMD



President Donald Trump has appointed Rep. Tom Price, MD (R-GA), an orthopedic surgeon, to head the U.S. Department of Health and Human Services (HHS). While EMRA will not support or oppose a nominee, we will keep an eye on health care issues relevant to our practice and patients. The following comparison list — built from personal perspective — offers a look at what Dr. Price’s past policies might mean for the future of health care delivery in America.

### BENEFICIAL

- First doctor to serve as HHS Secretary since 1989 and only the third doctor to serve as secretary of HHS.
- Experience and track record in House: He was chair of the powerful House Budget Committee.
- Medical liability reforms: He supported shielding physicians from liability if they adhered to clinical guidelines.
- Balance billing: He supported Medicare to contract with patients on a fee and then balance-bill them for the amount above the program’s allowable charge.
- He has reached out and worked with doctors’ groups.

### CONTROVERSIAL

- Women’s health: He supported defunding Planned Parenthood and opposes health plans covering contraception.
- Equal rights: He opposed same-sex marriage and opposed protecting members of the LGBTQ community from job discrimination.
- Funding for vulnerable populations: He supported Medicaid transitioned from defined benefit program into a block grant program, resulting in reduced funding.
- Policy experiments on payment reform: He opposed Medicare’s first mandatory, rather than voluntary, demonstration project for an alternative payment model (a.k.a. not fee-for-service) for joint replacements.

### INCREASED UNINSURED

- Repeal ACA with delayed implementation of repeal and replacement: He supported the plan to repeal fundamental and vital elements of ACA. According to the CBO this would result in 22 million uninsured, which the Urban Institute says would lead to near-collapse of the insurance marketplace and an additional 7.3 million uninsured.
- Grants for high-risk insurance pools operated by individual states: He would allow the sale of health insurance across state lines.

### TO BE DETERMINED

- Market privatization: His Empowering Patients First Act allows individuals to opt out of Medicare, Medicaid, and Veterans Affairs. They could then purchase a private health plan using refundable tax credits. There’s no mention of what happens if tax credits don’t cover the plans or if a person is too poor for the credits to be usable.
- Expanded use of Health Savings Accounts. ★

# The 21st Century Cures Act



**Rachel Solnick, MD**  
EMRA Legislative Advisor  
Yale University  
New Haven, CT  
@RachelSolnickMD

## Big Pharma Handout or Drug Development Boon?

One of the most important pieces of health care legislation since the Affordable Care Act snuck into law in the last days of President Barack Obama's term. Generally regarded as a bipartisan victory, H.R. 34 (the "21st Century Cures Act") enjoyed easy passage in the House and Senate after years of previous versions had failed. The primary goal is to expedite getting drugs and devices to market, but it also addresses several other issues germane to emergency medicine.

### Opioid Crisis

The Cures Act provides \$1 billion for state grants over 2 years to fund opioid abuse prevention and treatment activities. Money is aimed at improving prescription drug monitoring programs, offering training for prescribing, recognizing abuse, overdose prevention, and pain management. For treatment, the act supports access to health care providers who treat substance use disorders.

### Mental Health Reform

Emergency medicine physicians know well the inadequacies of our mental health system. The Cures Act offers several provisions that could help tame the surge of mental health emergencies and boarding. One of the most important changes is establishing an Assistant Health and Human Services (HHS) Secretary in charge of creating and coordinating federal policy for mental health and substance abuse. Additionally, a new National Mental Health and Substance Use Policy Lab will be charged with driving policy on all things related to mental health, mental illness, recovery supports, and substance use disorder services.

This act also provides regulatory changes and funding avenues to increase outpatient capacity and community alternatives. It directs HHS to enforce existing laws that mandate the same coverage for mental illness and substance use disorders as for physical conditions. It also ends a regulation in Medicaid that did not

allow payment to both providers if primary care and mental health services were provided on the same day. The Cures Act also offers grants for Assisted Outpatient Treatment, or court-ordered care for people who might otherwise not seek help, as well as Assertive Community Treatment that gives patients with severe conditions access to a team of on-call professions.

The new law encourages coordinated care by reauthorizing grants that improve coordination between mental health professionals and primary care doctors. It also bolsters programs to increase screening and support of suicide prevention and addresses criminal justice issues such as alternatives to incarceration for nonviolent, mentally ill offenders. While these payment, community and workforce reforms are welcome, unfortunately there is nothing to address the critical decline in inpatient psychiatric beds, which have decreased by 35% in the past two decades.<sup>1</sup>

### EHRs and Telehealth

The Cures Act offers hope for improving electronic health records (EHRs). The act facilitates the interoperability of clinical data for easier exchange of information and avoids unnecessary duplication. It creates the Health Information Technology Advisory Committee, charged with “achieving a health information technology infrastructure, nationally and locally.”

Another provision prevents EHR vendors from blocking the transmission of such data to third parties such as the Clinical Emergency Data Registry (CEDR) — a key ACEP initiative. CEDR will help with collecting and reporting quality metrics that under MACRA’s reimbursement reforms will comprise an increasing portion of our bottom line.<sup>2</sup>

Further and finally embracing technology, the Cures Act requests a report from CMS and the Medicare Payment Advisory Commission (MedPAC) on the current and potential uses of telehealth in the Medicare program. By 2018, the act commands lawmakers to address which telehealth services are eligible for fee-for-service reimbursement through Medicare and how Medicare can offer services similar to that of private insurers.<sup>3</sup>

### NIH Budget

The Cures Act will authorize \$4.8 billion to the NIH from 2017 to 2026. This money will be spread over three initiatives of the Obama administration: \$1.8 billion for cancer research called the Beau Biden Cancer Moonshot; \$1.56 billion for the Brain Research through Advancing Innovative Neurotechnologies (BRAIN) Initiative; and \$1.4 billion for the Precision Medicine Initiative that studies personalized treatment based on genetics, environment, and lifestyle.

### FDA Reforms

The Cures Act is presented as a mechanism to accelerate drug discovery and availability, but critics are concerned it weakens the safeguards built into Food and Drug Administration (FDA) approval. Despite the FDA’s tight budget, it is actually quite efficient: all new drug applications are evaluated within 6 to 10 months. However, critics of the approval process complain that the barriers to drug

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development are pervasive, citing that only 2 out of 10 drugs that enter clinical development result in FDA approval.<sup>4</sup>

It should give pause that the thrust for the change in the drug review pathways is not coming from within the FDA, but from legislators subject to re-election and under the influence of lobbyists.<sup>5</sup> The primary bill sponsor, Rep. Fred Upton, R-Mich., was the top recipient of contributions from pharma in the year prior to the initial House vote and received more than \$1.3 million in donations from health care political action committees.<sup>6</sup>

### Surrogate Endpoints and “Real World Evidence”

The Cures Act hopes to encourage new drug development by expanding acceptable forms of evidence, specifically increasing use of surrogate endpoints, patient experience and summary data. Supporters hope that targeting surrogate endpoints such as biomarkers can enable trials of smaller size and duration, lowering the threshold for

drug companies to be willing to invest in research for a potentially successful drug. Tracking biomarkers proved to be a successful surrogate of disease progression for HIV therapies. Critics of the increased use of surrogate markers are concerned this could lead to more drugs being approved that improve biomarkers but don't improve clinically significant outcomes, such as the case in some diabetes, hypercholesterolemia, and oncology therapies.

The Act also makes it easier for drug companies to apply for new indications for existing drugs, enabling them to expand markets and thus profits. Pharmaceuticals will be able to use data summaries, “real world evidence” such as observation studies, patient reported outcomes instead of randomized clinical trials as grounds for getting FDA approval, a change opponents say effectively lowers the quality of data the FDA uses to judge if drugs are safe and effective.

### Antibiotic Development

In recognition of the rising threat of antibiotic resistance, the Cures Act allows antibiotics and antifungals to be approved more quickly with only preliminary data in cases of “unmet medical need.” Through this “limited population antibacterial drug” pathway, drugs can be FDA approved after small trials based on the benefit-to-risk profile. The concern is that these approved drugs could be extended for large populations having skipped the prerequisite clinical studies, putting more people at risk.

### Medical Devices

Already an area of more lax regulation, reforms made to the medical device approval process further lower the burden of proof required for devices deemed by their manufacturer to be “breakthrough” devices. This label can be had if the device can claim having “significant advantages over existing approved or cleared alternatives, including

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the potential... to improve patient quality of life.” Thus companies can submit case studies or reports instead of randomized control trials.

### Conclusion

The medical establishment relies on a presumption of the public’s trust in order to practice medicine. While at face value the Cures Act is a vehicle to expedite biomedical research, address mental health reform, reverse the opioid crisis, and increase access to novel therapies, **we must remain critical and thoughtful of the complex balance between fiduciary responsibility, industry influence, and patient empowerment.** ★

Generally regarded as a bipartisan victory, H.R. 34 (the “21st Century Cures Act”) enjoyed easy passage in the House and Senate after years of previous versions had failed.

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- ▶ **12:30 - 12:40 p.m.**  
**Welcome and Introductions**  
*Sandra Williams, MD*  
*Alicia M. Kurtz, MD*
- ▶ **12:40 - 1:15 p.m.**  
**Introduction to Health Policy**  
*Rachel Solnick, MD*
- ▶ **1:20 - 1:40 p.m.**  
**The Current and Future State of Graduate Medical Education Funding**  
*Leonard Marquez, MD, Director, Government Relations AAMC*
- ▶ **1:55 - 2:25 p.m.**  
**Mental Health: What’s Broken and How Can it be Fixed**  
*Leslie S. Zun, MD, FACEP*
- ▶ **2:30 - 2:40 p.m.**  
**World’s Fastest Introduction to the ACA**  
*Nicolas Sawyer, MD*
- ▶ **2:40 - 3 p.m.**  
**Panel Discussion - Is it Working Like It Should?**  
*Nicolas Sawyer, MD*  
*Aimee K. Moulin, MD, FACEP*  
*Adam P. Dougherty, MD*  
*Seth Trueger, MD, MPH*
- ▶ **3 - 3:10 p.m.**  
**Introduction to Journal Club**  
*Jamie Dhaliwal, MD, MPH*
- ▶ **3:10 - 3:55 p.m.**  
**The Levers of MACRA: What Will Work? Is there evidence for MACRA Strategies?**  
*University of Colorado Admin Fellows*
- ▶ **3:50 - 4 p.m.**  
**A Roadmap to Getting Involved**  
*William P. Jaquis, MD, FACEP*
- ▶ **4 - 4:30 p.m.**  
**Closing Remarks**  
*Alicia M. Kurtz, MD*
- ▶ **5 - 6 p.m.**  
**Resident and Young Physicians Section Reception**

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# Assisted Outpatient Therapy for Psychiatric Patients



**Patrick Olivieri, MD**  
Chair, EMRA Education Committee  
Mt Sinai West–St Luke’s Roosevelt  
New York, NY

## Balancing Public Health and Personal Freedom

“5 and 2?” the nurse asks, as you see EMS wheeling in a patient who is flailing his arms and screaming at security. You recognize this patient — in fact, most of your colleagues have seen this patient at least once in the past year. He was discharged from the emergency department yesterday. He was also discharged the day before, and the day before. He has a longstanding history of psychiatric illness and presents today after attacking a bystander on the

street. You begin to wonder — is there anything else we can offer mental health patients to prevent repeated emergency department visits and admissions?

Over the past several decades, there has been a significant shift in the ability to treat individuals with mental illness in the inpatient setting. A lot of this has to do with a significant decrease in the number of inpatient psychiatric beds available, which has occurred due to a multitude of reasons. Looking purely at numbers, in 1955, there were 3.4

psychiatric beds per 1,000 people in the United States.<sup>1</sup> By 2005, there were only 0.17 psychiatric beds per 1,000 people.<sup>2</sup> To date, based on recommendations from a group of psychiatric experts, **there is a current estimated deficit of nearly 100,000 beds across the country**, with 49 out of 50 states below the recommended number of beds for their state population.<sup>3</sup>

A large component of the decrease in psychiatric beds over the years is partly due to the development of

## New York State enacted ‘Kendra’s Law’ to assist with outpatient treatment for certain people with mental illness who, based on treatment history, were unlikely to survive safely in the community.

---

better outpatient pharmaceuticals for diseases like schizophrenia and bipolar disease. Take chlorpromazine, for example. Since its introduction as an oral antipsychotic more than 50 years ago, pharmacotherapy has become the primary treatment modality in psychiatry.<sup>4</sup> More recent long-acting injections such as Haldol Decanoate further assist patients who are otherwise at high risk of medication noncompliance.

Unfortunately, the combination of repeated life stressors, high incidence of homelessness and drug abuse, and inability of most emergency department providers to prescribe antipsychotics to patients with unreliable follow up, has led to an increase in the number of psychiatric patients visiting emergency departments on a daily basis. It is this combination of factors that served as the impetus for the development of assisted outpatient therapy (AOT) programs.

AOT is a civil/legal procedure by which a judge identifies patients with psychiatric disorders who have been repeatedly dangerous to themselves or other people, despite optimal attempts at outpatient therapy. When these patients are identified, they are committed to involuntary outpatient treatment, whereby their medication compliance is no longer optional. It can be considered similar to the mandatory tuberculosis isolation in patients who have demonstrated they cannot take their medications and pose a risk to others.<sup>4,5</sup> **The result is a program that targets patients who are at very high risk of danger to themselves or others with the**

**goal of decreasing hospital visits, police arrests, and morbidity and mortality.**

The quick and dirty — it’s very effective. New York, California, the District of Columbia, Florida, Ohio, North Carolina, Georgia, Iowa, Arizona, and Utah have all used some variation with success. Perhaps the most well-known legislation is out of New York, where in 1999, the state enacted “Kendra’s Law” to assist with outpatient treatment for certain people with mental illness who, based on treatment history, were unlikely to survive safely in the community. It was named after Kendra Webdale, a young woman who died in January 1999 after being pushed in front of a New York City subway train by a person who was living in the community at the time, but was not receiving treatment for his mental illness.

A study performed in 2010 examined the effect of New York’s AOT program. It found a significant decrease in arrests, incarceration, psychiatric admissions, and homelessness with improvement in medication management and case management reports. The majority of patients involved agreed it was “a good thing in their lives” at the end of the study.<sup>6</sup> Similar trends were seen in the other states studied. Additionally, there seems to be a significant financial benefit of AOT, such as when the District of Columbia estimated savings of \$1.3 million over 2 years in a sample size of 115 patients.<sup>7</sup>

So why isn’t everyone jumping on board? **There exists a significant**

**ethical dilemma in forcing people to do something against their will.**

Capacity is an incredibly gray area in patients with underlying psychiatric diseases, since some health care decisions are mandated but others are left to the patient’s discretion. Further, there have been some questions raised about racial discrimination in selecting patients for AOT.<sup>8</sup>

That said, the argument that AOT takes away patients’ rights seems misplaced. Fewer than 50 years ago, these patients were removed from their homes and forced to live confined within hospital walls. AOT provides an effective outpatient treatment that these patients have demonstrated they cannot obtain on their own. Further, we now have good data that these patients frequently end up in jail if they are not in AOT, and one could argue jail is an even greater infringement on someone’s personal freedom.

This battle is twofold. On a day-to-day basis, providers in states that practice AOT can reach out to social workers and attempt to have high-risk patients evaluated by their court system. More broadly, AOT is an issue being fought at a political level. Therefore, letting your local advocates know your opinion can go a long way. The more that intelligent and informed people can participate in policy, the better off we will all be. **Hopefully awareness surrounding this issue will allow us to best advocate for what we think is just regarding outpatient and emergency mental health treatment. \***

Editor’s note: To learn more about the recently passed 21st Century Cures Act approved by the Senate in early December 2016, which addresses mental health reform, please see page 10 of this edition.

# When **DISASTER** Strikes

## Crisis Management from Inside Hurricane Matthew

**E**mergency department (ED) physicians are trained and expected to think on our feet, to make the best of unusual circumstances and to provide the best care for patients no matter the obstacles. This training was tested to the limit in October when Hurricane Matthew stormed up the East Coast and came barreling inland.

Within 48 hours, the small, stalwart city of Lumberton, North Carolina, was underwater, and lives were changed forever. Nobody had seen the environmental disaster looming.

### Background

Lumberton, located just off the Atlantic coast, is a quaint city fringed by the lush banks of the Lumber River. Nobody expected the river, which is usually a beautiful and calming element, to so forcefully exacerbate the effects of Hurricane Matthew.

A week prior to the hurricane, several unyielding thunderstorms drenched the area. When the storm was its strongest on Saturday, Oct. 8, 2016, the already saturated soil gave way to uprooted trees and toppled power lines. But, it was the record-high water levels from the Lumber and other rivers, along with subsequent flooding, that caused so much devastation. The storm took the lives of 28 people and displaced several thousand residents throughout the state.



While members of the Southeastern Health EM team ended up at different locations — Jenna Santiago-Wickey, DO, at a shelter and Elizabeth Gignac, DO, at the hospital with Krelin Naidu, DO, Gregory Capece, DO, and many other emergency medicine residents — they remained united in their efforts to support one another while caring for a community in crisis.

### Saturday, Oct. 8

#### Disaster Medicine at the Hospital

**Dr. Gignac:** Friday was the calm before the storm. But, as the rain picked up in the evening and into Saturday, dumping 9 inches within 24 hours, I realized the storm was more catastrophic than anticipated. Suddenly, water levels began to rise, making more roads impassable and knocking the power out at the hospital — fortunately, the generators kicked in and restored our power.

**Dr. Naidu and Dr. Capece:** As we walked into work on Saturday we realized the hospital was running on the backup generator, one of two we had. People began swarming the emergency department waiting room — some for refuge, others for serious medical aid. This quickly became an all-hands-on-deck operation. Initially, certain lights and electronics were disabled in favor of essential services. However, our progressive power predicament required the air conditioning be turned off as well. Despite the dimly lit ominous heat wave that surrounded us in the department, we dug deeper into our roles to provide the best care possible to our much-in-need patients.

The post-shift evening raised the difficult question of whether to brave



**Jenna Santiago-Wickey, DO**  
**Krelin Naidu, DO**  
**Gregory Capece Jr., DO**  
 EM Residents, Class of 2020  
 Southeastern Health  
 Lumberton, NC



**Elizabeth Gignac, DO, FACOEP**  
 EmCare Physician and Program  
 Director  
 Southeastern Health  
 Lumberton, NC

increasingly flooded roads to go home, or to be safe and practical within the confines of the hospital. Many residents of the emergency medicine, family medicine, and internal medicine programs decided to band together and spend the night in the hospital. Our program director, Dr. Elizabeth Gignac, was there at our side. The hospital graciously provided rooms and cots. We were truly “residents” of Southeastern Health.

#### Disaster Medicine at the Shelter

**Dr. Santiago-Wickey:** I was scheduled to ride with EMS the week of the hurricane. As the storm hit, callously washing away our plans, we all scrambled to help however we could. I made my way to St. Pauls High School, which was serving as a shelter when blocked roads made it impossible for me to reach the base. The first day was frustratingly chaotic. We had limited supplies — only stethoscopes and glucometers — and a small inventory of medication. Pushing through the disorder, we hurriedly implemented a system and began assessing and caring for patients.

**Sunday, Oct. 9 – Monday, Oct. 10  
At the Hospital**

**Dr. Gignac:** Sunday was eerily quiet and peaceful with sunny, cloudless skies. The water levels receded a little and the roads even opened up enough for some of us to return home. Just when we thought we had reached the end of our rather brief ordeal, Monday came, swelling water levels to record highs and vigorously wiping more defenseless residents out of their homes.

**Dr. Naidu and Dr. Capece:** Monday presented us with a new challenge: no more running water. The rumor was the levees had broken and some of the city water pipes had burst. Our EMS Dispatch was handling more than 200 calls at any given time; one by one, survivors started to arrive. Many of these individuals were rescued from their homes and were very ill. Some had run out of essential medications, including basic oxygen. Others had oxygen supplies, but no power to run their machines. We modified our fast track area as a temporary oxygen bar for patients struggling to breathe.

Meanwhile, in the emergency department, the temperature continued to rise. Certain blood chemistries were unable to be run because we lacked necessary water for the equipment. We were unable to get the most basic labs on the sickest of our patients. Our attendings urged us to provide the best care possible through thorough histories and physical exams, which utilized our most fundamental skills learned in medical school.

**At the Shelter**

**Dr. Santiago-Wickey:** We saw a variety of needs that included panic attacks, diabetes management, and dialysis treatment. One patient was overdue for a catheter change, and when we finally received a new one for him on the third day, we ended up using the locker room as a procedure room.

The fear, lack of information, and general distress contributed to a lot of frustration among hurricane victims and, in turn, made the atmosphere extremely tense. Some evacuees criticized our zero-tolerance policy for narcotics.

Meanwhile, others saw our presence as an opportunity to have an exam, requesting to have their blood pressure and heart rate checked.

Some of our most pressing concerns centered around so many people living in such close quarters, the lack of hygiene, the risk of contamination, and the potential for a flu outbreak. Nearly 400 people stayed in the school that first week, filling the gymnasium with row upon row of cots.

**Tuesday, Oct. 11 – Thursday, Oct. 13  
At the Hospital**

**Dr. Gignac:** Tuesday was one of the most challenging days. We did not have any water, which made it impossible to flush toilets and cook as well as perform

dialysis and other procedures and tests. Additionally, the lack of air conditioning sent inside temperatures to a sweltering 90 degrees.

**Dr. Naidu and Dr. Capece:** We were tired. Many residents, nurses, and even attendings had to spend multiple nights away from the comfort of their homes and families. We had no access to showers and limited use of the restrooms. We were still running on limited power and we were told the water pipes were still attempting to be fixed.

We looked out the window and saw numerous tractor trailers pulling into the parking lot. Two trailers with generators and another team of vehicles, Carolinas MED-1 Mobile Hospital Unit, had arrived



with much-needed aid. This mobile hospital and command center offered coordination and relief in our resource-depleted crisis.

**Dr. Gignac:** The self-sustaining mobile hospital with 14 beds and a two-room suite for the ICU parked outside the ED and took some of our low acuity patients. Then, on Wednesday, as if working conditions weren't difficult enough, we occasionally experienced complete blackouts. The generators sent black smoke into the air, foreshadowing their total failure.

**Dr. Naidu and Dr. Capece:** Code Black - our generators had failed. Our greatest concern was the ICU. These patients were the sickest in the hospital, many of whom required mechanical ventilation, now not an option. Ambu-Bags were attached to all endotracheal tubes, and hand ventilation was required to keep many of our patients alive. The staff all took turns ensuring every individual received the appropriate care with the limited resources available.

**Dr. Gignac:** That short time during the blackout on Wednesday felt like an

eternity. We all felt a little helpless, when we only had 1 headlamp that a colleague used to check on patients. It was at that point that leadership strongly considered closing the hospital. Then, as if on cue, the emergency generators kicked in, enabling us to remain functioning.

**Dr. Naidu and Dr. Capece:** Our objective at this point was to transfer all critically ill patients, especially those requiring ventilator support to our neighboring hospitals. In the dark, we were communicating with medical intensive care units and emergency departments at UNC, Duke, and Cape Fear Valley. Although the situation seemed like it was out of control, as emergency residents and attendings, we felt comfortable enough to handle the stress. We were in our element.

Over the next few hours we cleared the ICU as helicopters and ambulances safely transferred patients. It was amazing to see so many diverse staff members from every department coming together in a cohesive force to do what was right for each and every patient.

**Dr. Gignac:** We evacuated the 8

patients from the ICU; however, more people who were oxygen-dependent, chronically ill, and debilitated started trickling into the ED. We were all a little perplexed because, while we saw people coming in, our patient count remained below the daily average of 180. On Thursday, we also gained some much-needed access to pressurized water via several tanker trucks that connected to the hospital's plumbing. Soon, the blackouts ceased and conditions at the hospital began to stabilize.

Still, some roads remained closed, and it was heartbreaking to see so many hurricane victims, often in disbelief and without anywhere to go, seek shelter at the hospital. As hard as it was to turn them away, we had to be very selective and only admit those who met strict criteria. Managing our resources and our patients' expectations as well as sending victims to safe, alternative locations, turned out to be one of our most difficult challenges.

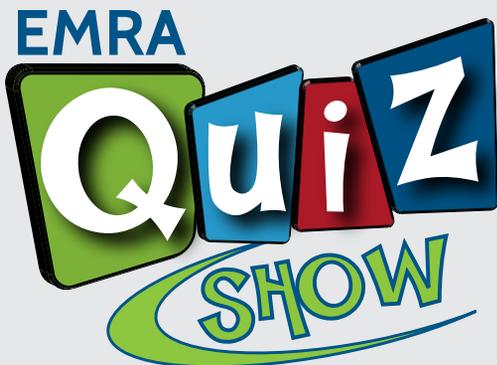
#### At the Shelter

**Dr. Santiago-Wickey:** Fortunately, I was able to return home every day to the

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warm embrace of my husband. But, when the night fell quiet, I could not help but think about those who were not as lucky, particularly the children. Volunteers entertained the kids at the shelter with music and games, yet the kids had no idea this was not just a temporary distraction, but their indefinite new normal.

Being from Long Island, I was accustomed to dealing with hurricanes, but I never imagined one would make it so far inland and cause so much damage.

### The Aftermath

**Dr. Santiago-Wickey:** While riding with EMS the second week I was exposed to even more of the storm's devastating consequences. We saw people still living in their shattered homes with trees collapsed on top of them. We were also on-scene when firefighters extricated a body from a car that had been submerged in 10-15 feet of water. While they suited up in jumpers, many of us rubbed Vicks VapoRub under our noses in an attempt to mitigate the smell of the decomposing body. It was by far the worst event I had ever experienced. Nevertheless, it taught me not to take anything for granted.

**Dr. Gignac:** As time passed, people began returning home to face the daunting cleanup process. During this phase, we saw more incidents of carbon monoxide poisoning, gastrointestinal issues and skin infections from exposure to toxic substances. Water levels remained high for about a week, and crime incidents increased. Now, months have passed, and the community is still adjusting.

### Lessons Learned

**Dr. Gignac and Dr. Santiago-Wickey:** Before the hurricane, we had disaster response and relief plans in place. Moreover, as emergency clinicians, we are always mentally prepared for the unknown. However, we learned that while you can prepare to a certain extent, nobody is truly capable of predicting or being fully prepared for what may happen during a storm. You just have to keep a clear mind, communicate effectively, and find solutions – no matter how challenging the circumstances.

Our colleagues handled the situation with incredible professionalism and

**It was heartbreaking to see so many hurricane victims, often in disbelief and without anywhere to go, seek shelter at the hospital.**

resolve. Hurricane Matthew taught us just how extraordinary and brave our team is and how proud we are to be a part of such a strong community.

**Dr. Naidu and Dr. Capece:** As emergency medicine residents, this experience was truly humbling. Many people lost everything – cars, homes, and more. No one would have expected Hurricane Matthew to have had this profound effect on Lumberton. It is simply amazing the support that came from the local community, the state, and even the federal government to help us through this tragic period. The spirit of our town was struck hard, but Lumberton and its people will endure. ★

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# Passport to Health



**Michael Holdsworth, MD**

Emergency Medicine/Pediatrics Residency  
University of Maryland Medical Center  
Baltimore, MD

**B. Barrie Bostick, MD**

Emergency Medicine/Pediatrics Residency  
University of Maryland Medical Center  
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## Challenges of Caring for Undocumented Children in the Emergency Department

### Introduction

An undocumented immigrant is an individual who enters the United States without inspection by U.S. Citizenship and Immigration Services, or who enters with expired legal status.<sup>1</sup> In 2014, there were an estimated 11.1 million undocumented immigrants living in the U.S.; approximately 1 million of those were children. An additional 4 million children were characterized as “citizen children” – those born to undocumented parents while in the United States.<sup>2,3</sup>

While some states do offer health care coverage to undocumented children, the federal government does not. **For many undocumented children, the first visit to an emergency department may represent his or her first encounter with the US healthcare system.** It gives emergency providers a

unique opportunity to provide more than just “safety net” care.

### Challenges for Undocumented Children

Undocumented families comprise a particularly vulnerable population. They face challenges not only in navigating the US healthcare system, but in breaking through cultural and language barriers, dealing with the consequences of undiagnosed chronic disease, and suffering from mental health conditions such as depression or posttraumatic stress disorder.<sup>4-6</sup>

**The greatest concern for the undocumented immigrant is that of deportation,** which can negatively impact the doctor-patient relationship due to lack of willingness to disclose a complete medical history, or failure to present to a physician until a true

emergency presents.<sup>7</sup>

While legal immigrants (including naturalized citizens, lawful permanent residents, refugees, and asylees) will have completed at least a requisite screening prior to entrance, illegal immigrants may have received little to no primary care prior to arrival.

Children may additionally suffer from malnourishment due to diet, parasitic infection, or environmental exposure. They may have experienced trauma, torture, or suffering during or prior to their journey. Indeed, in some instances, physicians have played a role in such torture or abuse, further endangering an already fragile doctor-patient relationship.<sup>5</sup>

### Challenges for Providers

It is imperative that emergency medicine providers make every effort to establish trust and rapport with immigrant

families, particularly since it is often their only interface with the health care system. Whenever possible, interpreters should be used, which can present its own set of challenges.<sup>7</sup> For example, language barriers have been shown to increase length of stay and decrease threshold for imaging within the emergency department.<sup>8,9</sup> In addition, certain dialects may not be available for a given interpreter service.

Beyond language barriers, cultural differences can present a challenge to providers because of alternative healing practices, poor health literacy, different interpretation of the provider-patient relationship, and gender roles. Therefore, a provider who is able to build rapport in an initial encounter may better be able to ease a family's transition into a medical home.

### Recommendations for Providers

The Centers for Disease Control and Prevention (CDC) makes recommendations for a medical screening exam on all immigrants and refugees.<sup>7</sup> Of particular importance for children presenting to the emergency department are questions pertaining to vaccination status, nutrition, environmental exposure, history of trauma, and mental health.<sup>4-6</sup>

While families from South America, for example, are traditionally very supportive of **vaccination**, immunization requirements vary widely. A list of standard immunizations by country is available on [cdc.gov](http://cdc.gov), but it is important to note that documentation of vaccinations is the only reliable means of

ensuring completion.<sup>1,10</sup> While vaccination requirements go beyond the purview of most ED encounters, it does provide insight into which communicable diseases a child may be at risk for contracting or transmitting.

**Environmental exposures, poor nutrition, and infectious diseases** also play an important role in evaluation. Malnourished children may appear younger than stated age due to short stature. Chronic lead or copper exposure may lead to significant anemia or hepatic failure, respectively. Depending on presentation, a differential for infectious disease must include conditions such as tuberculosis, HIV, Hansen's disease (leprosy), syphilis, malaria, and typhoid. Based on presentation, **additional workup as recommended by the CDC may include: a CBC, lead level, tuberculosis screen, stool for O&P and giardia, a newborn metabolic screen, and an HIV test.**<sup>1</sup>

**Trauma** may also play an important role in presentation. This population is at risk for infected or poorly healed wounds, malunion or nonunion of fractures, or abuse. A provider should be looking for evidence of prior abuse or trauma, such as characteristic scar patterns from whipping, burn patterns, or female genital mutilation.<sup>4,6</sup>

**Mental health** is an often-overlooked issue. Both undocumented and documented immigrants are at very high risk of posttraumatic stress disorder (PTSD) and depression.<sup>9</sup> Adolescents in particular may turn to their peer groups or run away from home, placing them at an additional risk for substance abuse, behavioral issues, and trauma.<sup>1</sup>

In children presenting with vague somatic complaints or with histories that don't quite fit the presentation, abuse should be high on the differential. **A provider should also consider sex trafficking** and pay careful attention to child-caregiver dynamics. Any suspicion should prompt an assessment without the caregiver present.

### Available Resources for Patients

Once an acutely ill child has been stabilized, or the family of a not so acutely ill child has been reassured, the next step for a family is establishment

of a medical home, or a place that can coordinate long-term care. **There are approximately 1,200 federally qualified community health centers nationwide.** They are funded in part by federal grants and provide care to all comers, regardless of immigration status. In addition, many communities have clinics and health centers that accept undocumented families without pay or with payment on sliding scale. While undocumented families are not able to independently purchase insurance on the current health exchange, they may do so directly through a broker. However, this is an expensive option and often beyond the means of most families.

There are a number of counties that provide insurance at low or no cost to immigrants, regardless of immigration status. This includes certain counties in Texas, Massachusetts, California, Nevada, Illinois, Maryland, Georgia and New York.<sup>8</sup> California allows all undocumented children under the age of 19 to receive affordable care under the Medi-Cal program.<sup>11</sup> **Of course, it is unclear how any or all of this will change with the current political environment.**

Referrals for subspecialty care can be equally, if not more, challenging. As with primary care, referrals for undocumented children will vary from state to state. A provider should be aware of the options within his or her community and make use of social work if available. Obtaining a reliable contact number for follow up and provision of resources is very important.

### Conclusion

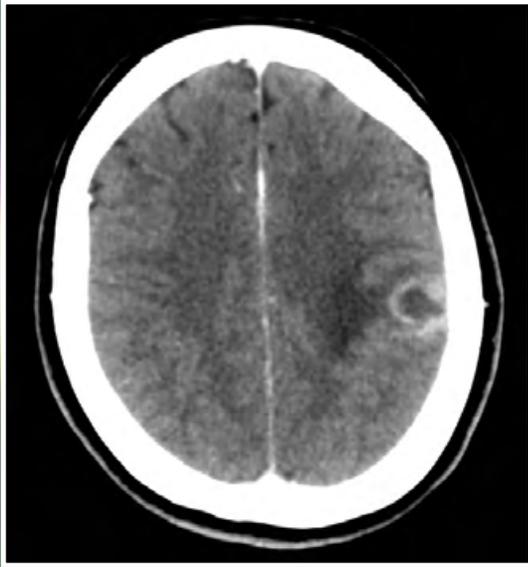
One of the greatest privileges of emergency medicine is the provision of care to all.

Whether by personal ideology or federal mandate, we take pride in our ability to care for all patients who present to the emergency department: anyone, anywhere, anytime. In caring for undocumented immigrants, particularly for their children, we can offer good treatment, safety, and the opportunity for entry into a medical home. While many undocumented immigrants are hesitant to seek medical help, it is our duty to provide compassionate and culturally competent care. ★

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**In 2014, there were an estimated 11.1 million undocumented immigrants living in the U.S.; approximately 1 million of those were children.**

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**FIGURE 1.** CT scan revealing cerebral edema and ring enhancing lesion in the left parietal region.

# CNS Toxoplasmosis



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**A** 26-year-old Spanish-speaking female patient presents to the emergency department (ED) with right-sided weakness after a witnessed seizure. The patient is postictal, combative, and has right-sided neglect. The patient's husband reports that she had been complaining of headaches and subjective fevers for the past day. Vital signs are as follows: Heart rate 167 beats per minute, blood pressure 119/80 mmHg, respiratory rate 38, oxygen saturation 95%, temperature 37 Celsius. Laboratory studies are remarkable for a glucose of 129, a negative urine pregnancy test, a negative toxicology screen, and a lactic acid of 5.4. HIV screening test ordered in the ED is positive. Chest radiograph shows bilateral lung infiltrates. Computed tomography (CT) reveals cerebral edema and a ring enhancing lesion in the left parietal lobe, consistent with toxoplasmosis (Figure 1).

## Background

Toxoplasmosis is an infection caused by the single cell parasite *Toxoplasma gondii*. It is typically acquired through ingestion of oocysts, usually from soil or cat litter contaminated with feline feces. It can also be acquired via undercooked meat from an infected animal. In the United States, it is estimated that 11 percent of people aged 6 to 49 are seropositive for *T. gondii*, although the vast majority are completely asymptomatic.<sup>2</sup> In comparison, toxoplasmosis of the CNS occurs in up to 40 percent of all patients with AIDS, and it is the most common opportunistic infection to cause encephalitis or focal intracerebral lesions.<sup>1</sup> It is most commonly associated with a CD4 count of <100 cells/mm<sup>3</sup>.

CNS toxoplasmosis in the immunocompromised host can present in multiple ways. Frequently, the earliest symptoms are vague and may emerge as a minor headache or fever. More serious complications such as seizure, hemiparesis, aphasia, ataxia and even cranial nerve palsies, may develop.<sup>3</sup> These serious complications are often the impetus for seeking immediate medical evaluation. While CNS toxoplasmosis in HIV positive patients is quite common, the differential must include brain abscess (fungal, parasitic, or bacterial), neoplasm, progressive multifocal leukoencephalopathy (PML), mycobacterial infection, viral encephalitis (CMV, HSV, etc), and stroke.<sup>4</sup>

## Diagnosis

Proper diagnosis requires a corresponding clinical syndrome in the setting of a CT or MRI that shows ring enhancing lesions.<sup>5</sup> Serologic testing is also often used to clinch the diagnosis. The vast majority of patients with CNS toxoplasmosis are seropositive for anti-toxoplasma IgG antibodies. However, a small portion of these will not be positive. In these patients, a biopsy may be needed to provide definitive diagnosis.<sup>1</sup>

Although lumbar puncture (LP) is not required for diagnosis, it is recommended to evaluate for possible co-morbidities in the immunocompromised patient, or to confirm diagnosis in a patient whose IgG

serum antibodies are negative. LP should be deferred in those cases wherein lies concern for herniation secondary to elevated intracranial pressure.

## Treatment

Treatment of CNS toxoplasmosis is relatively straightforward. If the patient is critically ill, resuscitation and stabilization is paramount (secure airway, halt seizure activity, treat suspected sepsis, etc.). Specific treatment after onset of neurologic symptoms includes a combination of pyrimethamine, folinic acid, and sulfadiazine. Trimethoprim-sulfamethoxazole may be used as an alternative regimen. For those allergic to sulfa type medications, clindamycin may be substituted for sulfadiazine. Primary treatment continues for about 6 weeks and is followed by long-term suppressive therapy until CD4 counts are persistently >200 cells/mm.<sup>3</sup> Meanwhile, the patient should either be started on or maintained on highly active antiretroviral therapy (HAART).<sup>3,4</sup>

For those patients presenting with seizure, treatment with antiepileptic drugs (AEDs) is an important consideration. Duration of treatment

with AEDs generally lasts 3-6 months after initial presentation, but can be prolonged if chronic seizures develop. In choosing the appropriate AED, the goal is to limit the interaction with HAART medications. Older generations of AEDs tend to induce enzymes that decrease the efficacy of HAART. Newer AEDs, such as levetiracetam, have limited medication interactions, lower side effect profiles, and lower probability of toxicity.<sup>6,7</sup> Seizure prophylaxis is not needed in HIV positive patients with *T. gondii* coinfection if the patient has not had prior CNS involvement.<sup>3</sup>

## Case Conclusion

The patient was admitted to the intensive care unit for two days and was started on trimethoprim-sulfamethoxazole, HAART therapy, and an oral anti-epileptic drug. Serology was positive for IgG toxoplasma antibodies. CSF was negative for neurocysticercosis antibodies and mycobacteria. Sputum samples were positive for *Mycobacterium avium* complex. She was ultimately discharged from the hospital in good condition and continues to do well on her current regimen. ★

**In the U.S., it is estimated that 11% of people aged 6-49 are seropositive for *T. gondii*, although the vast majority are completely asymptomatic.**



# CAN'T MISS KILLER

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## The Role of Point-of-Care Ultrasound in Diagnosing Acute Aortic Dissection

**A** 69-year-old female with a history of hypertension and abdominal aortic aneurysm (AAA) presents to the emergency department (ED) with syncope, altered mental status, and chest pain. A family member heard a thump in an adjacent room and discovered her unresponsive on the floor. Upon EMS arrival, she is initially hypotensive with systolic blood pressure around 70 mmHg that responds to fluids en route. Initial ED vitals show HR 58, RR 24, BP 110/37, T 37.5. She is somnolent but able to awaken, answer questions, and follow commands. An inferior ST-elevation myocardial infarction (STEMI) is confirmed on ECG. Given her unusual constitution of signs and symptoms a point-of-care ultrasound is performed to further investigate.

A type A aortic dissection is quickly confirmed with a bedside

echocardiogram, displaying a dilated aortic root with dissection flap extending proximally and distally with severe aortic insufficiency. CT surgery and cardiology are urgently consulted, and the patient is taken directly to the operating room for definitive repair.

### Background

Thoracic aortic dissection is an uncommon though catastrophic condition that classically presents with chest pain and hemodynamic compromise. The pathophysiology involves a tear in the aortic intima, usually proceeding degeneration of the aortic media. A false lumen is created that may extend proximally, distally, or both, as blood passes into the aortic media through the tear. Rupture of the dissection into the pericardium, dissection into the aortic valvular annulus, coronary artery

dissection leading to acute myocardial infarction, or organ failure due to abdominal aortic branch obstruction usually result in death.

Risk factors for aortic dissection include hypertension, collagen disorders, pre-existing aortic aneurysm, bicuspid aortic valve, aortic instrumentation or surgery, coarctation of the aorta, and pregnancy.

Several different classification systems have been used to describe aortic dissections; however, the Stanford classification is the one most frequently used by emergency physicians. A thoracic aortic dissection is labeled a Stanford type A dissection if there is any involvement of the ascending aorta, or a Stanford type B if the dissection is restricted to the descending aorta.

Signs and symptoms are dependent on the extent and location of dissection

and can include chest or back pain, hypertension or hypotension, peripheral pulse deficit, new murmur, focal neurologic deficit, and syncope. Mental status changes and hypotension are much more likely to occur in a type A dissection.

### Diagnosis

While type B aortic dissections are classically managed medically, type A dissections are considered a surgical emergency, with mortality rapidly increasing 1-2% per hour for the first 48 hours — leading to a 50% mortality rate after 48 hours.<sup>1</sup> Therefore, rapid diagnosis is paramount. CT angiography is the gold standard and most utilized imaging modality. In an unstable patient, however, transesophageal echocardiogram (TEE) is recommended at bedside. (See *The UtiliTEE of Ultrasound in Cardiac Arrest. EM Resident. 2016;43(5):16-17.*) This of course is not without its downsides, including the need for procedural sedation during a potentially tenuous clinical condition as well as the availability of the specialized equipment and staff necessary to perform the procedure.

Transthoracic echocardiogram (TTE) is a valuable and underutilized bedside tool that can provide immediate information in patients presenting with suspected aortic dissection. It is safe, portable, rapid, and readily available, making it an ideal screening tool to evaluate for the presence or absence of features that need timely and definitive intervention. **TTE is especially useful in identifying pericardial effusion from proximal dissection, severe aortic root dilatation, regional wall motion abnormality, aortic regurgitation, or intimal aortic flap.**

TTE images of the ascending aorta may detect an intimal flap that would appear as a hyperechoic linear structure within aortic lumen that moves with each heartbeat (Figure 1). Ascending aortic images can be obtained in parasternal long axis (PSLA) and suprasternal notch (SSN) views (Figures 2,3). Despite a low sensitivity, TTE carries a high specificity for ruling in the diagnosis.

One commonly used measurement that helps stratify a patient's risk for

aortic dissection in the case that the intimal flap is not detected is the aortic root measurement (Figure 4). Patients with thoracic aortic root aneurysms carry a much higher risk for dissection. The parasternal long axis is the preferred view for aortic root measurement and generally correlates with measurements on CTA. The aortic root should be measured from outside wall to inside wall at its widest point visible during diastole, usually across the sinuses of Valsalva. Measurements less than 4 cm are considered normal, 4.0 to 4.5 cm borderline, and greater than 4.5 cm aneurysmal.<sup>2</sup>

### The Evidence

The sensitivity of TTE is higher in proximal (versus distal) aortic dissections, which are generally the most emergent, high-risk cases and therefore the ones in need of a prompt bedside imaging modality.<sup>3</sup> A recent retrospective study including 178 patients referred to cardiac surgery for type A dissection showed that TTE was an equally reliable method for measuring the aortic arch when compared to CT for diagnosis, with the advantage of providing other clinically important information including cardiac tamponade, severe aortic dilatation, and aortic regurgitation.<sup>4</sup>

Unfortunately, despite a high number of case reports in the literature citing anecdotal diagnosis of dissection with point-of-care TTE, few high-quality studies within the emergency department population currently exist.<sup>5,6</sup> The increasing number of emergency medicine physicians trained in point of care ultrasound, combined with its increased availability as a diagnostic modality, makes this an area ripe for future exploration and research.

### Bottom Line

While TTE does not replace TEE, CT, or MR angiography, it is a safe and effective early adjunct for timely diagnosis and management of acute aortic dissection. ★

References available online.

**FIGURE 1. Sagittal view of aorta with dissection flap**



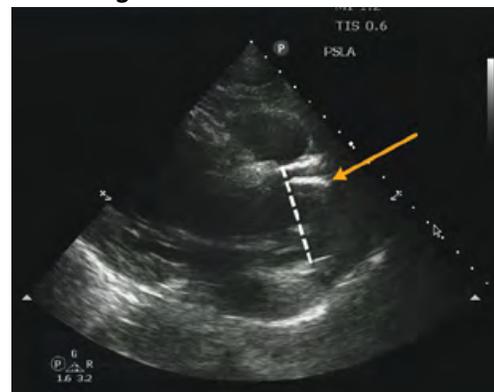
**FIGURE 2. PSLA with dissection flap**

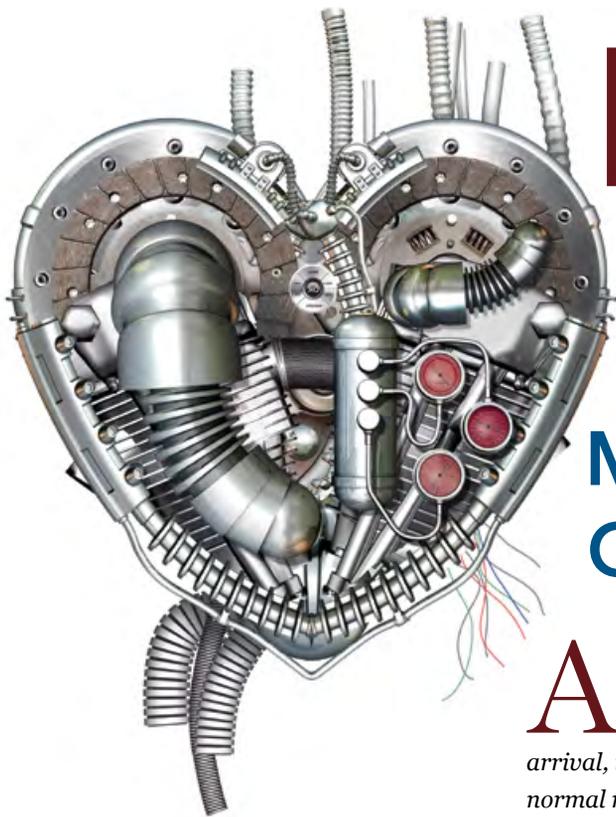


**FIGURE 3. An example of suprasternal sternal notch with a normal aortic arch**



**FIGURE 4. PSLA with aortic root dilatation measuring 4.7-5.2 cm**





# Poisoned Pump

## Management of Calcium Channel Blocker Toxicity

**A** 46-year-old male with a history of hypertension presents after an intentional overdose of 500 mg of amlodipine 1 hour prior to arrival. Initial mentation and vitals are within normal limits, but 45 minutes after arrival, the patient becomes bradycardic and hypotensive. He continues to have normal mentation and his initial laboratory studies are largely unremarkable. **How would you proceed?**



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### Pharmacology

Calcium channel blockers (CCB) act by inhibiting L-type voltage gated calcium channels preferentially in the myocardium and vasculature. The dihydropyridine class of CCBs, which include nifedipine, nicardipine, and amlodipine, are predominantly peripheral vasodilators with minimal cardiac myocyte depression. Non-dihydropyridines such as verapamil and diltiazem, on the other hand, bind cardiac myocytes preferentially, diminishing cardiac conduction and contractility with lesser effect on peripheral vasculature. At therapeutic doses, these generalizations hold true; however, in large overdoses, there is decreased selectivity for peripheral and myocardial channels among the CCB classes.<sup>1,2</sup>

### Presentation

Due to the mechanism of cardiovascular toxicity, CCB poisoned patients will primarily present with bradycardia and hypotension. CCBs are also known to decrease pancreatic insulin secretion and increase insulin resistance, frequently manifesting as

hyperglycemia.<sup>3</sup> Electrocardiogram may demonstrate reflexive sinus tachycardia at low dose ingestions; at larger doses, sinus bradycardia, varying degrees of heart block, or sinus arrest with junctional rhythm are more common.<sup>1</sup> **Any neurologic, pulmonary, or gastrointestinal symptoms can and should be attributed to systemic hypoperfusion.**<sup>1,2</sup> For example, one of the hallmarks of CCB toxicity is that the patient will maintain normal mentation despite extreme hypotension. This can falsely reassure the provider into thinking the patient is not as sick as he or she actually is.

### Treatment

Based on the severity of the ingestion, the following treatments should be considered:

**Activated charcoal** administration has never shown a survival benefit when used for ingestions, but could be considered in a large overdose taken less than one hour prior to arrival.<sup>4</sup>

**Calcium salts** such as calcium gluconate and calcium chloride work

to improve cellular contractility by increasing the concentration gradient of calcium in the extracellular fluid, driving calcium intracellularly via unblocked channels.<sup>5</sup> However, remember that calcium (as with many of these treatment options) works upstream of the calcium channel, and the effect of calcium salts has shown to be variable.

**Glucagon** increases cyclic adenosine monophosphate (cAMP) production at the myocardium, which can result in positive inotropic effects.<sup>6</sup> The dose is higher than the usual 1mg dose given for esophageal food impaction. Start with a 3-5 mg intravenous bolus and re-bolus as needed up to a maximum of 15 mg.<sup>5</sup> If a response is noted, a continuous infusion can be initiated.

**Atropine** may be considered for initial management of bradycardia; however, this is rarely effective and alternative interventions should be considered.<sup>5</sup>

**Transvenous and transcutaneous pacing** are generally reserved for persistent bradycardia less than 30 bpm. While pacing can improve cardiac output, it frequently is not sufficient to overcome the peripheral vasodilation of toxic ingestions.<sup>2</sup> In the setting of refractory hypotension, vasopressors must be

considered. Consensus opinion suggests **norepinephrine** as the optimal bridge due to its positive effect on inotropy, chronotropy and vasocontractility.<sup>7</sup>

**High dose insulin euglycemic (HIE)** therapy should be utilized in patients with continued depressed myocardial function as evidenced by hypotension, bradycardia, and decreased contractility on bedside ultrasound. HIE has a positive inotropic effect on cardiac muscle and also increases the carbohydrate uptake by cardiac myocytes, which is the preferred energy substrate in high stress states.<sup>3</sup> Anticipate supportive staff questioning your dosing calculations. Start with a 1 unit/kg bolus of regular insulin followed by 0.5 units/kg/hr infusion, increasing dose to effect. The patient will require pretreatment and continuous IV infusion with dextrose and close monitoring of serum glucose and potassium is absolutely necessary.<sup>5</sup>

**Intravenous lipid emulsion** has shown promise in lipid soluble toxicities. The proposed mechanism is that a “lipid sink” is created by the formation of micelles in circulation that can sequester hydrophobic compounds.<sup>1</sup> The usual starting dose is 1.5 mL/kg up to a maximum 100 mL bolus of a 20% lipid solution followed by 0.25mL/kg/hr infusion.<sup>2</sup>

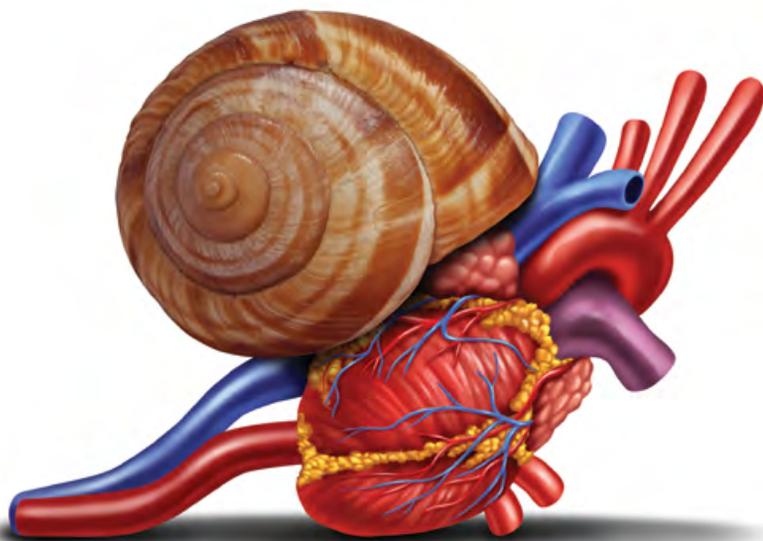
There have been case reports documenting improvement

in hemodynamics following administration of **methylene blue** after minimal response to other therapeutic interventions in multiple shock states, including septic, anaphylactic, and toxin induced shock. Methylene blue functions by inhibiting guanylate cyclase, decreasing downstream nitric oxide release. The end result is inhibition of vasodilation.<sup>8</sup>

**Extracorporeal membrane oxygenation (ECMO)** should be reserved and considered for only the most critically ill patients with high probability of death despite the aforementioned aggressive therapies.<sup>9</sup>

### Case Review

The patient was admitted to the intensive care unit with borderline hypotension but normal mentation after receiving multiple calcium gluconate boluses and glucagon in the emergency department. A calcium gluconate infusion was initiated at 1 mL/kg/hr. HIE therapy was titrated to over 600 units regular insulin/hr. Norepinephrine and vasopressin infusions were increased to maximum doses. Methylene blue was used as a last resort without effect. The patient was evaluated for ECMO but deemed a poor candidate. The patient died within 36 hours of presentation. ★



**Any neurologic, pulmonary, or gastrointestinal symptoms can and should be attributed to systemic hypoperfusion.**

# “I feel fine!”

## Approach to Abdominal Pain in the Geriatric Patient

**Y**ou are working in the emergency department on a pleasant Sunday afternoon when the paramedics wheel in an 85-year-old gentleman who has been having diffuse abdominal pain for 7 days. His daughter came to visit this afternoon and noticed that her father was in pain, so she called the ambulance. He doesn't feel like he needs to be here and would prefer to go home. He does admit to having diffuse abdominal pain for the past week, but denies any associated symptoms. He takes four pills but he's not sure what they are, one for high blood pressure and

one for cholesterol, maybe. He usually gets his care at Veterans Affairs, and therefore you have no records in your system. On exam, he is well-appearing and afebrile with mild tenderness to palpation of the right lower quadrant. His workup is remarkable for a white blood cell count of 14,000 and pyuria.

Should you treat this patient for a UTI and call it a day? What is your next step?

### Background

Geriatric patients, generally defined as persons age 65 and older, comprise a specific, vulnerable, and ever-growing

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population within the emergency department. Frequently, care of these patients requires modification of existing diagnostic and treatment paradigms.

In particular, older patients presenting with abdominal pain can be challenging for a few reasons. First, **the physical exam may be falsely reassuring.** For example, older patients with infections do not necessarily have fevers (Figure 1).<sup>1</sup>

Even in the face of a serious intra-abdominal pathology, they are equally as likely to be normothermic or hypothermic as hyperthermic.<sup>2</sup>

Second, medications such as beta-blockers or calcium channel blockers may mask tachycardia.

Third, peritoneal symptoms are much less common, possibly because aging changes the way elderly patients experience pain.<sup>3</sup> In one study of older patients, 80% of geriatric patients with *perforated* peptic ulcers did not have peritonitis.<sup>4</sup>

Finally, older patients often have multiple comorbidities, which can complicate diagnostic processes.

### Diagnostic Considerations

It may be helpful to think about a few idiosyncratic ways in which intra-abdominal pathology presents differently in older patients.

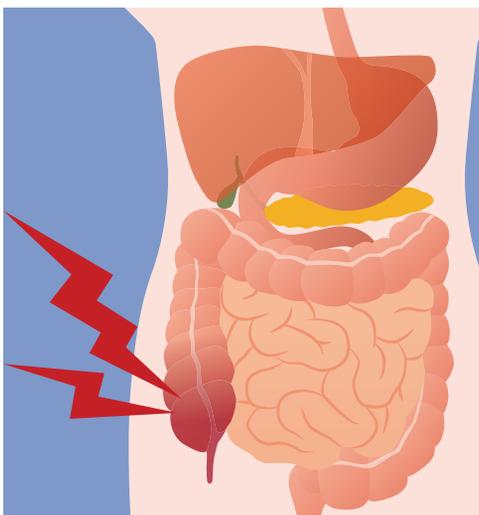
- **Appendicitis**

Appendicitis should be on your differential for geriatric patients presenting with abdominal pain, since it is **the most commonly missed**

## Appendicitis

### By the Numbers

In geriatric patients, appendicitis is misdiagnosed 54% of the time.<sup>2</sup>



- Only 23% of patients have fever<sup>6</sup>
- Up to 25% may not have any leukocytosis<sup>4</sup>
- Up to 40% have pyuria, frequently leading to anchoring and misdiagnosis<sup>7</sup>
- 50% have perforated by the time they reach the OR<sup>4</sup>
- 25% present after 3 days of symptoms<sup>5</sup>
- 5-10% present after 1 week of symptoms<sup>5</sup>

Patients over 65 account for only 14% of all appendicitis cases, but they account for 50% of all deaths from this conditions.<sup>3</sup>

**diagnosis in older patients** and carries high morbidity and mortality.

- **Abdominal Aortic Aneurysm (AAA)**

The most common diagnosis in missed ruptured AAA is renal colic.<sup>6</sup> Recall that a AAA can rupture into the retroperitoneum and tamponade, resulting in normotension. In addition, a AAA can irritate the ureter and cause microscopic hematuria. The classic combination of flank pain and hematuria in older patients should prompt consideration of AAA in addition to nephrolithiasis. In general, a new diagnosis of “kidney stones” in a patient older than age 50 should trigger imaging of the aorta before a patient is discharged from the hospital.

- **Mesenteric Ischemia**

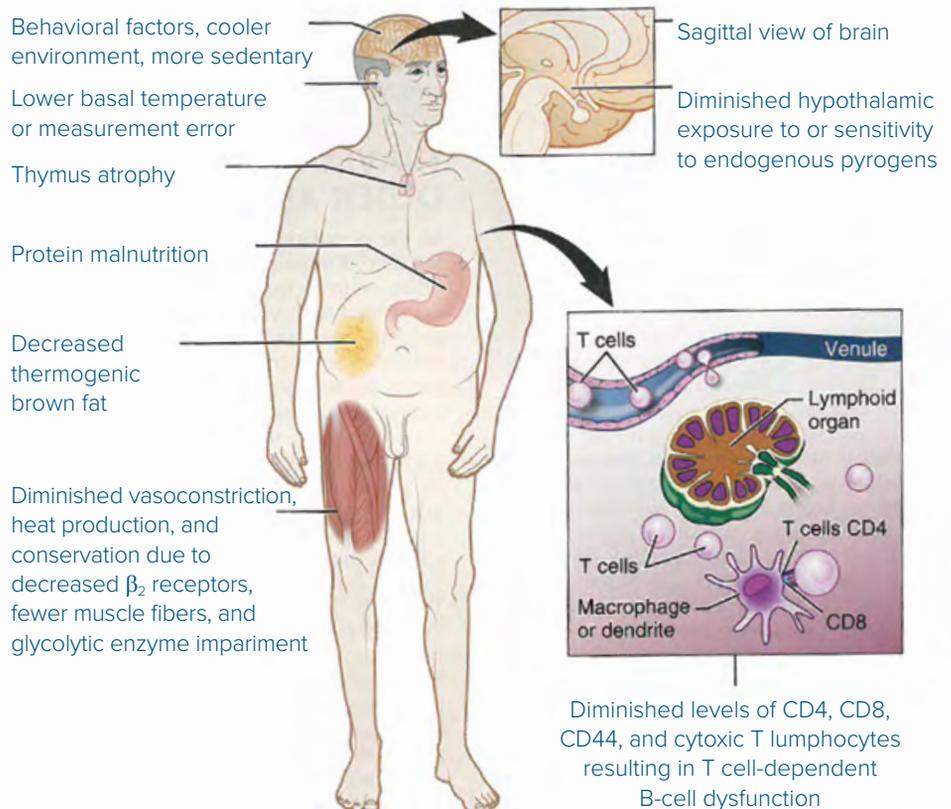
Another rare condition that can be challenging to diagnose in this population is mesenteric ischemia.<sup>7</sup> Perhaps not intuitively, the most common diagnosis in missed mesenteric ischemia is gastroenteritis. As bowel becomes ischemic, “gut emptying” can occur, causing nausea, vomiting, and diarrhea. As with younger patients, consider investigating serious pathology before anchoring on a diagnosis of viral infection. Likewise, an elevated lipase or amylase should not immediately point towards the direction of pancreatitis, as these lab values may also be elevated in mesenteric ischemia.

Atrial fibrillation is, of course, a risk factor for mesenteric ischemia, but so are other disorders leading to left ventricular stasis, such as ventricular aneurysm from a prior myocardial infarction. Although mesenteric ischemia can be challenging to diagnose, the high mortality rate should prompt thoughtful consideration in any older patient presenting with abdominal pain.

- **Peptic Ulcer Disease**

While peptic ulcer disease (PUD) is associated with less morbidity than mesenteric ischemia, it is also far

**FIGURE 1. Factors associated with diminished older adult response to thermoregulation and immune response.**



(From Katz ED, Carpenter CR: Fever and immune function in the elderly: In Meldon SW, Ma OJ, Woolard R, editors: Geriatric emergency medicine, New York, 2004, McGraw-Hill, Figure 9-1, p.59).

too often missed in older patients.

In this patient population, the first presentation of PUD is often an acute complication of the disease, such as perforation.<sup>8</sup> Serious pathology, including peritonitis, can have a relatively benign exam. As previously stated, in one study, only 20% of geriatric patients with perforated peptic ulcers actually had peritonitis.<sup>4</sup> Moreover, plain films are often non-diagnostic, as demonstrated in one study that found a whopping 39% of patients with perforated peptic ulcer without evidence of pneumoperitoneum on plain films.<sup>9</sup> CT is therefore the imaging modality of choice.

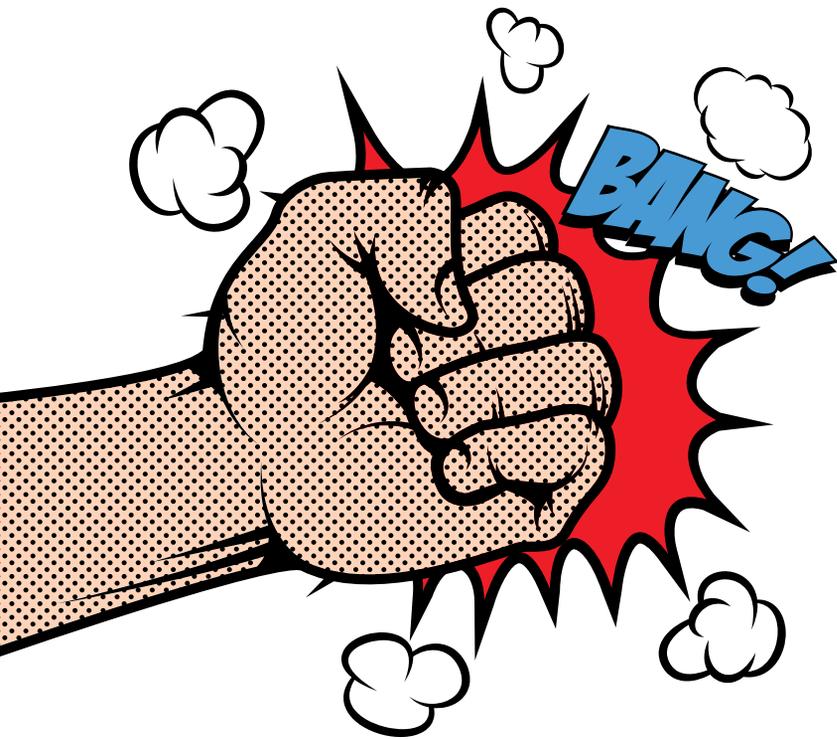
*You decide to order a computed tomography (CT) scan of your patient's abdomen and pelvis, which reveals acute appendicitis. Surgery is consulted and the patient is added on for the operating room.*

## Conclusion

In general, the approach to abdominal pain in geriatric patients requires careful consideration of the physiologic changes associated with aging, differences in pain perception, and the confounding effects of medical comorbidities and polypharmacy.

## Want to Know More?

If interested in learning more about geriatric emergency medicine, please visit [www.gempodcast.com](http://www.gempodcast.com), a blog/podcast devoted to older adult emergencies. Another great resource is [www.pogoe.org](http://www.pogoe.org), which is a free collection of expert-contributed geriatrics educational content for both educator and learners. We would also encourage you to join SAEM's Academy of Geriatric Emergency Medicine, as well as ACEP's Geriatrics Section at [www.acep.org/geriatricsection](http://www.acep.org/geriatricsection). ★



# Fight Bites

## AND OTHER HUMAN BITE INJURIES

**A** 27-year-old male presents to the emergency department complaining of purulent drainage from a wound to his right hand. He says that he was in a fight about one week prior and punched another individual in the mouth during a night of drinking. His vital signs are within normal limits. On exam, he is noted to have a 1 cm laceration over the fourth metacarpophalangeal joint. There is localized erythema and swelling around the bite as well as thick, yellow drainage. Range of motion is limited by pain, and sensation is intact. What is your next step in management?

### Background

Mammalian bites account for almost 1% of emergency room visits annually in the United States. Human bites are the third most common cause, only behind cat and dog bites.<sup>1</sup> However, **human bite wounds have a much higher incidence of infection and can cause serious complications if not treated appropriately.**<sup>2</sup>

Human bites usually occur in one of two ways. A “fight bite” occurs when one person punches another person in the mouth with a clenched fist. An occlusive



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bite occurs when one human directly bites the tissue of another individual in an attempt to harm. These types of bites most commonly occur on the extremities or face. For bites that occur on the hand (such as in a fight bite scenario), harm is done when the tooth penetrates the capsule of the metacarpophalangeal joint. Bacteria from the mouth enter the joint but then become trapped as the fist is released from a clenched position.

At first, the bite wound usually appears innocuous. However, without treatment, severe complications may occur. These include local skin infections, lymphangitis, septic arthritis, tenosynovitis, tendon injury, fracture, osteomyelitis, or uncommon systemic complications such as bacteremia, endocarditis, or meningitis.<sup>3</sup>

### Microbiology

Human bite wound infections tend to be polymicrobial, and organisms originate from both the oral cavity of the biter and from the skin of the bite victim.<sup>4</sup> *Staphylococcus aureus* and alpha-hemolytic streptococci (eg, *Viridans* group *streptococci*) are the most common isolated organisms. *Eikenella corrodens*, a gram negative anaerobic bacillus, is also a frequent isolate.<sup>5</sup> Other organisms include *Bacteroides spp*, *Corynebacterium*, and *Fusobacterium spp*.

Since hepatitis C virus (HCV) and human immunodeficiency virus (HIV) transmissions require blood exposure, and since saliva is usually blood-free, the risk of HCV-HIV transmission from

a biter to a bitee is negligible. However, since a biter's oral mucosa invariably gets exposed to the victim's blood (reverse exposure), testing for HCV and HIV should be considered.<sup>5</sup>

*Clostridium tetani* is not commonly encountered in human bites, but it could potentially be transmitted via this pathway. Therefore, it is recommended that appropriate tetanus prophylaxis be administered.<sup>7</sup>

### Treatment

Human bites almost *always* require antibiotics and fight bites *always* require an operating room. Unfortunately, many patients do not present immediately after the event because of the initial unassuming nature of the wound. Patients will often not present to a physician until after colonization by a number of microorganisms has already occurred and the wound starts to exhibit macroscopic signs of infection. **The infection rate can be as high as 47% for any human bite that is not treated with antibiotics.**<sup>6</sup>

Radiographs are indicated in all cases in order to rule out any foreign objects, such as dislodged teeth.<sup>8</sup> Imaging will also assist in ruling out fracture, and in chronic presentations, osteomyelitis.

Initial treatment involves copious irrigation and exploration. If a joint capsule or tendon is involved, it must be washed out and immobilized.<sup>8</sup> All fight bites need to be taken to the operating room for irrigation and debridement of the wound and joint capsule. If the wound is located on a limb, without joint involvement, it is preferred to leave the wound open. The only exception is facial wounds, which may be closed for cosmetic reasons as long as there is no overt sign of infection after proper irrigation and examination. A surgery consultation is recommended for the following:<sup>3</sup>

- Fight bite
- Presence of necrotic tissue
- Osteomyelitis
- Tenosynovitis
- Foreign body
- Abscess
- Septic arthritis
- Nerve or vascular injury

**Considering the high infection rate of human bites, antibiotics are given prophylactically whenever the wound penetrates the epidermis.** If the wound is grossly infected, if systemic symptoms are present, or if the patient will be going to the operating room, they should receive intravenous antibiotics. The duration of antibiotic prophylaxis is 3-5 days, whereas treatment is 5-7 days (Table 1).

**TABLE 1. Human Bites<sup>9</sup>**

Key organisms: *Viridans group streptococci*, *Bacteroides spp.*, *Coagulase-negative staphylococci*, *Corynebacterium spp.*, *S. aureus*, *Eikenella corrodens*, *Fusobacterium spp.*, *Peptostreptococcus spp.*

**Treatment duration: 5-7 days, prophylaxis 3-5 days**

- Amoxicillin/clavulanate 875mg PO two times daily
- Doxycycline 100mg PO two times daily
- Moxifloxacin 400mg PO/IV once daily
- Ampicillin/sulbactam 3g IV four times daily
- Imipenem 1g IV four times daily

**Human bites almost *always* require antibiotics and fight bites always require an operating room.**

### Key Points

- Nearly half of human bite wounds will become infected if not treated with antibiotics.
- The goal should always be to prevent infection with proper wound irrigation, exploration, and antibiotic prophylaxis.
- Consult surgery for patients with fight bites, or any other wound complications. ★

### Acknowledgements

We would like to thank Josh Bucher, MD (Assistant Professor, Rutgers – RWJMS Department of Emergency Medicine) for his help proofreading the article.

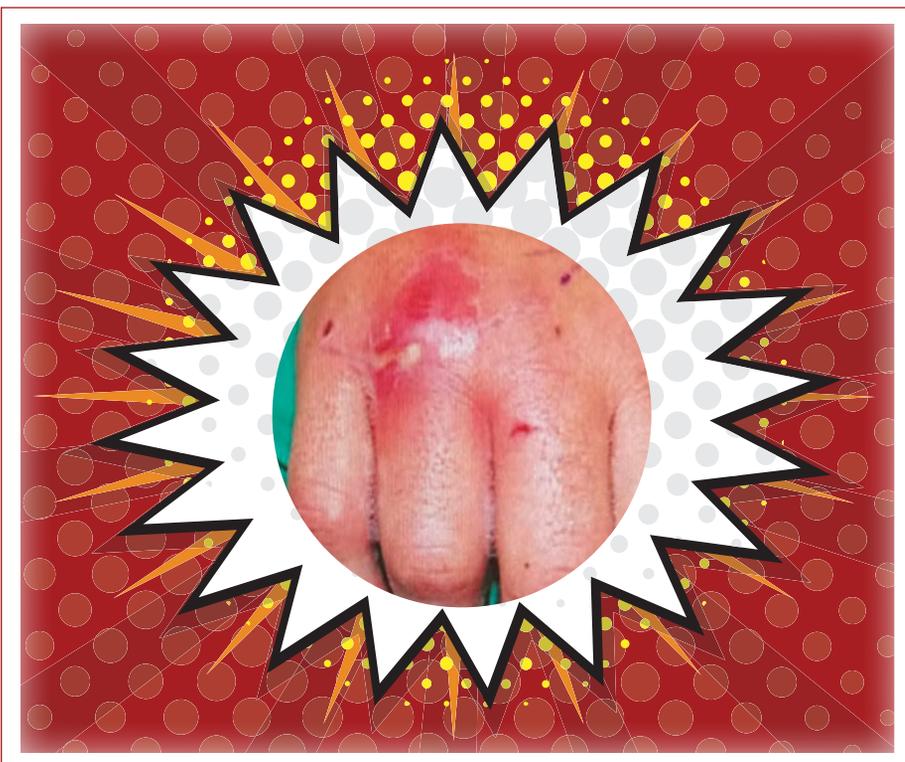


Image reprinted with permission from Jeffrey Sterling, MD



In October, EMRA welcomed a new representative from the ACEP Board of Directors, Vice President Bill Jaquis. Join us in getting to know the ACEP leader who will be plugged in to residents' concerns during the coming year.

# empower

Sharing our Stories

## Your Time, Your Legacy

Bill Jaquis, MD, FACEP  
ACEP Vice President

**Medical school:** Medical College of Ohio (now University of Toledo College of Medicine)

**Residency:** Case Western – Mount Sinai Medical Center of Cleveland

**Current Position:** System Chief of emergency medicine, LifeBridge Health in Baltimore; Chief of EM and attending physician, Sinai Hospital in Baltimore

### Why emergency medicine?

From the start it was the idea of having interesting work every day. I could not see spending all my time and training doing the same thing. As I continue it is the ability to care for all people at their time of greatest need.

### What keeps you coming to work every day?

The people — both the ones I work with and the ones I take care of.

### Best career insight you want to pass along?

For me “success” has come from always learning and being open to new opportunities, regardless of whether it was the “right” time.

### How (or why) did you become a leader in the specialty?

The “how” came from having mentors and champions who believed in me and helped put me in positions to be successful.

### If you were just starting your residency now, what would you do differently?

I would certainly be poorer — education has gotten ridiculously expensive. Other than that I can't think of a thing. All of our experiences are important in getting to where we are.

### How do you get your exercise?

However I can — gym for weight work a couple days a week, running when I can, hiking and biking occasionally, and chasing my sons around.

### Last song stuck in your head?

“All I Want for Christmas” — only because I just saw it on James Corden's carpool

### Dog or cat?

Dog or allergy for me — dog.

### Beach or mountains?

Beach

### What makes you laugh every time?

The opening 15 minutes of “Wedding Crashers” — especially Vince Vaughan's monologue

### Family?

Two teenage sons



# Can I Take Your Order?

## Patient Satisfaction in Emergency Medicine

A man named Tim goes out to eat at a restaurant. He asks Joe, the server, for his recommendation. Joe insists the salmon is by far the best choice, based on his experience and extensive culinary expertise. Tim inquires about the steak, as he has read online that it is a much better choice. Just as Tim says “I think I’ll go for the steak...” Joe cuts him off politely, saying, “Sir, please trust that the salmon is the best choice for you at this time.” Tim is served the salmon, and even though it is an excellent dish, he leaves the restaurant flustered and dissatisfied. **Sound familiar?**

Customer satisfaction is achieved when the goods or services rendered by a company meet or exceed the customer’s expectations. **Similarly, patient satisfaction is achieved when a patient’s own expectations for treatment are met or exceeded.**<sup>1</sup> Notice that the terms “customer” and “patient” as well as “goods” and “treatment” are being used interchangeably. The problem with substituting these terms is that unlike most other industries, health care providers do not allow their customers (patients) to readily choose the goods and services (treatment) provided, thus making it exceedingly challenging to meet patient expectations and provide appropriate clinical care.

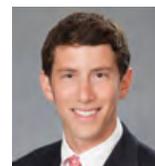
Emergency physician compensation is becoming more dependent on patient satisfaction scores. In 2012, the value-based purchasing program was introduced as part of the Affordable Care Act, with the intent of compensating delivery of health care based not only on the quantity of care provided, but also on the quality. Various patient surveys (HCAHPS, Press Ganey,

etc.) have been created to evaluate the patient’s perception on an array of factors that influence the hospital visit experience. Hospital systems, however, are beginning to focus on individual practitioner scores with arguments such as “the most robust predictor of global satisfaction is the quality of interpersonal interactions with the emergency department provider.”<sup>2</sup>

**While there is clearly substantial benefit in developing positive relationships with patients, there is a concern that involving patient satisfaction survey results in the emergency physician compensation model will change the way we make clinical decisions.**

Emergency physicians may be more likely to bend to patients’ requests for antibiotics, advanced imaging, laboratory testing, or narcotics, particularly in patients presenting with low or mid acuity complaints.<sup>2,3</sup> In an age where medical information and clinical opinion are available at a patient’s fingertips, the number of patients presenting with requests for certain medications and tests will only increase. In a survey performed in 2012 to assess the impact of patient satisfaction ratings on physicians and clinical care, physician responses were overwhelmingly negative. The sentiment was that such ratings are a defective tool for measuring quality of care, that they encourage improper medical practices, and that they can create a conflict of interest when tied to a physician’s salary.<sup>4</sup>

We are entering a climate in which patient experience will continue to have direct financial implications for physicians. So what are we to do? **We want to continue giving**



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New York, NY

**patients the best evidence-based care possible, but we also have a responsibility to understand and address their expectations during medical encounters.** It has been shown that a patient’s perception of their experience is in part related to the amount of information relayed and the total time spent with the physician.<sup>1,5</sup> In the setting of emergency department overcrowding and significant administrative pressure to reduce length of stay, it is difficult to imagine being able to spend the time that every patient desires and deserves.

Frustration caused by unmet expectations is inherently human. For now, the best we can do is continue caring for our patients to the best of our ability while treating them with the respect they all deserve. This means the following:

- ✓ Always introduce yourself.
- ✓ Maintain good eye contact.
- ✓ Give estimate on how long the visit will take.
- ✓ Use simple terminology.
- ✓ Review test results.
- ✓ Provide an opportunity for questions.
- ✓ Utilize shared decision-making in appropriate clinical scenarios.

Focus on communication and collaboration with each patient, so that even though many will not get the steak they thought they wanted, they will leave with a good understanding of why they ended up with the salmon instead. ★

# CONSULT CORNER

# Radiology



**Bradley Strout, MD**  
Assistant Professor of  
Radiology  
UT Southwestern  
Medical Center  
Dallas, TX

**H**ow often do you call radiology for assistance? Learn how to present your case in the most efficient, professional manner — and how to avoid any pitfalls. Bradley Strout, MD, assistant professor of radiology at UT Southwestern Medical Center, offers insight into the specialty.

**EM Resident: What is the most effective way to present a case to a radiologist over the phone?**

The phone calls I receive from the ED are most often requests for advice on the best exam to order for a patient, requests for an over-read on an outside exam that the patient brought with him, requests for a delayed or missing read on an urgent exam performed today, or requests for clarification on an existing report. Please understand that frequently I am already dictating a case when I receive your phone call. If I am interrupted in the middle of a complicated exam, I may be trying to juggle listening to your request without derailing my train of thought on my current case. Simple requests for advice and quick radiograph reads are minimally disruptive. However, I may need to complete the dictation I have open before I can devote my total attention to a new CT, MRI, or ultrasound on a different patient. I might ask you to call back in 5 minutes, or I may ask for your phone number so that I may call you back when I have looked further into your request. A courteous, friendly, and professional phone-side manner will more quickly get you what you are seeking.

**EM Resident: What basic workup would you like completed prior to being called?**

When I receive a call, I want to know in one breath why you are calling. I need to make a decision either to stay with my

current task and call you back, or mentally switch gears to help you and potentially lose track of what I was doing before you called. Please don't try to give me a patient's complete history and physical over the phone; it can cause information overload. A good example is the following: "My patient is having abdominal pain and I am worried he might have diverticulitis but cannot receive contrast due to elevated creatinine. Will a non-contrast CT be sufficient, or is there a better alternative you can suggest?"

If you call me to review a radiology exam, I appreciate it if you have already looked at the images or the report and are calling me for clarification.

If you need an over-read of an exam from another facility, I prefer that you have read the report from the outside exam and that you to explain why you need an over-read. When an exam is read a second time, the patient gets billed a second time; also, over-reads are just as time-consuming as an exam performed in-house. If, for example, a patient is being brought in with an outside diagnosis of acute appendicitis, explain why the report from the outside radiologist is deemed insufficient for your needs.

**EM Resident: What do you consider to be urgent or emergent requests?**

I generally consider it reasonable to request an emergent radiology exam if it will lead to a decision to admit or discharge the patient today, such as if the suspected diagnosis would lead to surgery today, or if the results of the exam will otherwise impact the patient's care received today. I do not like to see CT or MRI exams ordered "STAT" out of the ED to evaluate for interval change of a known indolent, slowly progressive disease such as spread of cancer. Neoplasia would be

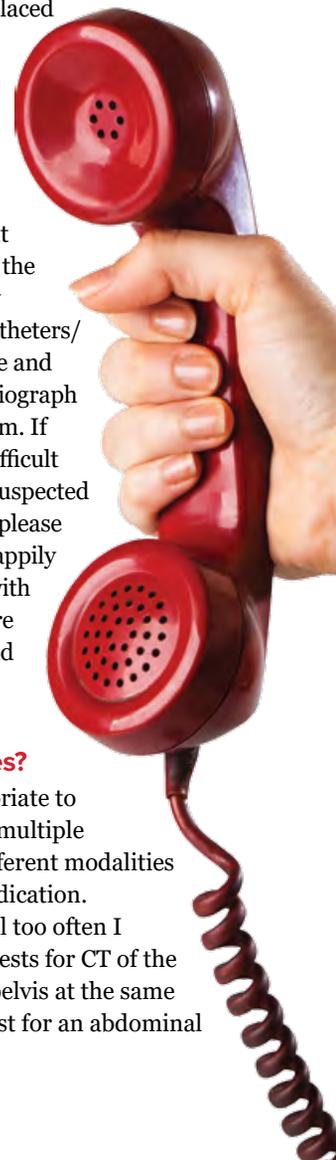
best followed with scheduled outpatient exams, or with a "routine" rather than "STAT" urgency as an inpatient.

**EM Resident: What are some common radiology exams that an EM resident should feel comfortable reading?**

I expect all physicians to be able to interpret a basic radiograph. Non-radiologists should be able to tell if an ED patient has large pneumonia, moderate to large pneumothorax, probable bowel obstruction, or displaced bone fracture. A physician should be able to place a catheter, tube, or drain into a patient and then be able to look at a subsequent radiograph to tell if the catheter is correctly positioned. Most catheters/lines are radiopaque and easily seen on a radiograph from across the room. If the radiograph is difficult to interpret or the suspected diagnosis is subtle, please call me and I will happily discuss the image with you — but make sure you at least tried and looked at it first.

**EM Resident: Top 3 pet peeves?**

- ❶ It is not appropriate to shotgun-order multiple exams from different modalities for the same indication. For example, all too often I encounter requests for CT of the abdomen and pelvis at the same time as a request for an abdominal



ultrasound — both for the indication of abdominal pain. If the diagnosis is made on the first exam, the hospital loses money and/or wastes resources with further imaging.

- ② I think that non-radiologists sometimes forget that radiology is a type of consult service. At night when I am the only radiologist on duty, I am in charge of the department, and I am legally responsible for the exams performed. It is my duty to decide if a radiology request is reasonable and safe for the patient. Unfortunately, I don't always have all the necessary information about the patient's illness when a computerized request comes to my attention. If we have a conflict of opinion, I invite you to call me so that we can have a discussion regarding the necessity of the requested exam.
- ③ All too often I am asked to give a quick, over-the-phone impression of a radiograph. No problem! For me, a radiograph is a very quick interpretation; almost the moment it comes up on the computer monitor, I have a pattern-recognition first

impression. This is not the case with multi-image exams like CT, MRI, and sometimes ultrasound. These exams encompass a thorough search of all organs, a time-intensive evaluation where I may not arrive at a complete impression until I have reached the end of a dictation. If you wish to ask me a pointed question such as "Does he have a ruptured appendix?," I will interrupt the exam I am currently dictating and gladly look at your case to answer your question. But, if you call me up and ask me to read a CT or give an impression on a CT I have not yet seen, I will likely tell you I will read that exam next, after I have concluded the one already in progress.

#### **EM Resident: Other pearls of wisdom for emergency medicine residents?**

1. Get to know your radiologists in person. Establish a friendship or at least a professional relationship. If you and your radiologists see each other as real people, you will develop a measure of trust and respect for

each other, which will translate into better patient care.

2. Please tell me the indication for the exam, not what you think might be the diagnosis. For example, a good indication for a CTA Chest is chest pain or shortness of breath. Don't give me an indication of "Rule out PE." I am already going to evaluate for PE; that is one of the most important things we look for when we read a CTA Chest. The billing department needs a solid indication order to submit a bill to the insurance provider.
3. Chest radiographs are often terrible. We have had them for well over 100 years, but that doesn't make them good. I have seen radiographs that looked clear, but CT exams performed later the same day showed a lemon-sized tumor of the posterior lung base, or a moderate-sized pleural effusion, or a multifocal pneumonia. Chest radiographs are quick, cheap, and low radiation. They are a reasonable starting point when working up a patient, but they may have poor sensitivity compared to CT or MRI. ★

## EMF Resident VIP Club

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\*Emergency medicine resident or medical student who contributes \$100 annually.

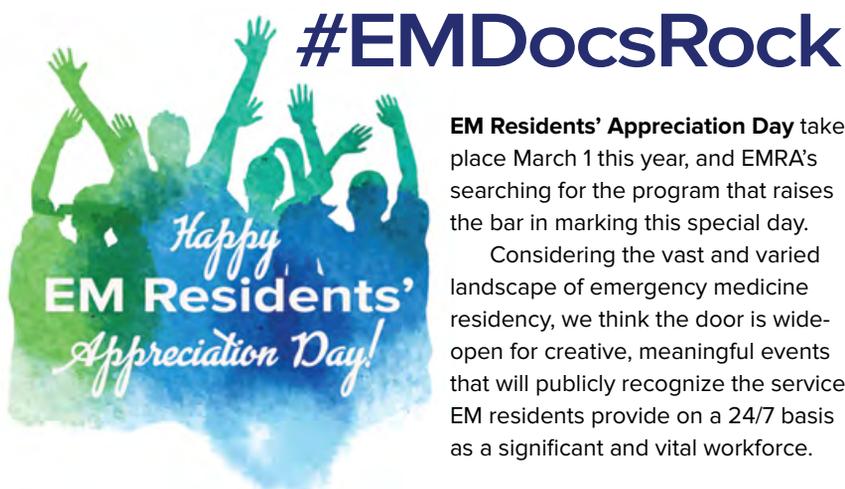
### Spring Resolutions Due

The deadline to submit EMRA resolutions for the next Representative Council meeting is April 3! If you have an idea about EMRA policies and practices, or you want your association to take a stand on a topic near and dear to you, write a resolution before the deadline. Find the Guidelines for Writing a Resolution at [emra.org](http://emra.org), under the "Leadership > Representative Council" tab. ★

### Need a Peds Speaker?

The ACEP Pediatric EM Section and ACEP PEM Committee have launched the Pediatric Emergency Medicine Speaker Database Initiative (PEM+SDI), a new resource for education, clinical policy review, advocacy and research expertise. The goal is to connect the emergency medicine community, PEM residency directors, and fellowship coordinators with PEM experts who can provide lectures on PEM-specific topics.

Does your residency, program, or fellowship have a knowledge gap in pediatric emergency medicine? Go to the database, search among the available lecture topics and speakers, and find out if one of the featured speakers can help you! Please email us at [PedsEMSpeakers@acep.org](mailto:PedsEMSpeakers@acep.org), if you would like to contact a speaker about a potential speaking engagement. If you or your colleagues have presentations that you would like included in this database, send them to [PedsEMSpeakers@acep.org](mailto:PedsEMSpeakers@acep.org). ★



EM Residents' Appreciation Day takes place March 1 this year, and EMRA's searching for the program that raises the bar in marking this special day.

Considering the vast and varied landscape of emergency medicine residency, we think the door is wide-open for creative, meaningful events that will publicly recognize the service EM residents provide on a 24/7 basis as a significant and vital workforce.

Let us know how you celebrate EM Residents' Appreciation Day — post your #EMDocsRock photos on Twitter, Facebook, or send them to us at [emra@emra.org](mailto:emra@emra.org)! ★

### Now Recruiting Health Policy Task Force

With the upcoming changes to how health care is delivered in the U.S., EMRA leaders are convening a Health Policy Advocacy Task Force to prepare an interim set of health care principles that reflect the beliefs of EM residents across the country. Preliminary topics are found at <http://bit.ly/2jw1flv>. To get involved, email [legislativeadvisor@emra.org](mailto:legislativeadvisor@emra.org). ★

### PolicyRx Journal Club Publication Opportunity

We have an exciting new project with the website [policyrx.org](http://policyrx.org) to do a monthly journal club of health policy articles. This is an opportunity to get published! If you're interested in writing a review please email Vidya Eswaran, MD at [vidya.eswaran@gmail.com](mailto:vidya.eswaran@gmail.com). ★

**Critical Care Alert**  
**Intensive BP-Lowering in Patients with Acute Cerebral Hemorrhage**  
The EMRA Critical Care Division offers insight on managing hypertension in the presence of acute cerebral hemorrhage. Visit [emresident.org](http://emresident.org) for the latest Critical Care Alert. ★

## Advocate for Your Specialty at ACEP LAC



EMRA urges all residents and medical students to attend the ACEP Leadership & Advocacy Conference, March 12–15 in Washington, D.C. The EMRA Health Policy Committee and ACEP Young Physicians Section will present a can't-miss Health Policy Primer on Sunday, March 12, to help familiarize new attendees with the issues at hand, ranging from GME funding to MACRA and more. The primer also explains how to get involved in advocacy at every level.

Strong participation in the LAC event in March and ongoing involvement throughout the year is crucial in the changing political climate. **Sign up now to join your colleagues at the Capitol!** ★

*We  
Succeed  
Because  
of You*

## Recognizing EMRA's Committee and Division Leaders

As the EMRA Committee and Division leadership year transitions in May, with vice-chairs assuming the role of chairs during the SAEM annual meeting, we want to recognize the outstanding work our outgoing chairs have offered.

Each of the following individuals has given precious time and attention to make EMRA shine in the past year. Every project has been carefully executed to benefit all members of the association. But we asked our chairs, **“What has been your group’s best accomplishment during your year at the helm?”**

### **Kristen Cadden Swann, MD, Awards Committee**

Most of the awards work is behind the scenes, like increasing award applicants and turnout and revamping the awards ceremony with themes, adding new awards, etc.

### **Danish Malik, MD, and Jenelle Holst Badulak, MD, Critical Care Division**

The new ventilator management card and critical medications badge cards.

### **Pat Olivieri, MD, Education Committee**

Recruiting high-quality judges for EMRA's 20 in 6 Resident Lecture Competition while continuing to add new innovations.

### **Joshua Enyart, DO, Health Policy Committee**

The newly launched Health Policy Journal Club is giving members another avenue to dig into policy issues that matter to them.

### **Michael Mollo, MD, Informatics Committee**

We've begun creation of an open-access Emergency Medicine Macro database that we hope to launch later this year.

### **N. Shakira Bandolin, MD, International Division**

This is tough. I would say creating and organizing a global EM workshop with record attendance at both SAEM and ACEP has probably been our biggest accomplishment.

### **Megan Cobb, MD, Pediatric Emergency Medicine Division**

The EMRA PEM Division makes a concerted effort to include educational and insightful PEM articles in every edition of *EM Resident*.

### **Natalia Rumas, MD, Toxicology Division**

The EMRA Toxicology Division has made efforts to connect residents with their counterparts in the ACEP Toxicology Section, to help further their interest and their professional network.

### **Seth Kelly, MS-IV, Medical Student Council**

Our significant expansion of our advising and mentorship opportunities for students, including the (highly successful) launch of EMRA Hangouts into what it is today, and revitalizing our student-resident mentor program, including information and new dedicated mentors for our military-bound student members.

### **Hashim Zaidi, MD, Prehospital & Disaster Medicine Division**

I would say creating a strong community of dedicated prehospital care enthusiasts, strengthening our relationship with the ACEP EMS section, working with the folks at innovED, connecting future EMS fellows with mentors and finding a great vice-chair.

### **Cara Bergamo, MD, and Rebecca Karb, MD, Research Committee**

1. Top Research Articles of 2015 was a great collaborative effort that involved all the EMRA Committees and Divisions and was a lot of fun to put together.
2. Keeping the Rapid Research Review alive has been amazing and a great way to give back to our *EM Resident* readers interested in research. Other members of our committee are now participating in writing the reviews, which makes it even more rewarding.

### **Scott Pasichow, MD, MPH, Simulation Division**

Building the bridge that allowed for EMRA to take over logistics, marketing, and funding of EMRA Resident SIMWars is our biggest accomplishment. We also were able to create the simulation fellowship map.

### **R. Ian RossFrye, MD, Sports Medicine Division**

Look for a new resource coming soon to serve as a guide when splinting various musculoskeletal injuries!

### **Michael Prucha, MD, Ultrasound Division**

Check the Ultrasound Division page at [emra.org](http://emra.org) for a repository of ultrasound educational resources, Twitter feeds, apps, and more.

### **Lara Vanyo, MD, Wellness Committee**

I would have to say the creation and dissemination of our national resident and program director wellness surveys (in addition to building the committee up from scratch).

### **Carrie Jurkiewicz, MD, Wilderness Medicine Division**

The first-ever EMRA MedWAR was such a hit that the second event has been scheduled for Nov. 1, in conjunction with ACEP17. Stay tuned for details!

LE'SHANN SCOTT, MD  
OLGA KOVALERCHIK, MD  
EMRA RESEARCH COMMITTEE

References available online.



# Rapid Research Review

## MORE STUDY TYPES

### Case Series

This is used when the objective is to describe and find patterns related to a particular disease/problem. Case series are useful for observing predictive signs, symptoms, and test results. In addition, they help create definitions for medical conditions, promote clinical education/research, and establish safety profiles.

**Advantages:** useful for rare diseases; can lead to clinical trials.

**Disadvantages:** no data for true analysis; strong publication bias favors positive results.

### Case-Control Study

This is generally an observational, retrospective study of diseased subjects to determine possible exposure risks. One group with a condition/disease, deemed the “case” group, is compared to the “control” group that is similar but does not have the particular disease of interest.

**Advantages:** Useful for rare diseases, disease with long latency between exposure and onset of illness, and when population is dynamic and difficult to follow over time; convenient to study multiple exposures; relatively low cost

**Disadvantages:** Many confounding factors; high likelihood recall and selection bias.

### Randomized Controlled Trial

A prospective study in which patients with a particular disease are randomly allocated into either a treatment (intervention) or a control (placebo) group.

**Advantages:** Unbiased distribution of confounding factors; can statistically analyze results

**Disadvantages:** Ethical issues, time, cost.

### Crossover Study

In this type of study there are two or more treatments applied sequentially on each participant. The participant is first randomized to treatment 1 and then crossed over to treatment 2.

**Advantages:** All participants serve as a control so fewer participants are required; all participants receive the treatment; blinding can be maintained; statistical tests can be applied.

**Disadvantages:** Carry over effect in which action of treatment 2 is impacted by treatment 1.

### Clinical Trial

This is an experimental study that compares therapeutic benefits of two or more treatments against a placebo. The quality of a study is thought to be best when the study is randomized, controlled and double-blinded.

If participants serve as a control so fewer participants are required; all participants receive the treatment; blinding can be maintained; statistical tests can be applied.

- Phase I: Small number of healthy volunteers to assess safety, toxicity, and pharmacokinetics.
- Phase II: Small number of patients with the disease of interest to assess the treatment efficiency, optimal dosing, and adverse effects.
- Phase III: Large number of patients randomly assigned either to the treatment being investigated or to the best available therapy or placebo. Often this is to compare the investigated treatment to the standard of care.
- Phase IV: Post-marketing surveillance after the drug has been approved to detect rare and/or long-term adverse effects.

visit  
[www.cordem.org](http://www.cordem.org)  
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Thursday, April 27 -  
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# Diagnose this Condition



PHOTOS COURTESY OF ROSANNE NAUNHEIM, MD



**Maia Dorsett, MD, PhD**  
 EMS Fellow  
 Washington University in St. Louis  
 St. Louis, MO

## The Patient

An elderly gentleman is sent to the emergency department by his primary care physician. He complains of dark intraoral lesions that he has noticed appearing and disappearing over the past 2-3 days. He also complains of generalized weakness and dark, foul-smelling stools.

**What is the diagnosis?**

See the **DIAGNOSIS** on page 40



# ECG Challenge

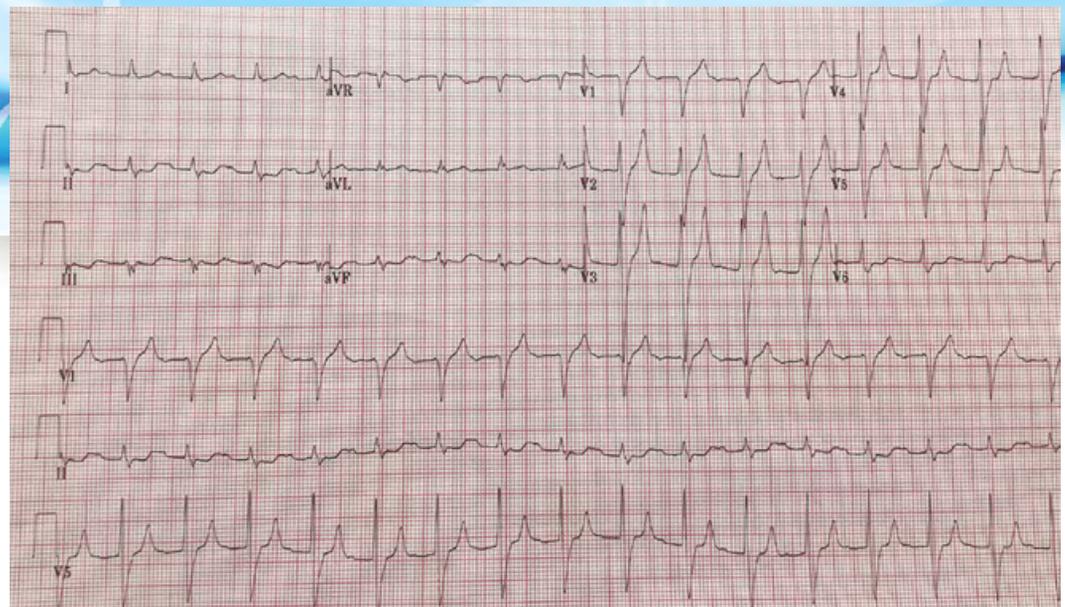
See the **ANSWER** on page 40



**Ari Edelheit, MD**  
 John Stroger Hospital  
 of Cook County  
 Chicago, IL

**CASE.** A 56-year-old female with a history of chronic kidney disease and hypertension presents with diffuse weakness and fatigue over the past 3 days.

**What are you seeing in this ECG?**



# The Diagnosis

## Idiopathic Thrombocytopenic Purpura (ITP)

The patient was diagnosed with ITP, likely related to an underlying (and previously unknown) pulmonary malignancy. Further skin exam revealed diffuse petechiae covering the lower extremities. His platelet count was  $5 \times 10^9/L$  and he was found to have acute blood loss anemia because of an ongoing upper GI bleed.

The intra-oral purpuric lesion seen in this patient (at right) is most commonly known as “wet purpura” (also known as hemorrhagic bullae). Hemorrhagic bullae are a clinical exam finding associated with ITP.

While “dry-purpura” such as bruising and petechiae are indicative of low or dysfunctional platelets, wet purpura has clinical significance in that the patient *is actively bleeding*. Patients with wet purpura are at serious risk for life-threatening hemorrhage in the gastrointestinal tract or the brain. First line treatment for ITP is steroids. However, if the patient is actively bleeding, the recommended treatment is platelet transfusion together with IVIG administration to prolong circulating platelet half-life.



# ECG Challenge

## ANSWER

**This ECG demonstrates an accelerated idioventricular rhythm (AIVR) with peaked T-waves in the septal leads. Given the patient’s renal disease, hyperkalemia should be considered.**

A systematic approach to reading ECGs will help prevent overlooking important subtleties. The rate is about 100 with a regular, wide-complex rhythm. There are no p waves. Regular, wide complex tachycardia without p waves should always prompt a consideration of ventricular tachycardia (VT). However, true VT tends to have a rate closer to 120 beats per minute (bpm). A lack of p waves in the presence of a regular rhythm suggests that the heart’s pacing is originating from a focus below the atria. This includes the AV node (“junctional rhythm”) or the ventricles.

In the setting of a wide QRS complex, this must be either an idioventricular rhythm or a junctional rhythm with an associated bundle branch block (BBB). To understand this, we must first recall that the QRS segment represents ventricular depolarization. In a normal heart, this conduction pathway proceeds through the typical Bundle of His → bundle branches → Purkinje fiber pathway. Any changes to this will create a widened QRS. These are generally secondary to BBBs, accessory pathways, or rhythms originating from the ventricles, called idioventricular rhythms. Therefore, this patient has either an accelerated junctional rhythm with LBBB or AIVR. Ultimately, this patient was found to be profoundly hyperkalemic. Her ECG normalized with treatment of her hyperkalemia.

## LEARNING POINTS

1. The differential for regular, wide complex tachycardias include ventricular tachycardia, supraventricular or junctional rhythms with bundle branch blocks, or an idioventricular rhythm.
2. Causes of AIVR include electrolyte abnormalities, ischemia/infarction, structural disease, and medications (ie, digoxin toxicity).
3. Treatment of AIVR includes ensuring patient stability, and identifying and treating the underlying cause.
4. Hyperkalemia may mimic many other conduction abnormalities. ★

# Board Review

## QUESTIONS

*PEER* (Physician's Evaluation and Educational Review in Emergency Medicine) is ACEP's gold standard in self-assessment and educational review. These questions are from *PEER VIII*. For complete answers and explanations, visit the [Board Review Questions](#) page under "Features" at [emresident.org](#).

To learn more about *PEER VIII*, or to order the newly released *PEER IX*, go to [acep.org/bookstore](#).



- A patient presents with peripheral cyanosis with no central cyanosis. Which of the following is the most likely etiology?
  - Dilated cardiomyopathy
  - Primary pulmonary hypertension
  - Tetralogy of Fallot
  - Tricuspid atresia
- A patient presents with tachycardia, mild hyperthermia, dry skin, delirium, and mydriasis after drinking a tea made from a plant. Which of the following plants was most likely used?
  - Dieffenbachia*
  - Jimsonweed
  - Nicotiana tabacum*
  - Oleander
- A 13-year-old boy presents with progressively worsening left knee pain of 2 weeks' duration after he fell. The family's primary care physician diagnosed growing pains, but the mother is concerned because he has also started to limp. Examination reveals no swelling or instability of the knee but pain with internal rotation, abduction, and flexion of the affected lower extremity. The patient is obese, but his vital signs are normal for age. What is the most likely injury?
  - Anterior cruciate ligament rupture
  - Slipped capital femoral epiphysis
  - Tibial spiral fracture
  - Toxic synovitis
- What is the best solution to resolve a Foley catheter balloon that does not deflate properly?
  - Instill a chemical such as toluene
  - Overextend the balloon
  - Pass a guidewire into the balloon port
  - Puncture the balloon with a suprapubic needle
- A 65-year-old man with hypertension and diabetes presents after a 20-minute episode of left arm and leg weakness and numbness. His symptoms have completely resolved. He had a similar episode the previous day that lasted between 5 and 10 minutes. He takes furosemide 40 mg daily, insulin, and aspirin 325 mg daily. Which of the following statements best summarizes his level of risk for future episodes?
  - High risk: symptoms occurred while he was taking a prophylactic antiplatelet agent
  - Low risk: symptoms did not involve dysphagia or dysarthria
  - Low risk: symptoms resolved in less than 30 minutes
  - Moderate risk: based on past medical history

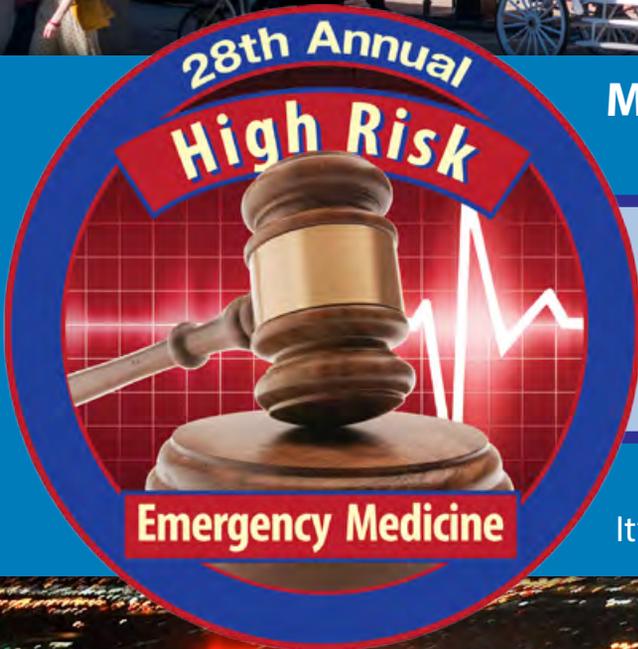
1. A; 2. B; 3. B; 4. C; 5. A  
ANSWERS

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# WHAT IS CULTURE AND WHY DO I NEED IT?

## CULTURE IS TRENDING

You can't open a magazine or read an article lately without a reference to culture. But what is it, really, and why do organizations need it?

## WHAT IS CULTURE?

Like an iceberg, culture is largely invisible. If you ask your nursing or medical staff to describe your hospital's culture, they'd probably have a hard time. However, it's likely that everyone in your organization shares an unspoken understanding of the rules and their place in the pecking order.

**"Culture represents your organization's core, its true self."**

It's expressed continuously by what your people do and say. For this reason, it can't be faked or changed through directives. It has to be changed through hearts and minds.

## CULTURE IS MISSION CRITICAL

Developing and maintaining a positive culture probably isn't in your job description as a leader. But make no mistake, it's one of the most important things you can do.

Culture touches everything in your organization. It influences behavior, relationships, decisions, and ultimately, effectiveness. A survey of top supply chain executives found that they viewed culture (or lack thereof) as the number one barrier to business success. Culture has elevated many ventures — and crushed many more. On the positive side, the best and the brightest minds compete to work for culture-conscious companies like Google, Twitter, Facebook, and even the fully unionized Southwest Airlines. On the negative side, we have the culture of unchecked greed that tanked Enron. Glaring cultural differences made the \$35 billion Sprint Nextel merger a disaster.

## CULTURE & HEALTHCARE

Let's talk about what this all means for hospitals and health systems.

As a vice president and former regional director of CEP America, it's been enlightening to work with dozens of hospitals over the years.



BY DAVID BIRDSALL, MD

CHIEF OPERATIONS OFFICER & EMERGENCY MEDICINE PARTNER

Very often, when a department is struggling, team members will point out why their department is different. Maybe they're in a part of the country where recruiting top-notch providers and staff is difficult. Maybe the facilities are outdated, cramped, and uncomfortable. Or maybe they have high patient volumes, high acuity, or a challenging population.

Granted, these difficulties are real. But I also think these departments are underestimating the role culture plays.

In my day, I've seen hospitals with every advantage struggle with staff retention, patient satisfaction, and quality. And I've seen hospitals with stark disadvantages excel at all of the above. Performance areas directly impacted by culture include: patient satisfaction, provider satisfaction, and medical staff alignment.

To read more about the importance of culture and how CEP America enacted change, visit: [go.cep.com/OurCulture](http://go.cep.com/OurCulture)

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## Emergency Medicine Faculty

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

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

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

Qualified candidates must be ABEM/ABOEM certified/eligible. Salary and benefits are competitive and commensurate with experience. For consideration, please send a letter of intent and a curriculum vitae to: **Robert Eisenstein, MD, Chair, Department of Emergency Medicine, Rutgers Robert Wood Johnson Medical School, 1 Robert Wood Johnson Place, MEB 104, New Brunswick, NJ 08901; Email: Robert.Eisenstein@rutgers.edu; Phone: 732-235-8717; Fax: 732-235-7379.**

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**Kankakee: Signing bonus available!** Presence St. Mary's Hospital hosts an efficient, recently renovated ED seeing 31,000 emergency patients/yr. This Level II Trauma Center has an admission rate of 19% and broad pathology. Situated 50 minutes south of Chicago, the local area is very affordable and offers great housing/schools. US Acute Care Solutions US Acute Care Solutions (USACS) is a coalition of like-minded groups that share a strong commitment to a physician-owned business model. As a USACS physician, you'll be an equity owner with unparalleled access to personal and professional growth resources. Our outstanding benefits package includes groundbreaking 100% paid parental leave, student/med. school loan refinancing as low as 2.99%, excellent compensation, the best medical malpractice (occurrence – includes tail), industry leading company-funded retirement plan, family healthcare and our legendary camaraderie. At USACS, we control our careers and love our lives! Visit us at [www.usacs.com](http://www.usacs.com). Contact Darrin Grella, Vice President of Recruiting: [careers@usacs.com](mailto:careers@usacs.com) or (800) 828-0898.

### INDIANA

**Fort Wayne:** Emergency Medicine of Indiana (EMI) is seeking BC/BE emergency physicians for our Fort Wayne locations. Volumes range from 14k-45k with varying acuities and demographics. Our compensation package includes sign-on up to 100k, loan repayment up to 100k, relocation, paid health/dental, paid malpractice, short/long term disability and 401k plan. Some positions qualify for ownership after one year! EMI is a 100% physician owned democratic group staffing nine contracts in NE Indiana. Fort Wayne is the #1 City in Indiana to raise a family with a very low cost of living. It is an easy drive to metro areas such as Chicago, Indianapolis, Detroit, Cleveland and Cincinnati! Visit us at [www.emipg.com](http://www.emipg.com). Email CV to [mschenkel@emipg.com](mailto:mschenkel@emipg.com) or call 260-203-9607.



Contact us at  
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### KANSAS

**Garden City:** St. Catherine Hospital is the regional healthcare hub for western Kansas. This 132-bed facility uses the latest innovations to care for all of western Kansas, Eastern Colorado and the Oklahoma pan handle. Newly renovated ED sees 18,000 emergency pts./yr. US Acute Care Solutions (USACS) is a coalition of like-minded groups that share a strong commitment to a physician-owned business model. As a USACS physician, you'll be an equity owner with unparalleled access to personal and professional growth resources. Our outstanding benefits package includes groundbreaking 100% paid parental leave, student/med. school loan refinancing as low as 2.99%, excellent compensation, industry leading company-funded retirement plan, family healthcare and our legendary camaraderie. At USACS, we control our careers and love our lives! Visit us at [www.usacs.com](http://www.usacs.com). Contact Darrin Grella, Vice President of Recruiting: [careers@usacs.com](mailto:careers@usacs.com) or (800) 828-0898.

### MARYLAND

**Hagerstown:** Meritus Medical Center is a 265-bed regional facility serving patients from western Maryland, southern Pennsylvania and the panhandle of West Virginia. Opened in 2010, the ED treats 78,000 pts./yr.. Hagerstown offers small-town living within reach of Washington, DC and Baltimore, MD, and is situated between the Blue Ridge and Allegheny Mountains. US Acute Care Solutions (USACS) is a coalition of like-minded groups that share a strong commitment to a physician-owned business model. As a USACS physician, you'll be an equity owner with unparalleled access to personal and professional growth resources. Our outstanding benefits package includes groundbreaking 100% paid parental leave, student/med. school loan refinancing as low as 2.99%, excellent compensation, the best medical malpractice (occurrence – includes tail), industry leading company-funded retirement plan, family healthcare and our legendary camaraderie. At USACS, we control our careers and love our lives! Visit us at [www.usacs.com](http://www.usacs.com). Contact Sandra Lee, Senior Recruiter: [lees@usacs.com](mailto:lees@usacs.com) or (301) 944-0049.

**Leonardtown:** Medstar St. Mary's Hospital is a 114-bed, full-service facility seeing 52,000 emergency pts./yr. Situated in a beautiful waterfront community, the area also boasts excellent schools, housing, dining options and more. US Acute Care Solutions (USACS) is a coalition of like-minded groups that share a strong commitment to a physician-owned business model. As a USACS physician, you'll be an equity owner with unparalleled access to personal and professional growth resources. Our outstanding benefits package includes groundbreaking 100% paid parental leave, student/med. school loan refinancing as low as 2.99%, excellent compensation, the

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**WASHINGTON DC area:** Shady Grove Medical Center and Germantown Emergency Center offer a main ED, a Fast Track ED, a pediatric ED, and a psychiatric ED, plus an 18-bed Observation Unit created exclusively for ED patients. 70,000 pts./yr. are seen at SGAH and about 37,000 at GEC. Rockville is just minutes from Washington, DC and a short drive to Baltimore. US Acute Care Solutions (USACS) is a coalition of like-minded groups sharing a strong commitment to a physician-owned business model. USACS physicians are equity owners with unparalleled access to personal and professional growth resources. Our outstanding benefits package includes groundbreaking 100% paid parental leave, student/med. school loan refinancing as low as 2.99%, excellent compensation, the best medical malpractice (occurrence), industry leading company-funded retirement plan, family healthcare and our legendary camaraderie. At USACS, we control our careers and love our lives! Visit us at [www.usacs.com](http://www.usacs.com). Contact Sandra Lee, Senior Recruiter at [careers@usacs.com](mailto:careers@usacs.com) or (800) 828-0898.

### MASSACHUSETTS

**Framingham and Natick:** MetroWest Boston – Established, democratic, physician managed group has open position for a BC/BE emergency physician. MetroWest Emergency Physicians provides staffing for the Emergency Department of MetroWest Medical Center, located in the western suburbs of Boston. We have campuses in Framingham and Natick, MA with a combined annual volume of 70,000 visits. MetroWest Medical Center is a Stroke Center, Point of Entry for STEMI patients, staffs 12 hours of pediatric ER coverage 7 days a week, and staffs 24 hours of pediatric hospitalist coverage. We offer flexible scheduling, comfortable work environment, excellent salary and benefits package. Please submit inquiries to: Maureen Galaid, MetroWest Emergency Physicians, 115 Lincoln Street, Framingham, MA 01702, 508-383-1104, [maureen.galaid@mwmc.com](mailto:maureen.galaid@mwmc.com).

### MICHIGAN

**Grand Blanc:** Genesys Regional Medical Center is located 45 minutes north of metro-Detroit and minutes from a number of desirable residential areas. This award-winning facility hosts both allopathic and osteopathic emergency medicine residency programs and sees 62,000 emergency pts./yr. US Acute Care Solutions (USACS) is a coalition of like-minded groups that share a strong commitment to a physician-owned business model. As a USACS physician, you'll be an equity owner with unparalleled access to personal and professional growth resources. Our outstanding benefits package includes groundbreaking 100% paid parental leave, student/med. school loan refinancing as low as 2.99%, excellent compensation, the best medical malpractice (occurrence – includes tail), industry leading company-funded retirement plan, family healthcare and our legendary camaraderie. At USACS, we control our careers and love our lives! Visit us at [www.usacs.com](http://www.usacs.com). Contact Darrin Grella, Vice President of Recruiting: [careers@usacs.com](mailto:careers@usacs.com) or (800) 828-0898.

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## Assistant/Associate Residency Program Director

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## Emergency Medicine Core Faculty

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## Pediatric Emergency Medicine Faculty

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## Community-Based Site Opportunity

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The Emergency Medicine Department at Penn State Health Milton S. Hershey Medical Center seeks energetic, highly motivated and talented physicians to join our Penn State Hershey family. Opportunities exist in both teaching and community hospital sites. This is an excellent opportunity from both an academic and a clinical perspective.

As one of Pennsylvania's busiest Emergency Departments treating over 75,000 patients annually, Hershey Medical Center is a Magnet<sup>®</sup> healthcare organization and the only Level 1 Adult and Level 1 Pediatric Trauma Center in PA with state-of-the-art resuscitation/trauma bays, incorporated Pediatric Emergency Department and Observation Unit, along with our Life Lion Flight Critical Care and Ground EMS Division.

We offer salaries commensurate with qualifications, sign-on bonus, relocation assistance, physician incentive program and a CME allowance. Our comprehensive benefit package includes health insurance, education assistance, retirement options, on-campus fitness center, day care, credit union and so much more! For your health, Hershey Medical Center is a smoke-free campus.

Applicants must have graduated from an accredited Emergency Medicine Residency Program and be board eligible or board certified by ABEM or AOBEM. We seek candidates with strong interpersonal skills and the ability to work collaboratively within diverse academic and clinical environments. Observation experience is a plus.

For additional information, please contact:

**Susan B. Promes, Professor and Chair, Department of  
Emergency Medicine, c/o Heather Peffley, Physician Recruiter,  
Penn State Hershey Medical Center, Mail Code A590,  
P.O. Box 850, 90 Hope Drive, Hershey PA 17033-0850,  
Email: [hpeffley@hmc.psu.edu](mailto:hpeffley@hmc.psu.edu) OR apply online at  
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The Penn State Health Milton S. Hershey Medical Center is committed to affirmative action, equal opportunity and the diversity of its workforce. Equal Opportunity Employer – Minorities/Women/Protected Veterans/Disabled.

Our clients are looking for team players with strong patient focus. Contact me for more information on the following Emergency Medicine opportunities:

**Memphis, TN: Methodist University Hospital, annual volume - 65,000**

**Henderson, KY: Methodist Hospital, annual ER side volume - 13,000**

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### NEVADA

**Las Vegas:** Full time opportunities for Pediatric Emergency Medicine Physicians. Children's Hospital of Nevada at UMC is the main teaching hospital of the University of Nevada School of Medicine and serves as the region's only Pediatric Trauma Center and Burn Center. Our 20-bed department cares for 30,000 pediatric patients annually. There is excellent sub-specialty coverage with 24 hour in-house intensivist coverage and a level 3 NICU. US Acute Care Solutions (USACS) was founded by EMP and other like-minded groups that share an ironclad commitment to a physician-led and majority-owned, democratic business model. As a USACS physician, you'll have an equal voice as an owner, and unparalleled access to personal and professional growth resources. Our incredible benefits package includes excellent compensation, the best medical malpractice, an industry leading company-funded 401(k), exceptional healthcare and the camaraderie that is exclusive to a physician led and majority owned group. At USACS, we control our careers and love our lives! Visit us at [www.usacs.com](http://www.usacs.com). Ownership matters! Contact Bernhard Beltran directly at 800-359-9117 or email [bbeltran@usacs.com](mailto:bbeltran@usacs.com).

**Las Vegas:** Full time opportunities for Emergency Medicine Physicians to staff our Micro-hospitals. These are smaller facilities located in desirable suburban locations. Despite their size, they offer the same type of comprehensive healthcare services that are typically found on a larger hospital campus but with improved efficiency that results in better patient access and an overall more positive patient experience. US Acute Care Solutions (USACS) was founded by EMP and other like-minded groups that share an ironclad commitment to a physician-led and majority-owned, democratic business model. As a USACS physician, you'll have an equal voice as an owner, and unparalleled access to personal and professional growth resources. Our incredible benefits package includes excellent compensation, the best medical malpractice, an industry leading company-funded 401(k), exceptional healthcare and the camaraderie that is exclusive to a physician led and majority owned group. At USACS, we control our careers and love our lives! Visit us at [www.usacs.com](http://www.usacs.com). Ownership matters! Contact Bernhard Beltran directly at 800-359-9117 or email [bbeltran@usacs.com](mailto:bbeltran@usacs.com).

### NEW YORK

**Albany area: Signing Bonus Available!** Albany Memorial Hospital has a newer ED that sees 43,000 pts/yr. and hosts EM resident rotations. Samaritan Hospital in Troy is a respected community hospital situated minutes from Albany and treats 42,000 ED pts/yr. US Acute Care Solutions (USACS) is a coalition of like-minded groups that share a strong commitment to a physician-owned business model. As a USACS physician, you'll be an

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**Binghamton: Emergency Medicine Opportunities** with Signing Stipend, Loan Forgiveness!! UHS Medical Group is a progressive multi-specialty group with a large primary care base, consisting of 200+ physicians providing care in over 20 medical and surgical specialties in multiple locations. The group is affiliated with United Health Services Hospitals, the regional leader in healthcare. There is a strong market presence in the region and an excellent referral base. We are seeking BE/BC EM trained or ABEM physicians to join our Emergency Medicine Departments. One opportunity is located in Binghamton, NY, in our level 2 ED's. They see a combined 60,000 patients a year and have single to quadruple coverage during the busiest times. The Binghamton locations include a Level II Trauma Center, comprehensive stroke and cardiac care. There are opportunities for teaching residents, and medical students with Upstate Medical University in Syracuse, and the ability to participate in clinical research. The area boasts numerous cultural and recreational activities and is noted for its excellent quality of life. Competitive starting salary, signing stipend, educational loan repayment, excellent benefits and malpractice insurance. Contact Denise B. Harter: [denise\\_harter@uhs.org](mailto:denise_harter@uhs.org) or 607 337-5627.

**Cortland: Signing bonus available** at Cortland Regional Medical Center. This modern, full-service facility is situated in the Finger Lakes Region between Syracuse and Ithaca. A broad mix of pathology makes up 33,000 ED pts/yr., and there is strong support from medical staff and administration. US Acute Care Solutions (USACS) is a coalition of like-minded groups that share a strong commitment to a physician-owned business model. As a USACS physician, you'll be an equity owner with unparalleled access to personal and professional growth resources. Our outstanding benefits package includes groundbreaking 100% paid parental leave, student/med. school loan refinancing as low as 2.99%, excellent compensation, the best medical malpractice (occurrence – includes tail), industry leading company-funded retirement plan, family healthcare and our legendary camaraderie. At USACS, we control our careers and love our lives! Visit us at [www.usacs.com](http://www.usacs.com). Contact Darrin Grella, Vice President of Recruiting: [careers@usacs.com](mailto:careers@usacs.com) or (800) 828-0898.

**Physician Affiliate Group of New York (PAGNY)**, is proudly affiliated with NYC Health + Hospitals, which is the country's largest public hospital system. We are partners with Coney Island Hospital, Harlem Hospital Center, Jacobi Medical Center, Lincoln Medical and Mental Health Center, Metropolitan Hospital Center and North Central Bronx Hospital.

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**Coney Island Hospital/ SUNY Downstate**  
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**Jacobi Medical Center/ Albert Einstein College of Medicine**  
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Director of Emergency Ultrasound  
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EOE

# CLINICAL & ACADEMIC EMERGENCY PHYSICIANS

South Carolina

**Rapid expansion in Greenville, SC  
due to new EM Residency Program starting 2017  
and community hospital growth.**

**Greenville Health System (GHS)** seeks BC/BE Emergency Physicians to become faculty in the newly established Department of Emergency Medicine. Successful candidates should be prepared to shape the future Emergency Medicine Residency Program and contribute to the academic output of the department.

GHS is the largest healthcare provider in South Carolina and serves as a tertiary referral center for the entire Upstate region. The flagship Greenville Academic Department of Emergency Medicine is integral to the patient care services for the:

- **Level 1 Trauma Center**
- **Dedicated Pediatric Emergency Department within the Children's Hospital**
- **Five Community Hospital Emergency Departments**
- **Accredited Chest Pain Center**
- **STEMI and Comprehensive Stroke Center**
- **Emergency Department Observation Center**
- **Regional Ground and Air Emergency Medical Systems**
- **Accredited 3 year Emergency Medicine Residency Program**

The campus hosts 15 other residency and fellowship programs and one of the nation's newest allopathic medical schools - University of South Carolina School of Medicine Greenville.

Emergency Department Faculty enjoy a flexible work schedule, highly competitive salary, generous benefits, and additional incentives based on clinical, operational and academic productivity.

Greenville, South Carolina is a beautiful place to live and work. It is one of the fastest growing areas in the country, and is ideally situated near beautiful mountains, beaches and lakes. We enjoy a diverse and thriving economy, excellent quality of life, and wonderful cultural and educational opportunities.

## CURRENTLY SEEKING PHYSICIANS FOR THE FOLLOWING ROLES:

- **Clinician Educator**
- **Medical Toxicology**
- **Prehospital Medicine**
- **Observation Medicine**
- **Advanced Practice**
- **Research**

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**Qualified candidates should submit a letter of interest and CV to:  
Kendra Hall, Sr. Physician Recruiter, kbhall@ghs.org, ph: 800-772-6987**

GHS does not offer sponsorship at this time. EOE



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Goldsboro Emergency Medical Specialists, Inc. is seeking a full-time BC/BE Emergency Medicine Physician to join its private practice.

Well established group of 10 ABEM certified physicians and 15 physician assistants. Since 1998 we have been covering Emergency Medicine at Wayne UNC Health Care. The hospital has a new state of the art Emergency Department allowing us to treat over 66,000 patients last year.

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- **Top tier income, annual bonus, partnership after one year of satisfactory performance.**
- **Total benefit package includes 401K, Health Insurance, HSA employer contributions, and Malpractice Insurance with tail coverage**
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**Port Jefferson:** John T. Mather Memorial Hospital is situated in a quaint coastal town on Long Island's north shore and sees 43,000 EM pts./yr. Pathology is broad with moderate acuity, and most services are represented. Enjoy a variety of residential options, outdoor recreation and shopping and access to NYC. US Acute Care Solutions (USACS) is a coalition of like-minded groups that share a strong commitment to a physician-owned business model. As a USACS physician, you'll be an equity owner with unparalleled access to personal and professional growth resources. Our outstanding benefits package includes groundbreaking 100% paid parental leave, student/med. school loan refinancing as low as 2.99%, excellent compensation, the best medical malpractice (occurrence – includes tail), industry leading company-funded retirement plan, family healthcare and our legendary camaraderie. At USACS, we control our careers and love our lives! Visit us at [www.usacs.com](http://www.usacs.com). Contact Darrin Grella, Vice President of Recruiting: [careers@usacs.com](mailto:careers@usacs.com) or (800) 828-0898.

### NORTH CAROLINA

**Charlotte:** US Acute Care Solutions (USACS) is partnered with ten community hospitals and free-standing EDs in Charlotte, Concord, Harrisburg, Kannapolis, Lincolnton, Pineville and Statesville. A variety of opportunities are available in urban, suburban and smaller town settings with EDs seeing 12,000 – 83,000 pts./yr. US Acute Care Solutions (USACS) is a coalition of like-minded groups that share a strong commitment to a physician-owned business model. As a USACS physician, you'll be an equity owner with unparalleled access to personal and professional growth resources. Our outstanding benefits package includes groundbreaking 100% paid parental leave, student/med. school loan refinancing as low as 2.99%, excellent compensation, the best medical malpractice (occurrence – includes tail), industry leading company-funded retirement plan, family healthcare and our legendary camaraderie. At USACS, we control our careers and love our lives! Visit us at [www.usacs.com](http://www.usacs.com). Contact Darrin Grella, Vice President of Recruiting: [careers@usacs.com](mailto:careers@usacs.com) or (800) 828-0898.

**Charlotte/Statesville:** Iredell Memorial Hospital is a respected community hospital situated north of Charlotte and seeing 42,000 ED pts./yr. Statesville is easily commutable from desirable north-Charlotte suburbs like Mooresville (highly regarded schools), with access to lakeside, small town and rural residential

options as well. US Acute Care Solutions (USACS) is a coalition of like-minded groups that share a strong commitment to a physician-owned business model. As a USACS physician, you'll be an equity owner with unparalleled access to personal and professional growth resources. Our outstanding benefits package includes groundbreaking 100% paid parental leave, student/med. school loan refinancing as low as 2.99%, excellent compensation, the best medical malpractice (occurrence – includes tail), industry leading company-funded retirement plan, family healthcare and our legendary camaraderie. At USACS, we control our careers and love our lives! Visit us at [www.usacs.com](http://www.usacs.com). Contact Darrin Grella, Vice President of Recruiting: [careers@usacs.com](mailto:careers@usacs.com) or (800) 828-0898.

**Morehead City:** Modern community hospital on the Atlantic coast minutes from Atlantic Beach and Emerald Isle! This 135-bed facility sees 38,000 emergency pts./yr., is active in EMS, and has a supportive medical staff and administration. US Acute Care Solutions (USACS) is a coalition of like-minded groups that share a strong commitment to a physician-owned business model. As a USACS physician, you'll be an equity owner with unparalleled access to personal and professional growth resources. Our outstanding benefits package includes groundbreaking 100% paid parental leave, student/med. school loan refinancing as low as 2.99%, excellent compensation, the best medical malpractice (occurrence – includes tail), industry leading company-funded retirement plan, family healthcare and our legendary camaraderie. At USACS, we control our careers and love our lives! Visit us at [www.usacs.com](http://www.usacs.com). Contact Darrin Grella, Vice President of Recruiting: [careers@usacs.com](mailto:careers@usacs.com) or (800) 828-0898.

**New Bern:** CarolinaEast Medical Center is a respected 313-bed regional medical center located at the intersection of the Trent and Neuse Rivers just off the central coast. 71,000 ED pts./yr. are seen in the ED. Beautiful small city setting offers great quality of life. US Acute Care Solutions (USACS) is a coalition of like-minded groups that share a strong commitment to a physician-owned business model. As a USACS physician, you'll be an equity owner with unparalleled access to personal and professional growth resources. Our outstanding benefits package includes groundbreaking 100% paid parental leave, student/med. school loan refinancing as low as 2.99%, excellent compensation, the best medical malpractice (occurrence –

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**Berkshire Health Systems**

### Big City Medicine, Hometown Feel!

**Berkshire Medical Center is seeking full-time BC/BE Emergency Physicians to join our Emergency Services Team.** We are a 302-bed community teaching hospital in the Berkshire Hills of Western Massachusetts. Annual volume is 60,000 at our main ED with an additional 30,000 visits at our Satellite ED and urgent care centers.

A regional referral center and trauma center, BMC boasts award-winning programs, nationally recognized physicians, world-class technology and a sincere commitment to our community; we are delivering the kind of advanced healthcare usually associated with larger urban centers. As a major teaching affiliate of UMass Medical School, BMC combines the best of academic and community practice, all in a beautiful location.

The Berkshires, one of the most picturesque regions in the nation, offers unique cultural opportunities, including Tanglewood (the summer home of the Boston Symphony Orchestra), Jacob's Pillow dance festival, and the Williamstown Theatre Festival, as well as year-round recreational activities from skiing to hiking and kayaking. Outstanding school systems make the Berkshires an ideal family location. Enjoy a high quality of life, located 2½ hours from both Boston & New York City.

Physician group is stable. Hospitalist support and specialty backup are excellent. Competitive salary and benefits package offered, including sign-on bonus, relocation assistance, paid time off, and CME.

Please apply online at our website  
[berkshirehealthsystems.org](http://berkshirehealthsystems.org).

# Advocate Health Care

## Emergency Medicine Opportunities

Advocate Medical Group is expanding its Emergency Medicine service line throughout the state of Illinois!

Advocate is seeking BE/BC Emergency Medicine physicians to join our progressive organization. Advocate is named among the nation's Top 5 large health systems and is the largest health system in Illinois. Advocate is the largest emergency and Level I Trauma network in Illinois.

### Details:

- Collegial practice environment with superior physician leadership
- High physician satisfaction with low attrition rate
- Competitive salary and excellent benefits package
- No financial tail obligation and no restrictive covenant

### Why choose Advocate?

- Advocate Medical Group is physician-led and physician-governed
- Advocate has over 1,400 employed physicians and offers more than 300 sites of care, 12 acute-care hospitals
- Advocate's mission to provide the highest level of care available has resulted in a series of national recognitions
- Advocate is a financially stable organization
- Advocate offers a great work/life balance

### Locations currently recruiting:

- **Advocate BroMenn**-Bloomington/Normal, Illinois- Level II trauma, 40,000 visits
- **Advocate Trinity**- Chicago, Illinois- 40,000 visits
- **Advocate South Suburban**- Hazel Crest, Illinois- 52,000 visits

If you are interested in providing high quality, compassionate care, please submit a CV and cover letter to:

Sarah Smith, Physician Recruiter at [Sarah.Smith5@advocatehealth.com](mailto:Sarah.Smith5@advocatehealth.com)

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## OHIO

**Akron area: Signing bonus available!** USACS is pleased to announce our affiliation with the Summa Health System. Outstanding opportunities are available at Akron City Hospital (Level I trauma with EM residency and 100,000 ED visits/yr.), Barberton Hospital (community hospital; 41,000 ED pts./yr.), Medina Medical Center (freestanding ED; 9,000 pts./yr.), Wadsworth-Rittman Hospital (beautiful suburban area; 10,000 pts./yr.) and Green Emergency Department (21,000 visits/yr.). US Acute Care Solutions (USACS) is a coalition of like-minded groups that share a strong commitment to a physician-owned business model. As a USACS physician, you'll be an equity owner with unparalleled access to personal and professional growth resources. Our outstanding benefits package includes groundbreaking 100% paid parental leave, student/med. school loan refinancing as low as 2.99%, excellent compensation, the best medical malpractice (occurrence – includes tail), industry leading company-funded retirement plan, family healthcare and our legendary camaraderie. At USACS, we control our careers and love our lives! Visit us at [www.usacs.com](http://www.usacs.com). Contact Darrin Grella, Vice President of Recruiting: [careers@usacs.com](mailto:careers@usacs.com) or (800) 828-0898.

**Cincinnati Region: Signing bonus available!** The Mercy Health System in eastern and western Cincinnati includes nine respected community hospitals seeing 14,000-60,000 emergency pts./yr. Locations are proximate to desirable residential areas. US Acute Care Solutions (USACS) is a coalition of like-minded groups that share a strong commitment to a physician-owned business model. As a USACS physician, you'll be an equity owner with unparalleled access to personal and professional growth resources. Our outstanding benefits package includes groundbreaking 100% paid parental leave, student/med. school loan refinancing as low as 2.99%, excellent compensation, the best medical malpractice (occurrence – includes tail), industry leading company-funded retirement plan, family healthcare

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**Concord, Madison, and Willoughby: New increased compensation and signing bonus!** Lake Health is situated in the eastern Cleveland suburbs and includes TriPoint Medical Center (modern facility seeing 27,000 emergency pts./yr.), Madison Medical Campus (freestanding ED seeing 12,000 pts./yr.) and West Medical Center (state-of-the-art acute care hospital serving 35,000 ED pts./yr.). US Acute Care Solutions (USACS) is a coalition of like-minded groups that share a strong commitment to a physician-owned business model. As a USACS physician, you'll be an equity owner with unparalleled access to personal and professional growth resources. Our outstanding benefits package includes groundbreaking 100% paid parental leave, student/med. school loan refinancing as low as 2.99%, excellent compensation, the best medical malpractice (occurrence – includes tail), industry leading company-funded retirement plan, family healthcare and our legendary camaraderie. At USACS, we control our careers and love our lives! Visit us at [www.usacs.com](http://www.usacs.com). Contact Darrin Grella, Vice President of Recruiting: [careers@usacs.com](mailto:careers@usacs.com) or (800) 828-0898.

**Lancaster: Signing bonus available!** Located 30 minutes SE of Columbus, Fairfield Medical Center sees 55,000 emergency patients per year. Modern facility, excellent back up, easy access to metro amenities, and dedicated partners make this a great place to live and work. US Acute Care Solutions (USACS) is a coalition of like-minded groups that share a strong commitment to a physician-owned business model. As a USACS physician, you'll be an equity owner with unparalleled access to personal and professional growth resources. Our outstanding benefits package includes groundbreaking 100% paid parental leave, student/med. school loan refinancing as low as 2.99%, excellent compensation, the best medical malpractice (occurrence – includes tail), industry leading company-funded retirement plan, family healthcare and our legendary camaraderie. At USACS, we control our careers and love our lives! Visit us at [www.usacs.com](http://www.usacs.com). Contact Darrin Grella, Vice President of Recruiting: [careers@usacs.com](mailto:careers@usacs.com) or (800) 828-0898.



### Bakersfield, California

Pinnacle Emergency Physicians (2007-present) with 3 local ED's (10h shifts) seeking FT/PT, BC/BE docs (all trauma goes to the County Hospital)

**Memorial Hospital:** 80k/y, STEMI, Stroke & Burn Receiving Center, currently 24/7 Peds, PICU, OB and adult hospitalist services.....Peds ED opening 4/2017

**Mercy Downtown:** 37k/y, Stroke Receiving Center w/ adult hospitalist services

**Mercy Southwest:** 52k/y, Stroke Receiving Center w/ adult hospitalist services

Staffed by 40 FT/PT physicians and 40 FT/PT mid-levels.

FT: 120h/mo, full profit sharing after 2 1/2y plus \$5k CME, \$12k/y health insurance, retirement contribution, paid malpractice with no tail, quarterly bonus, sign on bonus, interest free loan for moving expenses.

### Income in top 5-10% nationwide

Low cost of living, white water rafting, mountain biking/hiking, 2h to DTN LA or central coast beaches, 4h to Mammoth, Las Vegas, San Francisco, San Diego

Contact: Les Burson, DO, Medical Director [phogku@aol.com](mailto:phogku@aol.com)  
661-332-1064 or  
Dr. Kian Azimian, MD, Assistant Medical Director [kianazimian@yahoo.com](mailto:kianazimian@yahoo.com)  
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# Health System

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- **3 ERs (Community, Trauma and Pediatric)**
- **150,000 patient visits annually**
- **Level I Trauma/ Regional Referral Center**
- **40+ Physicians in current employed group**

The position offers an excellent compensation package including above MGMA average salary with RVU-based incentives, paid vacation, CME allowance, health and life insurance, malpractice insurance, and a 401k plan with employer contribution. The hospital has 24/7 in-house Hospitalist, Radiology, Cardiology, Trauma, Orthopaedic and Neurosurgical Coverage as well as EMR and Mid-Level support. Four different units make up our Emergency Department: Level I Trauma Center downtown with 75 beds and fast track, Medical Observation Unit with 16 beds, Pediatric ER at Children's hospital with 16 beds, and a 21 bed community hospital ER in Madison. Teaching opportunities with 3rd/4th year medical students from UAB and Family Medicine and Internal Medicine Residents at UAB-Huntsville rotate through our ED. Qualified candidates include: Emergency Medicine, Med/Peds, Pediatric Emergency and Family Medicine Physicians.

Huntsville, is situated in the fastest growing major metropolitan area in Alabama, and with the highest per capita income in the southeast, Huntsville is the best place to live, learn and work. We are a community on the move, rich with values and traditions while progressing with new ideas, exciting technologies and creative talents. With a population of 386,661 in the metro area, we are a high-tech, family oriented, multi cultural community with excellent schools, dining and entertainment.

**For further information, please contact Suzanne LeCroix  
at (256) 265-9639 or [suzanne.lecroix@hhsys.org](mailto:suzanne.lecroix@hhsys.org)**



[huntsvillehospital.org](http://huntsvillehospital.org)

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**Springfield: Signing bonus available!** Springfield Regional Medical Center is a new, full-service hospital with supportive administration committed to emergency medicine. Situated 45 miles west of Columbus and 25 miles northeast of Dayton, the ED sees 76,000 patients/yr. US Acute Care Solutions (USACS) is a coalition of like-minded groups that share a strong commitment to a physician-owned business model. As a USACS physician, you'll be an equity owner with unparalleled access to personal and professional growth resources. Our outstanding benefits package includes groundbreaking 100% paid parental leave, student/med. school loan refinancing as low as 2.99%, excellent compensation, the best medical malpractice (occurrence – includes tail), industry leading company-funded retirement plan, family healthcare and our legendary camaraderie. At USACS, we control our careers and love our lives! Visit us at [www.usacs.com](http://www.usacs.com). Contact Darrin Grella, Vice President of Recruiting: [careers@usacs.com](mailto:careers@usacs.com) or (800) 828-0898.

**Urbana:** Mercy Memorial Hospital services the SW Ohio region's residents in Champaign County. The facility treats approximately 16,000 emergency pts./yr. Desirable residential areas in Dayton are easily accessible. US Acute Care Solutions (USACS) is a coalition of like-minded groups that share a strong commitment to a physician-owned business model. As a USACS physician, you'll be an equity owner with unparalleled access to personal and professional growth resources. Our outstanding benefits package includes groundbreaking 100% paid parental leave, student/med. school loan refinancing as low as 2.99%, excellent compensation, the best medical malpractice (occurrence – includes tail), industry leading company-funded retirement plan, family healthcare and our legendary camaraderie. At USACS, we control our careers and love our lives! Visit us at [www.usacs.com](http://www.usacs.com). Contact Darrin Grella, Vice President of Recruiting: [careers@usacs.com](mailto:careers@usacs.com) or (800) 828-0898.

### OKLAHOMA

**Tulsa:** Brand-new, state-of-the-art, 85-room ED opened in fall 2014. Saint Francis Hospital is a modern 971-bed regional tertiary care center seeing 99,000 ED patients per year, with broad pathology, high acuity, modern facilities and supportive environment. US Acute Care Solutions (USACS) is a coalition of like-minded groups that share a strong commitment to a physician-owned business model. As a USACS physician, you'll be an equity owner with unparalleled access to personal and professional growth resources. Our outstanding benefits package includes groundbreaking 100% paid parental leave, student/med. school loan refinancing

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### OREGON

**Salem:** Outstanding BC/BE EM physician partnership opportunity at Salem Health Emergency Department (SEPS). Well-established, independent, democratic group with 37 physicians and 6 APPs who staff 110K annual visit, Level I trauma center, with excellent specialty backup. Competitive pay and benefits including scribes, flexible scheduling, malpractice, 401k, and more. We structure our practice to minimize turnover through maximizing work-life balance. We love living in Salem, the heart of Oregon wine country, as it is convenient to the bounty of Oregon's recreational opportunities, and is a safe and affordable community. See what we're about at [sepspc.com](http://sepspc.com), then send your CV, cover letter, and a recent photo to [sepspc@salemhealth.org](mailto:sepspc@salemhealth.org) or call us at 503-814-1278.

### PENNSYLVANIA

**Clarion:** Clarion Hospital is situated in the college town home of Clarion University 75 miles N-NE of Pittsburgh on the banks of the Clarion River near Cook Forest. A dedicated ED staff treats 19,000 pts./yr. in a modern, efficient ED. Allegheny Health Network Emergency Medicine Management is a partnership with USACS - a coalition of like-minded groups that share a strong commitment to a physician-owned business model. As an AHNEMM physician, you'll be an equity owner with unparalleled access to personal and professional growth resources. Our outstanding benefits package includes groundbreaking 100% paid parental leave, student/med. school loan refinancing as low as 2.99%, excellent compensation, the best medical malpractice (occurrence – includes tail), industry leading company-funded retirement plan, family healthcare and our legendary camaraderie. At USACS, we control our careers and love our lives! Visit us at [www.usacs.com](http://www.usacs.com). Contact Jim Nicholas ([jnicholas@usacs.com](mailto:jnicholas@usacs.com)) or call (800) 828-0898.

**Indiana: Signing bonus! New scribe and hospitalist programs!** Indiana Regional Medical Center is a full-service community hospital seeing 45,000 ED pts./yr. College town setting is 50 miles NE of Pittsburgh and offers very reasonable housing costs and easy access to metropolitan and outdoor recreation including ski areas, lakes and



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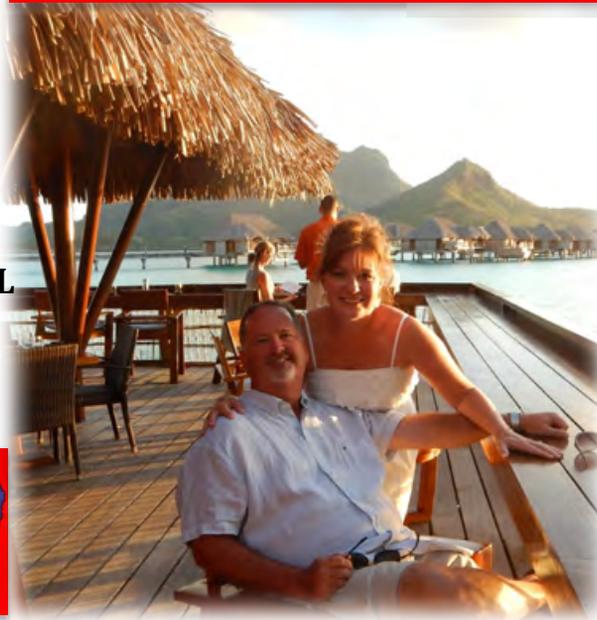
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**Pittsburgh:** West Penn Hospital is located in the desirable Bloomfield/Shadyside area in the city of Pittsburgh and sees 22,000 emergency pts./yr. Beautiful facility hosts a wide range of services including stroke center designation, full cardiac capabilities, busy obstetrics program and NICU. The ED also hosts EM resident rotations. Allegheny Health Network Emergency Medicine Management is a partnership with USACS - a coalition of like-minded groups that share a strong commitment to a physician-owned business model. As an AHNEMM physician, you'll be an equity owner with unparalleled access to personal and professional growth resources. Our outstanding benefits package includes groundbreaking 100% paid parental leave, student/med. school loan refinancing as low as 2.99%, excellent compensation, the best medical malpractice (occurrence — includes tail), industry leading company-funded retirement plan, family healthcare and our legendary camaraderie. At USACS, we control our careers and love our lives! Visit us at [www.usacs.com](http://www.usacs.com). Contact Jim Nicholas ([jnicholas@usacs.com](mailto:jnicholas@usacs.com)) or call (800) 828-0898.

**Pittsburgh – Canonsburg:** Canonsburg Hospital is a friendly, community oriented facility situated 21 miles south of Pittsburgh near the region's most attractive suburbs including Peters Township, Upper St. Clair and Mt. Lebanon. A modern ED sees 18,000 pts./yr., and most major services are available on-site. Allegheny Health Network Emergency Medicine Management is a partnership with USACS - a coalition of like-minded groups that share a strong commitment to a physician-owned business model. As an AHNEMM physician, you'll be an equity owner with unparalleled access to personal and professional growth resources. Our outstanding benefits package includes groundbreaking 100% paid parental leave, student/med. school loan refinancing as low as 2.99%, excellent compensation, the best medical malpractice (occurrence — includes tail), industry leading company-funded retirement

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**Pittsburgh – Natrona Heights:** Allegheny Valley Hospital is situated just 18 miles north of Pittsburgh and sees 39,000 ED pts./yr. A newer, state of the art ED and strong medical staff, administration and community support make for a great work environment. Allegheny Health Network Emergency Medicine Management is a partnership with USACS - a coalition of like-minded groups that share a strong commitment to a physician-owned business model. As an AHNEMM physician, you'll be an equity owner with unparalleled access to personal and professional growth resources. Our outstanding benefits package includes groundbreaking 100% paid parental leave, student/med. school loan refinancing as low as 2.99%, excellent compensation, the best medical malpractice (occurrence — includes tail), industry leading company-funded retirement plan, family healthcare and our legendary camaraderie. At USACS, we control our careers and love our lives! Visit us at [www.usacs.com](http://www.usacs.com). Contact Jim Nicholas ([jnicholas@usacs.com](mailto:jnicholas@usacs.com)) or call (800) 828-0898.

**Sharon: Signing bonus available** at Sharon Regional Health System. An extremely supportive director/administration/medical staff, newer ED, and full-service capabilities making this a great place to work with 37,000 patients treated annually. Small city setting offers beautiful housing, great schools and abundant recreation just an hour north of Pittsburgh. Allegheny Health Network Emergency Medicine Management is a partnership with USACS — a coalition of like-minded groups that share a strong commitment to a physician-owned business model. As an AHNEMM physician, you'll be an equity owner with unparalleled access to personal and professional growth resources. Our outstanding benefits package includes groundbreaking 100% paid parental leave, student/med. school loan refinancing as low as 2.99%, excellent compensation, the best medical malpractice (occurrence — includes tail), industry leading company-funded retirement plan, family healthcare and our legendary camaraderie. Visit us at [www.usacs.com](http://www.usacs.com). Contact Jim Nicholas ([jnicholas@usacs.com](mailto:jnicholas@usacs.com)) or call (800) 828-0898.

**Somerset:** Somerset Hospital is located in western Pennsylvania's Laurel Highlands. Easy access is afforded to the mountains and great ski resorts, biking/hiking, rivers and lakes, all within an hour of metropolitan amenities in Pittsburgh.



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

## Emergency Medicine

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**We are currently recruiting EM physicians to join Baystate Health's community hospitals in Palmer and Greenfield MA. These positions offer:**

- Team-based environments, excellent collaboration with local primary care providers, and close affiliation with Baystate Medical Center / University of Massachusetts School of Medicine.
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or contact: Niels Rathlev, MD, Chair of Emergency Medicine  
c/o Kristin Richard, Physician Recruiter,  
413-794-7847 | [Kristin.Richard@baystatehealth.org](mailto:Kristin.Richard@baystatehealth.org)

*Together we deliver a higher state of caring.®*

Baystate Health is an Equal Opportunity employer. All qualified applicants will receive consideration for employment without regard to race, color, religion, sex, sexual orientation, gender identity, marital status, national origin, ancestry, age, genetic information, disability, or protected veteran status.



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One thing that sets North Shore Medical Center apart - our team-based model of care, which is founded on the principle that physicians, nurses, and other care providers working together will provide a higher quality and a better patient experience. Today, that team focus drives our providers to be leaders of quality of care, patient safety, and process improvement initiatives throughout NSMC.

#### While practicing as an Emergency Medicine physician at NSMC you will enjoy:

- working at one of the top 5 hospitals in Boston as named by *U.S. News & World Report* for the fifth straight year
- the benefits of NSMC's membership in the Partners Healthcare System, founded by Massachusetts General Hospital and Brigham and Women's Hospital
- our combined annual adult ED volume of 80,000 visits provides an array of pathology with a fast track and PA program in place and excellent multispecialty backup
- a culture focused on communication, growth, and work/life balance
- excellent compensation and comprehensive fringe benefits
- being an active contributor to quality of care, patient safety, and process improvement initiatives

#### Do you share our philosophy? It's time to join our team.

Interested candidates should send their CV to: Louis Caligiuri, Director of Physician Services, at [lcaligiuri@partners.org](mailto:lcaligiuri@partners.org).

**Kettering Health Network**, a not-for-profit network of eight hospitals serving southwest Ohio, is assisting a highly regarded, regional group in their search for full-time **Board Certified/Board Prepared Emergency Medicine physicians**. These positions offer competitive salary, sign-on bonus of up to \$40,000, a rich benefits package, and moving expense reimbursement.

This group, comprised of 63 physicians and advanced practice providers, currently staffs six of Kettering Health Network's Emergency Departments; four hospital locations (Trauma Level II/III choices); and two freestanding Emergency Centers. Choose your perfect setting!

The network has received numerous awards for excellent clinical care and service. In fact, CareChex named Kettering Medical Center #1 in Ohio for trauma care – a testament to our team and the exceptional care it provides at its level II Trauma Center.

#### We are scheduling site visits now!

Contact Audrey Barker, Physician Recruitment Manager, at [audrey.barker@khnetwork.org](mailto:audrey.barker@khnetwork.org); (740) 607-5924 cell; (937) 558-3476 office; (937) 522-7331 fax.

Visit [ketteringdocs.org](http://ketteringdocs.org) for more information.



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### SOUTH CAROLINA

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### TEXAS



**Northeast:** Leading Edge Medical Associates is a one-of-a-kind, private, independent group of all board-certified EM physicians in northeast Texas, offering the top aspects of EM. LEMA is unique in its ability to offer physicians the best of both worlds, hospital-based and free-standing, academic and community medicine. LEMA doctors can tailor their practice to include hospital-based and/or free-standing clinical opportunities. LEMA is a group of exemplary physicians who work together as a team, value each member's input, and have a level of integrity, honesty and trust that make this innovative group truly one-of-a-kind. For More Info: SUZY MEEK, MD, email: [SMEEK@LEMA-EM.COM](mailto:SMEEK@LEMA-EM.COM) or call 903.235.9493.

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