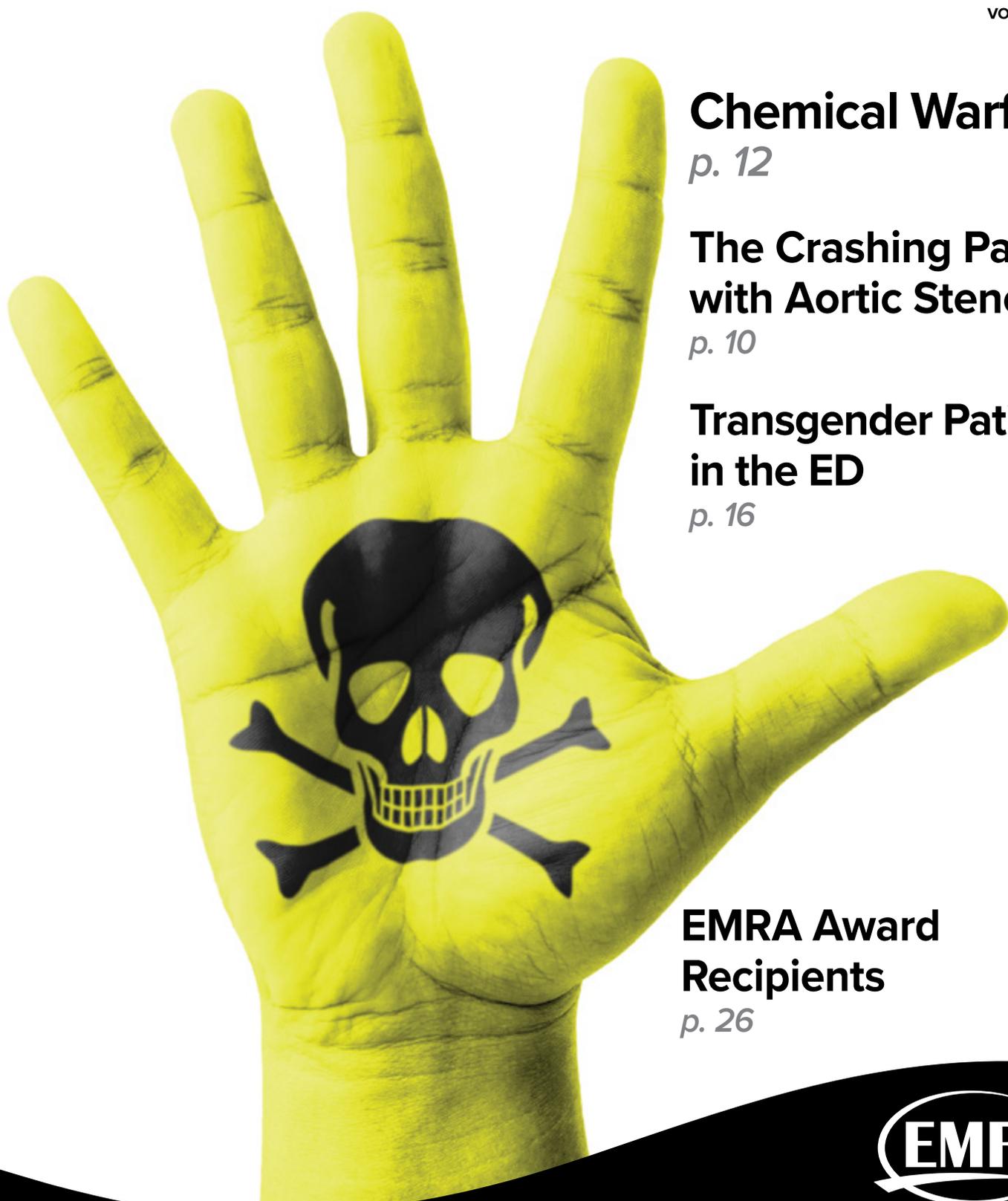


EM Resident

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October/November 2017

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Letter from the Editor



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

One of my first editions as Editor-in-Chief of *EM Resident* featured a story about the fascinating history of space medicine. I loved this article not only because it introduced an exciting prospect for emergency physicians in space travel, but also because it took me for a ride down memory lane: to the carefree days of grade school when I wanted nothing else in life than to be an astronaut; to the days when I would build space stations out of Legos, make solar system dioramas, and beg my mother to buy freeze-dried spaghetti so I could get accustomed to a “space menu” (weird, I know).

While I eventually deviated from a career with NASA due to a somewhat peculiar fear of roller coasters and the Gravitron, my fascination with the cosmos has persisted. For that reason, I feel incredibly lucky to have witnessed the Great American Eclipse in totality on Aug. 21, 2017, at a single point along its continental path. It was unlike anything I have ever experienced.

As the moon approached complete effacement of the sun, the air became cooler and the mid-day light turned to dusk. Cicadas began to chirp, and a hospital courtyard full of individuals wrapped up in their own lives looked toward the heavens as one. To my left was a patient transporter with whom I joyously shared eclipse glasses. Behind me, a cardiac surgeon who

appeared as if he had not slept in days. To my right, a pediatric cancer patient, her wheelchair parked by her IV pole. It truly was remarkable how many people had congregated for that rare glimpse of the solar corona.

There we all stood — together, in sheer awe, wonder, and humility — feeling equally insignificant and united in that moment of mystifying magnificence.

The timing of the total eclipse and its metaphorical significance could not have been more eerie. Historically, eclipses have been considered bad omens or harbingers of doom. And sure enough, while the sunlight returned within minutes, a much darker reality swept the country just days later in the form of two Category 4 hurricanes that made landfall in the same year for the first time in U.S. history. Meanwhile, wildfires raged throughout the American West, and Mexico experienced a magnitude 8.2 earthquake that proved to be the most powerful in over a century.

We will all experience times of extreme darkness and fear in our lives. Often it will be caused by forces and events completely out of our control. That pediatric patient and her family — how long had they been suffering? That patient transporter — was he going through the same type of agony that caused one of our own staff members to take his life weeks later? The

cardiac surgeon — had he just told a family member one of their loved ones had died? Yet despite all of this — had they felt as I had in that moment? Like a microscopic piece of an unfathomable universe?

In my final year of residency, I have come to appreciate how important it is for us to experience such moments together — to ground us, to help us feel connected to each other, to be transiently blanketed in darkness together, to let go of our differences and remember how truly precious life is, and to know that at the end of this crazy journey, we are merely imperfect human beings who are much more alike than we are different. **We are much more alike than we are different.**

As I close my two-year position with *EM Resident*, I thank you, the writers and readers, who have helped me through some of my own darkest days by granting me a venue for introspection and healing — a constant reminder that **while darkness may descend for a time, the light will always return.** In that spirit, you have helped me find ways to illuminate the true miracles of life through your own stories, experiences, enthusiasm, and excitement.

I am forever grateful for my EMRA family and vow to continue appreciating these “life-defining” moments, together with you, and with our patients, as the Earth turns — 24 hours a day, 7 days a week, 365 days a year. ★

Even the darkest night will end and the sun will rise.

— Victor Hugo

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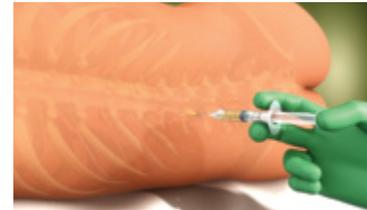
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Gracias. Merci. Danke schön. Domo arigato, Mr. Roboto!



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ABEM Fall Oral Certification Exam

October 26–November 1

EMRA Events @ ACEP Scientific Assembly, Washington, D.C.

November 6-11

ABEM Qualifying Exam

December 5

EM Resident articles due

January

Emergency Medicine Wellness Week

February 15

EMRA Committee & Division Vice-Chair applications due

EMRA Medical Student Council applications due

EMRA Spring Awards nominations due

EMRA
Hangouts

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GRACIAS. MERCI. DANKE SCHÖN. DOMO ARIGATO, MR. ROBOTO!

Random question: How many ways can you think of to say thank you? Seriously. Even if you're not multilingual, I'm sure you know the phrase "thank you" in more languages than English.

Gracias. Merci. Danke schön. Domo arigato, Mr. Roboto! How many other words do you know in that many languages? It's no accident. Gratitude is valued in just about every culture. It's something we're taught as children — mind your manners, say please, say thank you. But as an adult, I have come to find that gratitude is so much more than something I am *supposed* to feel or verbally express. It's more like "Namaste."

In Sanskrit, the term Namaste is often misinterpreted to mean "thank you." Literally translated, Namaste actually means "I bow to you" — but not just in the physical sense. It means, "I honor the place in you in which the entire Universe dwells. I honor the place in you which is of Love, of Integrity, of Wisdom, and of Peace. When you are in that place in you, and I am in that place in me, we are One." I know, I know — suuuuper cheese balls. But seriously, Namaste is a gesture of gratitude and respect between two parties — gratitude for their sharing of energy and peace, and an acknowledgement that we are all one when we live from the heart, aware of the gift of life we have each been given.

For me, October marks the end of what has been an incredible journey as your president, an experience that has challenged me and allowed me to grow in ways I could never have imagined. It brought me some of the most amazing people I will ever meet and has given me opportunities I didn't know existed! As I look back on my time on the board and



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in residency, I am *overwhelmed* with gratitude, with this feeling of "Namaste."

My co-residents, faculty, nurses, and all the staff at UCSF Fresno — the most loving and supportive family I could have ever been given. Your willingness to support each other and me through the toughest and most stressful parts of our training is second to none. You taught me even the worst days can end great if you remember to step back and look at the amazing people who really are in this with you. You made me the doctor I am today, and I will spend forever doing my best to make you proud.

The EMRA Board, Committee & Division leaders, Program Reps, Reps to ACEP Committees, and countless members who have touched my life this year — you inspire me! While my Fresno family kept me grounded, you kept me dreaming big, even in light of all the craziness happening in our government and our world. There is nothing more motivating than talking to and working with all of you, hearing your passion and seeing your drive to better emergency medicine and healthcare in general. It gives me hope for the future of our specialty and a certainty that we *will* make a difference.

EMRA Staff — there are no words to adequately express what we owe you for what you do for us, our training, and our specialty. We seriously have *THE. BEST. STAFF. EVER.* Thank you for keeping me honest, helping me grow as a leader, and supporting me as a human being.



And to our ED patients everywhere — *thank you* for giving me the opportunity to serve as your physician. For trusting me when you feel most vulnerable. For letting me into your personal bubble and sharing your story with me. For teaching me the surprises and subtleties of medicine, and constantly reminding me of my humanity — of the sacred transient nature of life, of my absolute inability to know it all, and of the desperate need we all have for one another. Every day you show me why I chose emergency medicine and why I am beyond privileged to be an emergency physician.

In case it isn't *ridiculously* obvious, what I'm trying to say is — **THANK YOU.** Each and every one of you. Thank you for letting me represent you, for trusting me to be your voice and to stand up for you, our training, and our patients.

Namaste, amigos! ★

EMRA YEAR IN REVIEW



MEMBERSHIP

EMRA's strength is in our people. Our students, our residents, our alumni — you're the reason we do what we do, and why we succeed.

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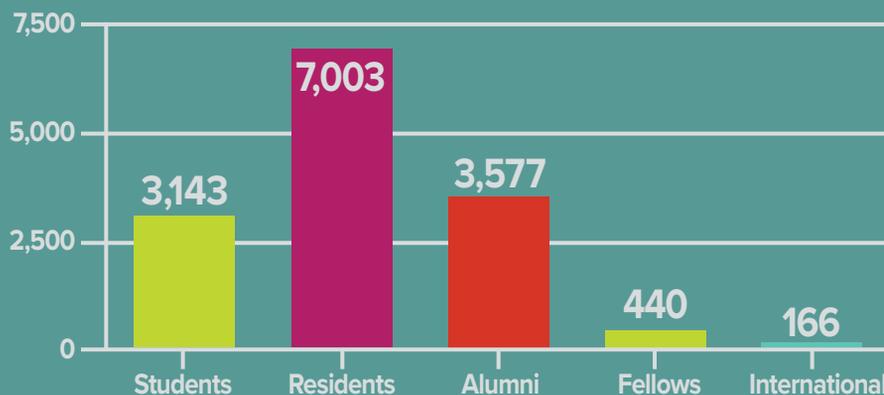
SCHOLARSHIP

If you don't grow, we don't grow. So we award \$97,000+ to make our members the most well-rounded emergency physicians they can be.

Members

2016–2017

This year our total membership increased 10.8%, and we counted 14,382 people as part of the EMRA family.



Fiscal Year 17 Accomplishments

- EMRA Antibiotic Guide, 17th ed.
- Critical Medications reference cards
- Rosh Review member benefit
- EMRA + PolicyRx Health Policy Journal Club

- Fellowship Guide, 1st ed.
- Ventilator Management card
- EMRA Match 3.0

- EMRA MedWAR Leadership Training
- Critical Care Conference award
- Airway Lab awards

- All-new EMRA website
- EMRA PressorDex®, 3rd ed.
- Basics of EM: Pediatrics, 2nd ed.
- Simulation Guide
- Splint Card

- EMRA EKG Guide
- Basics of EM, 3rd ed.
- Wellness Guide
- Fellowship Guide, 2nd ed.
- Ultrasound Card

- “Chaos in the ED” Skills Competition
- Art Therapy Experience
- EMRA moves to CORD Academic Assembly
- EMRA Simulation Research Grant

Fiscal Year 18 Plans

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Troubling Developments in Emergency Care Coverage

BAIT and SWITCH?

Anthem, the nation's second largest insurer, has adopted a policy under which emergency department (ED) visits could be denied coverage if Anthem retroactively determines the visit was not a true emergency. Culling from 2,000 diagnosis codes considered non-emergent by four Anthem-employed board-certified emergency medicine doctors, Anthem will flag the 300 highest volume diagnoses for review.¹

Although this list has the power to financially bankrupt patients, Anthem reveals nothing about the methodology of selection criteria, which experts were consulted, or which stakeholders were engaged. Nor does it appear to be publicly available. From Anthem's website, they request that patients use the following alternative options for conditions that could potentially deteriorate:

- **Online health provider** for: flu, fever, infections, diarrhea, eye infections, rash or skin infection
- **Retail health clinics** for: burns, cough, sore throat, allergic reactions
- **Doctor's office** for: asthma
- **Urgent care** for: animal bites, back pain, eye pain, headache

How could patients possibly be expected to know the severity of their condition, let alone their final diagnosis? **Patients should not be expected to self-diagnose**, according to the "prudent layperson standard" that became federal law in 1996 after years of advocacy to protect patients from insurers' whims. These protections were extended to Medicaid and Medicare in 1997's Balance Budget Act.²

The laws define emergency medical

condition as "a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part."³ This standard was further upheld in the ACA.

Anthem makes some exceptions to the policy, such as if the patient is directed to the ED by another medical provider, if the services are provided to a child under age 14, if there is no urgent care or retail clinic within 15 miles of the member, or if the visit occurs on a Sunday or a major holiday.⁴

Part of the reason behind the prudent layperson standard is the difficulty with which the acuity of presenting complaints can be deciphered, not only by lay people but also by trained professionals. An analysis published in *JAMA Internal Medicine* in 2016 found significant overlap between benign chief complaints and those that were emergencies. Of the top 10 diagnoses from nonemergency visits, half were identical to those of emergency visits: backache, lumbago, acute upper respiratory infection, cellulitis, and acute pharyngitis. **Moreover, the analysis found that 5.7% of visits labeled non-urgent by the triage protocol required admission or transfer, compared with 14.9% of visits labeled urgent.** These "non-urgent" patients were sometimes sick enough to



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require intensive care units — such as the case with 0.7% in the population studied.⁵ If these critically ill patients had stayed home because they were worried about Anthem retroactively denying their claim, they could have had fatal outcomes.

Additionally, studies have shown the majority of ED patients are there because they perceive their problems as urgent. Furthermore, having a regular doctor has not been shown to decrease a patient's use of the ED.⁶

Affected states have included New York, Missouri, Indiana, Georgia, and Kentucky. With Anthem active in 14 states with 40 million people insured, patients all over the country may soon find themselves in a precarious position.⁷

Historically, efforts to cost cut by deterring visits to the ED have not shown much success. Among Medicaid populations, the Deficit Reduction Act of 2005 allowed states to impose higher copayments for nonemergency use of the ED. In states that increased their copayments, there was no reduction in nonemergency use for the ED.⁸ There was also no increased use of outpatient providers as an alternative or increase in the acuity of patients presenting to the ED.⁹ This finding is further reflected in Maryland's experience with ED copays, in which the administrative burden of determining a nonemergency was greater than the amount that was recovered.¹⁰

Similar to Anthem, in 2012, Washington state's Medicaid created a list of 500 non-emergent diagnoses the state refused to cover. After significant backlash, the governor decided not to implement the plan.

For patients with commercial insurance, The RAND Health Insurance Experiment of 1970s found that increasing the cost to patients did not alter the appropriateness of the care they sought. The increased cost sharing decreased use of the care overall, regardless of the effectiveness of the care sought. Consequently, **patients missed necessary interventions.**¹¹

In a different era or a commercial sector, consumers would revolt against policies like Anthem and use a different insurer. But today, in this country, they can't. **For those with employer-sponsored insurance, employees are stuck with the deals negotiated by benefits managers.** Furthermore, the unstable ACA marketplace has left many counties with limited options — or sometimes no choice at all. In Georgia, for example, Anthem is the only insurer

offering individual insurance plans in 96 of the state's 159 counties. Anthem has been rapidly withdrawing from many states' individual marketplaces, leaving insurance deputies and state officials scrambling to find coverage for their citizens.

State and national medical organizations are pushing back against Anthem's policy, citing that the policy violates the prudent layperson standard. Four Missouri medical groups authored a letter to the Director of Missouri Department of Insurance demanding redress of the Anthem policy. **Additionally, the AMA and ACEP sent a letter to the Anthem CEO requesting they immediately rescind the new policy.**

Not discussed in these advocacy letters is that emergency medicine physician services are charged at much higher rates than other specialties. There is good reason for this premium: we are the only specialty that sees any patient at any time regardless of insurance status (per the EMTALA legal mandate). The downside of this is poor payer mix. The resulting high uncompensated care costs

and overcrowding drive up costs. One recent study found an overall markup of 340% of Medicare's rates, with markup ratios ranging 1.0 to 12.6 times higher.¹² For comparison, commercial rates for inpatient services were 189% of Medicare's FFS rates.¹³ For orthopedic procedures, commercial insurance paid 130% of Medicare's reimbursement.¹⁴

With rates higher than other specialties, the ED has been a lightning rod for criticism. Dr. Joseph Fox, medical director for Anthem's Indiana operations, said ED visits have increased 4-8% annually in recent years and three-quarters of these visits were for non-emergencies.⁷ **His estimates of non-emergent visits are not borne out by studies of patients' perceived urgency and ultimate disposition.**

If emergency physicians are to come to the negotiating table, we should also **be ready to find solutions to the issue of raising costs and wide pricing variations.** It will only advance our advocacy efforts to protect our patients' access to essential emergency care. ★

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The Crashing Patient (with) Critical Aortic Stenosis

A 90-year-old male with a past medical history of severe aortic stenosis, heart failure with reduced ejection fraction, and chronic kidney disease presents with shortness of breath. His vital signs are as follows: HR 112, BP 85/60, RR 28, SpO₂ 85% on room air. Bedside ultrasound reveals diffuse B lines consistent with pulmonary edema, and he is placed on non-invasive positive pressure ventilation.

What is the best way to manage this patient, particularly if he continues to decompensate?

Critical aortic stenosis (AS) is the single most problematic valvular disease we encounter in the emergency department. **Patients with critical AS have a fixed cardiac output and cannot meaningfully increase cardiac output to meet the physiologic demands of critical illness.** Avoiding systemic hypotension, maintaining sinus rhythm, and avoiding excessive tachycardia are therefore the cornerstones of resuscitation.

Background

AS is the third most common cardiovascular disease in the developed world, eclipsed only by systemic hypertension and coronary artery disease. The prevalence in the general population is 0.4%, but increases to 9.8% in octogenarians, with an overall prevalence of 2.8% in adults older than 75 years of age.^{1,2} Valve replacement, either surgical or catheter directed (ie, transcatheter aortic valve replacement, or TAVR), is the mainstay of treatment for advanced disease.

In a normal adult, the aortic valve area measures 2.6 to 3.5 cm². **AS becomes hemodynamically significant when aortic valve area approaches <1 cm².** As the valve becomes tighter, the pressure gradient across the valve increases. A pressure gradient >50 mmHg indicates severe disease.³⁻⁵ However, it is important to note that a substantial proportion of patients with severe and critical AS have a low gradient, which most frequently results from the decreased stroke volume associated with advanced disease.

Hemodynamically significant **AS must be on the differential in the undifferentiated patient presenting with acute pulmonary edema, syncope, or cardiogenic shock,** particularly if they are elderly. In addition to the identification of a systolic ejection murmur, bedside echocardiography can help screen patients. In fact, qualitative assessment of the aortic valve from the parasternal long and short axis views has been shown to be 75% sensitive and 93% specific for the diagnosis of severe AS among trained emergency medicine providers.⁶



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Physiology Primer

The stenotic aortic valve results in a buildup of pressure inside the left ventricle and a comparably lower pressure in the aortic root, resulting in low coronary perfusion pressure. This leaves the left ventricle uniquely susceptible to ischemia, which reduces cardiac output and promotes further ischemia.⁷ **Systemic hypotension reduces coronary perfusion pressure, and excessive tachycardia increases myocardial oxygen demand;** both contribute to a self-perpetuating cycle of ischemia and cardiogenic shock (see Figure).

The left ventricle hypertrophies in critical AS in response to chronically increased afterload. A stiff, hypertrophied left ventricle requires high filling pressures, and the “atrial kick” of **sinus rhythm** to fill in diastole. Hypovolemia and supraventricular tachyarrhythmias (eg, atrial fibrillation) dramatically reduce left ventricular preload and are tolerated poorly in this patient population.⁸ Excessive tachycardia not only promotes ischemia, but also reduces time spent in diastole for left ventricular filling.

Vasopressor Management

Phenylephrine is the vasopressor of choice in treating the hypotensive patient with AS.

Using an agent that solely increases afterload is initially counterintuitive. It is important to recognize that the massive afterload of aortic stenosis is at the level of the aortic valve, with little contribution from the systemic vasculature. As a pure alpha-1 agonist, phenylephrine increases diastolic blood pressure and thus improves coronary perfusion. Phenylephrine also may result in a reflex bradycardia — a favorable pharmacodynamic property for its use in aortic stenosis.⁹ Norepinephrine is, similarly, a reasonable choice. Avoid epinephrine as a first line agent given its strong beta-1 agonism and propensity to promote tachycardia and increase myocardial oxygen demand.

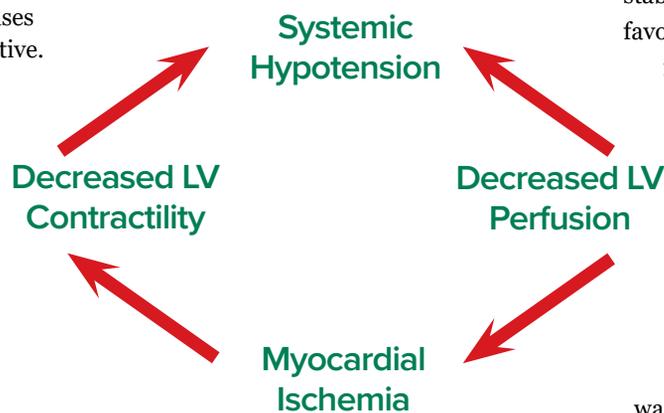
Fluid Management

The tight aortic valve increases left-sided pressures and can lead to pulmonary congestion. However, patients with AS also have diastolic dysfunction and depend on preload to fill the left ventricle and maintain cardiac output. Decisions on fluid administration are challenging in this patient population and should be made in the context of the clinical scenario.

Consider the hemodynamically unstable patient with critical AS who you are preparing to intubate. Any concern regarding pulmonary congestion is superseded by the need to optimize preload prior to induction. Assuming

the patient is not on the tail end of the Frank-Starling curve, temporarily infusing crystalloids to optimize preload and stave off peri-intubation hypotension is a good idea.

Now, consider a stable patient with critical AS who is having a slow GI bleed. So long as there are no hemodynamic perturbations to necessitate rapid replacement of blood products, the clinical scenario calls for a cautious fluid administration strategy because the patient is prone to developing pulmonary edema. Administer small volumes, and frequently reassess for signs of congestion (eg, B lines on lung ultrasound).



Intubation

Patients with critical AS depend on adequate left ventricular preload to maintain cardiac output. **Both induction agents and positive pressure ventilation** acutely drop left ventricular preload, and **place patients with critical AS at risk for peri-intubation hemodynamic collapse.** Hemodynamic optimization prior to induction, adequate monitoring, and selection of an induction agent with a favorable hemodynamic profile are the mainstays of safe intubation.

As you prepare to intubate, have push-dose phenylephrine at the bedside (or infusing). Prior to induction, the patient should be preload optimized. If there is any uncertainty regarding volume status, err on the side of fluid administration. **Even short periods of systemic hypotension can be devastating and are easily missed by a periodically cycling non-invasive blood pressure**

cuff. If time allows (eg, the urgent-not-emergent intubation), consider placing an arterial line prior to induction to decrease response time to systemic hypotension.

Patients with critical AS depend on the atrial kick of sinus rhythm for diastolic filling. If you are preparing to intubate a hemodynamically tenuous patient in new atrial fibrillation (or any SVT for that matter), consider cardioversion prior to induction.

Etomidate is the RSI induction agent of choice in patients with AS, because it is both hemodynamically stable and comes with a generally favorable side effect profile. Propofol is a profound vasodilator and can acutely drop preload and promote hemodynamic collapse. Ketamine promotes tachycardia — an unfavorable property in patients with AS.

Case Conclusion

The patient was placed on a phenylephrine infusion, and preload was optimized prior to intubation. After intubation he was admitted to the CCU, where he was cautiously diuresed throughout the next week. He responded well to medical management and was extubated without event. Ultimately, he was transferred to another institution for TAVR and had a full recovery.

Definitive management of AS is generally surgical or endovascular, and is informed by formal echocardiography. However, ED providers will no doubt encounter patients with previously unrecognized AS. Physical exam and bedside echocardiography can suggest the diagnosis of AS when little background clinical data is available. Patients with hemodynamically significant AS are challenging to manage in the resuscitation phase. **Avoid excessive tachycardia, maintain sinus rhythm, optimize preload, and treat hypotension aggressively with phenylephrine. ***

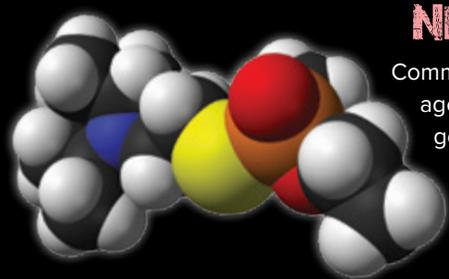
CHEMICAL WARFARE AGENTS

The threat of chemical warfare is hardly novel. Traditionally used by armies to break a stalemate against relatively defenseless targets (those lacking masks, antidotes, and easy mobility), today, chemical warfare agents (CWAs) may pose a greater hazard to civilians than soldiers. The use of sarin during the ongoing war in Syria and of mustard gas and tabun (GA) during the Iran-Iraq war is evidence of this fact.

Furthermore, industrial chemicals such as phosgene, ammonia, and chlorine are not only cheap, but also easy to manufacture. They are thus potentially attractive agents to low-tech terrorists seeking to injure large groups of people and instill fear writ large.

What follows is a review of only the most lethal forms of CWAs. Divided by class, it includes the most common agent names, their mechanisms of action, acute clinical presentations, and specific treatments.

NERVE AGENTS



Commonly referred to as tabun, sarin, soman, and VX, nerve agents have famously been implicated in attacks by the Syrian government against rebel forces and civilians, and by North Korea in the assassination of Kim Jong Nam.^{1,2} They were also, on a less serious note, popularized in the movie *The Rock*. Considered the most toxic of chemical weapons, these agents are extremely potent organophosphates, achieving toxicity through the inhibition of acetylcholinesterase at muscarinic and nicotinic receptors.

Patients thus present with the familiar constellation of “SLUDGE” symptoms: salivation, lacrimation, urination, diarrhea, gastrointestinal distress, and emesis. **Severe toxicity may progress to seizures, copious pulmonary secretions, bronchospasm, and ultimately respiratory arrest.** Miosis is a notably useful exam finding as it should be present in nearly all patients with significant toxicity.³

Treatment consists first and foremost of decontamination. The removal of all clothing and irrigation with copious water is critical to limiting toxicity not only to the patient, but also to first responders. Providers should cut off clothing (and thus avoid pulling it over the patient’s head), and store it in airtight bags.

Atropine, an anti-muscarinic, is the primary treatment modality. It should be titrated to the correction of respiratory symptoms (ie, it should be given until one sees adequate improvement in bronchoconstriction and respiratory secretions). Pralidoxime (2-PAM), another potential therapy, reactivates inhibited cholinesterase compounds. It must be given prior to aging — the time at which compounds become irreversibly inhibited. Unfortunately, as aging can occur within minutes, 2-PAM is of questionable clinical utility. Seizures, in turn, may be managed with benzodiazepines, such as diazepam.^{3,4}

BLOOD AGENTS



Infrequently used in warfare given their **high volatility and propensity for quick dispersal**, cyanogen chloride and hydrogen cyanide nevertheless occupy a uniquely infamous place in history because of their **use by Nazi Germany in WWII to kill up to 1 million civilians.**⁵ A chemical asphyxiant, cyanide blocks the aerobic utilization of oxygen and causes within the exposed individual a progressive hypoxia. Symptoms such as abrupt onset headache, dyspnea, and confusion may lead to obtundation, seizure, hypotension, and cardiovascular collapse.

Given their high volatility and mechanism, **the effects of these agents tend to be diametric: Should a patient withstand initial exposure, s/he is anticipated to recover with minimal complications.** Victims who survive to hospital presentation will benefit from decontamination, hydroxocobalamin, and 100% oxygen administration. If hydroxocobalamin is not available, amyl or sodium nitrite followed by sodium thiosulfate is indicated.^{3,4,6-7}

WHEN
FRONT
DISAPP



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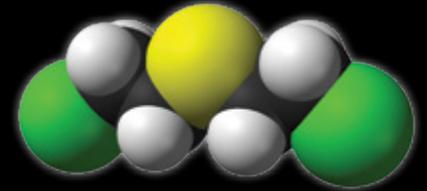
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THE LINE PEARS

**Today,
chemical
warfare agents
(CWAs) may
pose a greater
hazard to
civilians than
soldiers.**

VESICANTS

Frequently termed blistering agents for their propensity to induce dermal injury resembling that caused by burns, sulfur mustard agents are historically the most significant of these compounds, given their **extensive use during WWI.**⁵

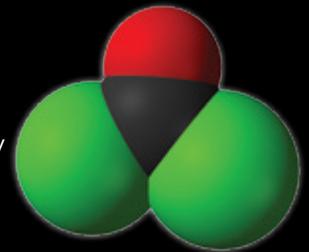


Toxicity is achieved through multiple mechanisms, most significantly via direct damage to DNA. Interestingly, but not unexpectedly given its mechanism, sulfur mustard toxicity is delayed and dose-dependent. Dermal vesicles and bullae form 4-12 hours after exposure and can progress to partial and even full thickness burns. Ocular exposure may cause corneal damage and blepharospasm, resulting in temporary blindness. Respiratory symptoms range from cough and hoarseness to pneumonitis and tracheobronchitis.^{3-4,6}

Mortality typically results from pulmonary injury or complications from dermal compromise. There exists no specific antidote to mustard agents. Treatment consists principally of decontamination and supportive measures: cut off the patient's clothing and irrigate him or her extensively with soap and water.

PULMONARY AGENTS

These so-called "choking agents" include some of the first CWAs; however, following their extensive use during WWI they have been largely replaced by more effective toxins. Still, they remain pervasive in the chemical industry and are relatively accessible to potential terrorists.



Chlorine and phosgene are the two most famous agents, leading to delayed pulmonary edema from increased alveolar-capillary membrane permeability. It is postulated that both lead to the production of hydrochloric acid, resulting in mucosal damage and acute lung injury.³⁻⁷

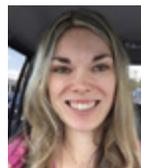
Patients initially have oropharyngeal pain, mucosal edema, and stridor. These symptoms may in turn progress to respiratory distress, pulmonary edema, and hypoxia, culminating in respiratory arrest. As with the agents above, the mainstay of treatment is decontamination and supportive care. Once again, providers should cut off clothing and store it in airtight bags. Remove contact lenses and rinse eyes thoroughly if there is evidence of irritation or ocular exposure.

While other kinds of CWAs exist, the aforementioned are the most common. It should be acknowledged that in the acute setting it may be difficult to distinguish between agent types. Fortunately, there is significant overlap in treatment, rendering specific agent identification less immediately relevant. **An emergency medicine physician need only recall the core principles of decontamination, stabilization, and supportive care;** all other information can (and should) be sought from a local poison center or toxicologist. ★

Subdural Hematoma Secondary to Epidural Anesthesia



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A 31-year-old multiparous woman who is 7 days postpartum after a c-section presents to the emergency department for the second time complaining of a severe headache. On her initial visit, she was diagnosed with a spinal headache (post epidural anesthesia) and had an epidural blood patch placed. She states the patch helped lower her pain slightly, but that the pain has continued to stay at an 8/10. She otherwise had an uneventful pregnancy and delivered at 39 weeks estimated gestational age. **A head CT-scan is performed and reveals a subdural hematoma.**

Intracranial Hemorrhage Types

To review, there are 4 different types of intracranial hemorrhages: epidural hematoma, subdural hematoma, subarachnoid hemorrhage, and intraparenchymal hemorrhage.

The meninges consist of three very different layers of protective tissues that surround the brain and spinal cord (Figure 1). When damage occurs to the skull or surrounding areas, blood can accumulate in the limited intracranial space and cause compressive damage.

Epidural hematoma occurs between the skull and the dura mater. It is most commonly seen after trauma and fracture to the temporal bone, which results in the rupture of the middle

meningeal artery. CT scan of the bleed will demonstrate biconvex, hyperdense, lentiform appearance that does not cross suture lines.

Subdural hematoma occurs in the space between the dura mater and the arachnoid matter called the subdural space. The blood is from the rupture of fragile bridging veins, which can shear even in relatively low-impact injuries in elderly and alcoholics. CT scan of the blood will demonstrate crescent-shaped hemorrhage that crosses suture lines.

Subarachnoid hemorrhage is usually seen in patients with congenital risk factors for intracranial bleeds but can also be idiopathic or secondary to trauma. Risk factors include berry aneurysms

secondary to multiple genetic diseases and arteriovenous malformations. The patients tend to bleed into the brain such as the regions of the sulci and ventricles.

Intraparenchymal hemorrhage occurs in patients with amyloid angiopathy, neoplasms, vasculitis, and uncontrolled systemic hypertension, among other etiologies. The blood is traditionally found in the internal capsule and basal ganglia region.

Pathophysiology of PDPH vs. CSH

A pregnant patient with a headache has a broad differential, which includes the following: pre-eclampsia, posterior reversible encephalopathy syndrome (PRES), hypertensive emergency, drug-induced headaches, migraines, postdural

puncture headache, and intracranial hemorrhage. Complications from spinal anesthesia are very rare, however, if not diagnosed in a timely fashion, can become life-threatening.

Post epidural puncture headache (PDPH) is a relatively common complication, occurring in around 40% of the cases. The pathophysiology is as follows:

Epidural needle inserted for spinal anesthesia → leakage of CSF fluid → caudal displacement of intracranial structures → stretching of pain sensitive sinuses, blood vessels, and the dura → spinal headache (*spinal headache does not progress if the CSF leakage stops spontaneous or epidural blood patch is placed correctly*).

Cerebral Subdural Hematoma (CSH) is a very rare post-epidural/post-lumbar puncture complication, occurring in less than 0.05% of patients. Pathophysiology commonly theorized for CSH secondary to epidural puncture is as follows:

Epidural needle inserted for spinal anesthesia → leakage of CSF fluid → caudal displacement of intracranial structures → stretching of pain sensitive sinuses, blood vessels, and the dura → spinal headache → incorrectly placed epidural blood patch/no spontaneous closure of CSF leakage → continual loss of CSF → low CSF pressure → sheering forces on fragile bridging veins → subdural hematoma

Prevention and Treatment

The most important intervention for prevention of a cerebral subdural hematoma secondary to epidural anesthesia is a correctly placed epidural blood patch. This should immediately alleviate a patient's headache, while more importantly preventing the progression from PDPH to CSH.

If a subdural hematoma does occur, however, most will improve on their

own via reabsorption and require inpatient monitoring only. Patients are recommended to be monitored using the Markwalder Grading System as a prognostic score for chronic subdural:

- 0 **MGS Score 0:** Neurologically intact
- 1 **MGS Score 1:** Alert and oriented; mild symptoms such as headache; absent or mild neurological deficit, such as reflex asymmetry
- 2 **MGS Score 2:** Drowsy or disoriented with variable neurological deficit, such as hemiparesis
- 3 **MGS Score 3:** Stuporous but responding appropriately to noxious stimuli; severe focal signs such as hemiplegia
- 4 **MGS Score 4:** Comatose with absent motor responses to painful stimuli; decerebrate or decorticate posturing

Large subdural hematomas can progress rapidly and result in acute neurological changes. While awaiting neurosurgical evaluation for possible craniotomy and evacuation of hematoma, it becomes very important to monitor the following:

- **Blood pressure:** Blood pressure changes are an indicator of increased intracranial pressure (Cushing's Triad: bradycardia, irregular respirations, and systolic hypertension with widening pulse pressures). Blood pressure control is important in

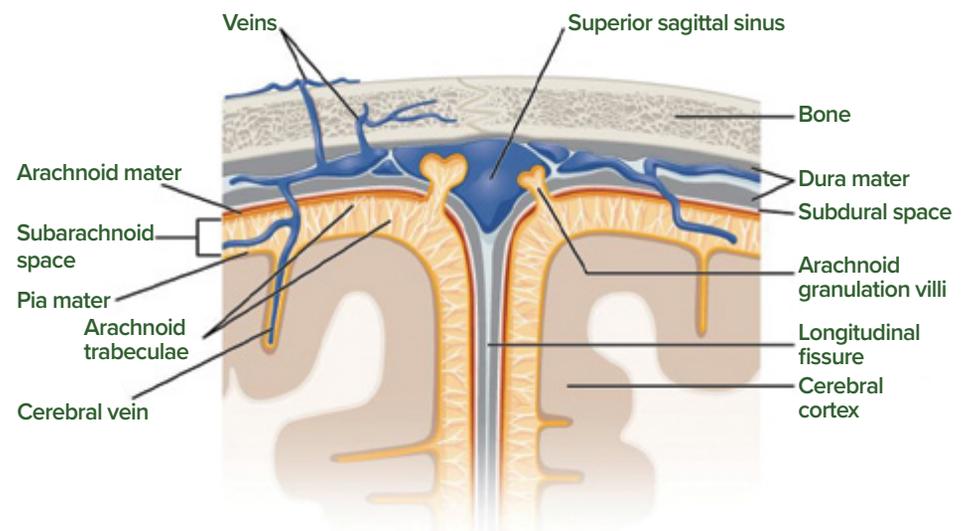
these patients to prevent further extension of the bleeding, with a goal recommended systolic blood pressure of <140 mmHg.

- **Seizures:** Although there is no indication to start patients on seizure prophylaxis, it is important to monitor the patient for development of seizures. Levetiracetam and phenytoin would be the traditional treatment options. It is important to note that some recommend starting seizure prophylaxis in patients who require evacuation of their hematomas.
- **Herniation:** In addition to neurosurgical interventions, if there is a concern for acute herniation, emergent maneuvers include mannitol or hypertonic saline, along with brief respiratory hyperventilation maneuvers.

Conclusion

As emergency medicine physicians, it is important to understand that an unrelenting headache in the setting of post-epidural or post-lumbar puncture procedure can be a sign of a serious complication. This patient also serves as an example of the importance of a thorough evaluation on any bounceback visit to the emergency department. *

FIGURE 1. Illustration of the Relationship Between the Layers of Meninges, Vasculature, and the Brain



In 2013, 72% of LGBT homicide victims had identified as transgender women.

What's the ?



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Caring for Transgender Individuals in the Emergency Department

Recently, I had my first experience caring for a transgender patient in the emergency department. The patient's chief complaint was testicular pain. After assessing the vital signs and triage orders, I noticed the patient's sex was listed in the medical record as female. **My initial inclination was to assume that this was an error**, or that the patient had been mistakenly registered under an incorrect name. However, closer inspection of the triage note stated the patient identified as a transgender female. In fact, the patient had been registered appropriately.

Although I had previously attended several sessions on caring for lesbian, gay, bisexual, and transgender (LGBT) patients, **I found myself overcome**

with anxiety. I became hyper-focused on "saying the right thing" so as not to offend my patient. Upon entering the room, my heart started to race. I introduced myself and began with my usual opening schema: "Tell me, what brought you in today?"

Fortunately, our conversation ensued as any other patient interview. I asked about her medical and surgical history, allergies, and medication use. **The patient disclosed that she was transgender and shared with me her preferred name and pronouns.** I asked for permission to share this information with my nurse and attending physician. In bold lettering at the top of my note, I wrote, "The patient's preferred pronouns are she/

her and her preferred name is..." When ordering an ultrasound, I informed the technician of the patient's preferred name and pronouns. After a suspected diagnosis of torsion was ruled out, the patient was discharged.

Though our interaction was over, I reflected heavily on her visit: **Why did I feel so anxious? What could I have done differently to make her feel more at ease?**

In the United States, it is now estimated that 700,000 American adults identify as transgender. The term "transgender" describes an individual whose gender identity differs from the sex marked on their birth certificate. Gender identity is defined as a person's internal, personal sense of their gender,



Transgender people
are 4 times more likely
to live in poverty.

41% of transgender
individuals have
attempted suicide.

be it man, woman, or perhaps something outside of that binary. Individuals may be gender fluid, meaning they do not identify as having a fixed gender. Collectively, these identities are referred to simply as “trans.”

Many transgender individuals have had negative health care experiences, rooted in stigma, rejection, or ignorance from their providers. Sadly, such negativity is not limited to the health care space. In 2013, a disproportionate 72% of

LGBT homicide victims had identified as transgender women; 41% of transgender individuals reported having attempted suicide, compared to 1.6% of the general population. Transgender people are 4 times more likely to live in poverty, and they experience unemployment at twice the rate of the general population. These numbers spike even higher among transgender people of color. These are only some of the barriers this community faces in accessing reliable health care. I was surprised to learn **this population is now becoming increasingly reliant on the emergency department (ED) for their health care needs.**

As an emergency medicine physician, I enjoy the incredible, rich diversity of the patients we care for. My patients inspire me to be a better physician by challenging me to understand their needs, motivations, and fears on a deeper level. During our short time together, my patient described her transition as “lifesaving”—and I now better understand why this was true for her. Laverne Cox, famous advocate for trans individuals, once stated, “It is revolutionary for any trans person to choose to be seen and visible in a world that tells us we should not exist.”

It is important to continuously reflect on our experiences and allow ourselves to grow into the competent, compassionate physicians our patients deserve. ★

I sought to understand how to best care for trans patients. Here are several key lessons I’ve learned.

- 1. Avoid overemphasis on surgeries and/or patient anatomy.** An inordinate focus on biological composition dehumanizes and ultimately minimizes the trans experience. As medical professionals, it may be relevant to ask about reassignment surgery or hormone therapy. However, probing out of curiosity is, simply put, inappropriate. In the majority of situations, one’s gender identity is irrelevant.
- 2. Structure interviews with open-ended questions.** This allows patients to share and disclose their identity as they deem appropriate. Ask known trans patients, “Which pronouns do you prefer and what may I call you?” Document this in the medical record and share this information with the patient’s care team. However, remember there is no universal trans experience. Each person’s transition is unique; each will come to you with a varying level of trust. Allow your patients to disclose as much or as little as they feel. Do not disclose a person’s transgender status to anybody who does not need the information for care.
- 3. Be an advocate.** If you find that a coworker or fellow staff member makes inappropriate comments, challenge their stance in a non-confrontational way. Ask, “What do you mean by this?” to unpack their thinking, or speak to the individual in private. It may feel awkward at first, but it is important to adopt this habit. Given the complex diversity of patients we care for, it is crucial that we continuously work to ensure our ED remains an open and inclusive space for *all* patients at *all* times.

Atrial Fibrillation after Naloxone Administration

A Rare Complication of Opioid Reversal

Background

Naloxone is a widely used antidote critical in reversing the lethal effect of respiratory depression after opioid overdose. In combating the opioid epidemic in the United States, its use has increased significantly.¹ Though usually benign, it is important to be aware of the possible adverse effects of this lifesaving drug, such as the risk of precipitating acute opiate withdrawal syndrome, which can lead to detrimental cardiac dysrhythmias and hypertensive crises.^{1,2,3}

Case Report

A 25-year-old male with a history of heroin abuse was brought in by ambulance after being found in a parking lot unresponsive. Upon arrival to the emergency department, the patient had agonal breathing and appeared cyanotic. The patient was immediately oxygenated with bag valve mask and given 2 mg of naloxone subcutaneously followed by 0.4 mg intravenously (IV) once IV access was obtained. The patient maintained an oxygenation saturation of 100% during bagging with 15 liters of supplemental oxygen, and had an initial blood pressure of 102/76.

Approximately 1 minute after naloxone administration, the patient became responsive. He admitted to snorting heroin and denied any other drug use. He was monitored with cardiac telemetry and capnography. After 5 minutes, the patient became tachycardic at 120 bpm, and a 12-lead ECG showed atrial fibrillation with rapid ventricular response. The patient was otherwise asymptomatic, so IV fluids and symptomatic care were provided. Labs including complete blood count,

basic metabolic panel, magnesium level, thyroid function tests, and troponin were all within normal limits. The patient was admitted for further monitoring.

While hospitalized, the patient spontaneously converted back to normal sinus rhythm and was scheduled to follow up with cardiology as an outpatient after 24-hour observation. The patient was not placed on cardiac medications or anticoagulation and was counseled on his illicit drug use.

Case Discussion

The theory behind this case was that naloxone caused sudden and near-complete reversal of opiate suppression of the sympathetic nervous system, leading to the patient's arrhythmia. With no known underlying cardiac disease in this young patient, it was believed that the arrhythmia would resolve spontaneously after the effects of naloxone subsided, roughly 2-3 hours after the time of administration. The risk of a poor outcome due to temporarily leaving the patient in atrial fibrillation was felt to be less than the risk of administering anticoagulation or rate-control medication, whose potential significant adverse effects would outlast the expectedly short duration of atrial fibrillation.⁴

Naloxone reverses opioid suppression of the sympathetic nervous system, and side effects are rare.¹ However, cardiac arrhythmias including ventricular tachycardia have been demonstrated in human cases as well as animal studies.^{5,6,7} Our patient experienced atrial fibrillation, a dysrhythmia associated with increased adrenergic tone. It is imperative to closely monitor patients after naloxone administration, not only for its weaning

effects and relapse into respiratory depression, but also its direct risk of acute opioid withdrawal syndrome.

Conclusion

Naloxone use for opioid overdose is not uncommon and is witnessed by many emergency physicians. It is necessary to understand the possible adverse reactions and effects that may occur after administration. The managing physician should be prepared for a sympathetic surge.^{8,9} We present a case demonstrating the rare complication of atrial fibrillation after opioid reversal with naloxone. The patient successfully recovered after attentive monitoring and supportive care. ★



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Journal Club

FOR

DUMMIES

How Not to Be Intimidated by Evidence-Based Medicine

Have you ever looked at a journal club article and felt overwhelmed? You are not alone! Many residents are in the same boat. However, there is no way to escape it once you enter residency, nor should there be. Evidence-based medicine is an essential and integral part of our practice.

With the advent of the internet, the number of publications readily available has dramatically increased.¹ It has become increasingly important for us to feel confident sorting through what is clinically relevant for our own practice. While this may feel like a tall order, here are a few tips and tricks that will make reading any article easier.

What is the Clinical Question?

All studies begin with a clinical question. This is the most important part of any study because the study was essentially crafted around this query. If you don't comprehend the question, then you will struggle through the entire article. Sometimes, it may be necessary to do some background reading of your own to familiarize yourself with the topic. Typically, you can find it clearly stated in the abstract.

Use the PICO Model

PICO is a model that will help you determine the “who, what, when, where, why, how” of the study. This can be determined by reading the abstract or by skimming the relevant sections in the article. Knowing these 4 pieces of information will provide you with a framework for reading the study.²

- “P” stands for patient, or population:

Who is the subject of this conversation?

- “I” stands for intervention: How did the study intervene on this subject?
- “C” stands for comparison: To what group is the intervention group being compared?
- “O” stands for outcome: What is the primary outcome for the study?

Determine the Level and Quality of Evidence

There are multiple types of studies, with the gold standard being the randomized controlled trial. In general, you can divide studies into primary vs. secondary literature. Primary literature studies the question directly. Secondary literature involves synthesizing and evaluating the primary literature. Both are necessary to answer a clinical question. Examples include:

Primary Literature: cohort studies, case control, case series, randomized control trials

Secondary Literature: meta-analyses, systematic review, evidence-based practice guidelines, critically appraised topics (CATs).

Of note, there are articles published in the medical literature specifically about how to evaluate an article, such as a meta-analysis. These articles may provide a helpful framework when evaluating the quality of the article that you are reviewing for journal club.

Read the Article in Your Preferred Order

Typically, one starts with the abstract, since this is the study's skeleton. Some



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people prefer to read the article in its printed order. Others prefer to read the figures or methods first. Table 1 is usually a helpful tabulation of patient characteristics.

Ask Yourself: Would I Apply this to My Clinical Practice?

At the end of your reading, remind yourself of the clinical question. Did the article convince you the authors answered the question well? Was there a confounding variable they did not account for? Do you still have some unanswered questions or doubts? Ultimately, it is up to you to decide if you will change your practice based on this article.

In addition to using these techniques, there are several other resources that may help you digest articles. For example, there are certain apps (like Journal Club) and websites (Wiki Journal Club) that will clearly spell out the clinical question, major points, and bottom line.

You may need to experiment with different methods before you find the one that works best for you. **Keep in mind: If you make learning article analysis a priority today, it will serve you for a lifetime. ***

ODE TO *Local Tenens* Lessons from the Real World

The search for a job out of residency can be an extremely daunting task. Dozens of employment models and practice settings exist, and it is difficult to decide which of these will ultimately fulfill your career aspirations while staying in-line with your values. Academics? Hospital-based employee? Independent contractor? Democratic group? Freestanding ED? Urban? Suburban? Rural? It is enough to make your head spin.

Fresh out of the residency pipeline, I simply wanted to work hard, find a good group of physicians to learn from, and retire after a fulfilling career. What I didn't realize is that 70% of physicians across all specialties change jobs within their first 2 years out of residency. I too became part of that statistic.

Some wonderful learning took place in those first 2 years out of residency on many fronts, but the learning curve regarding the 'business' side of medicine was particularly steep. I was a full-time, W-2 employee in a community group, yet I struggled to see the benefits. We were able to seek very fair compensation based on relative value units (RVUs), but I was not provided health insurance, disability insurance, or retirement benefits. In addition, I was expected to pay \$50,000 tail coverage on malpractice insurance if I decided to quit the group and work somewhere else. I also felt a constant pressure to work more shifts and to fill open shifts last-minute, not to mention many weekends and holidays. Needless to say, I did not feel that this model was a fit for me.

I did a little soul-searching and wrote down my three main goals:

1. Gain control of my schedule
2. Optimize my pay
3. Survey prospective employers by practicing in a variety of settings

Then it dawned on me: What would stop me from credentialing with multiple hospitals and groups in the area and working as an independent contractor (1099 status) to fill their open shifts? The idea of "local tenens" (my own phrase, not to be confused with locum tenens) materialized. In that one decision to transition from a W-2 to a 1099 employee, I gained more control over my schedule, optimized my pay (actually doubled it), and experienced how other hospitals operated. I knew my worth and negotiated for a rate that reflected this. I did not rely on anyone else to advocate for me.

Of course, "local tenens" will not work in every market and is certainly not the best choice for everybody. There are plenty of high-quality groups out there that offer great benefits. However, the take-home is that in today's physician marketplace, demand far exceeds supply. Do not feel bad about seizing the opportunity to craft a career that is flexible, balanced, and sustainable. Having a life and identity outside of medicine is the best for you, your family, your career, and your patients...yes, in that order, because if you don't take care of the first then the rest will surely suffer. ★



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**Editor's note: Interested in learning from Dr. Larson about contract negotiation? Check out his blog on www.medspoke.com.*

Lessons from Interview Season



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An Intern's Reflection on What Really Matters

Interview season provides a great opportunity to meet leaders in the field of emergency medicine, build new friendships with future colleagues, and begin envisioning your career. While an experienced advisor is an invaluable asset, faculty and residents along the way offer helpful insight and advice. At my final interview, this recommendation encapsulated the pearls from the interview trail:

“Throw away your spreadsheet comparing the finer points of residency, and consider the philosophy, people, and opportunities of each program.”

One faculty interviewer told me the residents who do best at their program are the ones who buy into the training philosophy. At the end of each interview day, I wrote down a sentence or two encapsulating each program's mission. This written summary helped me reflect on how I best learned during medical school and what types of challenges help me thrive. With these insights in mind, I considered whether I bought into the program's approach. There are many outstanding residencies across the country with the tools to help you become a great physician. Ultimately, the outcome of your training is not the result of a program's formula. **Rather, the outcome of your training is a product of your commitment and investment, both of which will be enhanced when you believe in a program's principles and practice.**

Not only do you want to buy into a program's mission, you also want to be part of a team with a shared commitment to one another. A sense of social support bolsters your success during residency and

helps stave off burnout. One of the best opportunities to evaluate the residency culture is during the interview dinner with residents. Consider how well you fit in and how much they seem to enjoy being together. If you can, call residents after the interview to corroborate your impressions and further evaluate if this could be your team. Amidst the rigor of training, you want to feel supported, have fun with your teammates, and trust that everyone has each other's backs. A residency program is a community that will mold and refine you into a reflection of its leadership, faculty, and trainees.

Residency will be your first job after medical school. Look at how the opportunities at each program align with

your career goals. Take into account who you are and who you want to be. Look at the program alumni to see if graduates practice what the program teaches. Just as you place your best foot forward on interview day, programs do the same. Evaluate the data for consistency between what the program claims and how well they are achieving this.

Interview season is a wonderful introduction to the emergency medicine family. Seize the opportunity to soak up the wisdom, encouragement, and hospitality of residents and faculty across the country. To the medical students interviewing this coming year: Don't sweat the details! **You have already chosen the best specialty.** Good luck! ★



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Your Time, Your Legacy

James A. D'Orta, MD, FACEP(E)

Advancements in medicine are driven by the curious, the dedicated — even, sometimes, the indignant.

Throughout his three-decade career, innovator and physician Jim D'Orta has been all those things. It's what led him to pioneer the "Minute Clinic" concept in the United States, and to lead the fight to make automated external defibrillators a customary piece of public safety equipment, and to encourage medical device improvements for everything from intubation to wound care.

During his residency, Dr. D'Orta served as EMRA President — and the leadership mantle fit him well. In the years since, he has founded and fostered several companies and become an influential voice in the house of medicine and within the Beltway. The Augustine D'Orta Award, presented annually by EMRA to a resident who demonstrates outstanding community-minded, grassroots-oriented political involvement in health policy or community issues, reflects Dr. D'Orta's ongoing commitment to public health.

What's your favorite EMRA memory?

You know, my EMRA chapter was such a great, great time. I remember being in Dallas, Texas, in the way back, and organizing our political ticket for the EMRA elections and putting together our leadership team. We focused pretty quickly on the EMRA awards, which we started during my administration as EMRA president. I think it really highlighted some great people in EM. We built support within the house of medicine where the specialties recognized the contributions we were making. We started the *EMRA Antibiotic Guide* — I think it was called the Antibiotic Handbook then — in our era. We

led several disaster relief efforts, thanks to Jim Dougall and Carla Murphy. We had great leaders in EMRA who truly reached back and pulled the younger residents to leadership positions within the college. Drs. David Tallon, Jim Dugal, Leslie Zun, and Woody Woodburn were the key EMRA resident leaders. Drs. Joseph Waeckerle, Richard Stenis, JD McKeown, Larry Bedard, Mike Bishop, Greg Henry, Steve Dersnick, and other ACEP leaders of the time, along with Collin Rorie and Ben Monger, all made a difference.

How can residents influence the specialty?

I think we need to be scholars but we need to not accept everything we read. We need to challenge the system. We need to challenge therapies — we need to be scientists. Had we not challenged the system we never would have had the AED, which was a landmark change in out-of-hospital cardiac arrest. If we did not have Minute Clinics, we would be just so suffocated in our specialty. If we didn't have NPs or PAs who are eager to be involved in EM the specialty would not have advanced, and I learned that during my time in EMRA. Many physicians are not as exposed to the team effort of emergency medicine. In EM, we're not an individual — we're a member of a team.

Best advice for a physician on the verge of a career in emergency medicine?

Be a great doctor to your patients, and at the same time you need to wealth-build. This is not something taught in residency, but you know — no money, no mission. And physicians really do not get that training. Seek out mentors who have been successful. I've found in my life that if you as an individual approach another individual who has been successful in

Medical School

Juarez University

Residency

EM residency at Georgetown University Hospital; surgical residency at Franklin Square, part of Johns Hopkins University

Current Position

Consultant; Associate professor, Georgetown University; Adjunct professor, George Washington University; Associate professor, University of Maryland

a field of interest to you, and you ask for help — they generally will give it. We as physicians start out essentially as humanists. We entered into a world where leadership didn't focus on one's abilities in the social field so much as in the scientific realm, but the fact is it's the centrist who is the successful physician. It's not the one who lacks an understanding of how things work. I had a great mentor back when I was just finishing my residency, Frank Pearl — one of the first leveraged buyout dealers in a company called Wesray, which included William E. Simon, a former Secretary of the Treasury. Frank taught me so much about leveraging and growing businesses. It's all about leveraging our knowledge of finance and joining it with the skilled leadership of physicians. It's the challenge of the young emergency physician to understand how to wealth-build.

How can residents develop an entrepreneurial spirit?

Remove the word fear from your vocabulary. Risks can be analyzed and overcome as long as you have a clear vision. You can't let fear stop you from wanting to move forward. I think Clay Christensen, a great innovator from Harvard, used the phrase "the disruptive thinker." The disruptive thinker understands that if there's an obstacle in front of them, they either go over it, or under it, or around it — or through it. But they don't let it stop them.

Looking for partners is the networking portion — and you can start with EMRA and ACEP and the events hosted at the national and state levels. Being active in the specialty is a way to reach out. Also, get involved in community-minded spirit awards or social awards; that's a way to meet major donors and grateful patrons. Those are some of the things that laid the foundation for me.

I also reached out to some of the large houses in private equity. They are always looking for dynamic individuals within their spheres of specialty. While the internet may give you a world of information, remember that most successful entrepreneurs don't blow their own horns online. Success is dealt on a one-on-one level. You need the human interaction.

Augustine D'Orta was my grandfather, who was a carpenter. He believed very strongly that the growth of business

comes from the fellowship of business. He developed coalitions of businesses in New York. He started a club called the Dog Eat Dog Club, which developed into the Chamber of Commerce. That concept of working with your competitor for the greater good tends to drive growth. My father (also Augustine D'Orta) was also a firm believer that great leaders in society make great business individuals.

What do you like most about emergency medicine?

I love the spirit of EM. I love the excitement of it. There's also a gratification: it's the greatest feeling to take someone who is sick and make them well or get them on the path to being well — it's a high that I've never been able to reproduce elsewhere in my professional career. Even if your patient dies, their family becomes your patient. You guide them through those first moments of loss. You are there for them, to help them face their new future.

How do you grow into that responsibility?

My mother and father were very caring and open people, and we had a great family. It was also modeled for me in my EM residency at Georgetown. Although I consider myself a believer, I'm not a great advocate of religion. But at Georgetown the Jesuit halo effect of caring for the whole person was evident in every corner of the institution — you couldn't get away from it. The Georgetown method of curing the entire person was very much the mission of both the medical school and the residency. That's where I felt it, I lived it, and I was taught it.

If you could change one thing about the practice of medicine today, what would you change?

We're going through a horrific time because of reimbursement. If I could change one thing it would be our reimbursement system. It tends not to reward the scholarship and tends to reward the techniques, and in EM what I see is we're just such a great blend of both technique and scholarship. We just seem to get it wrong because of reimbursement.

What's on your reading list?

I love to read history, and "No Ordinary Time" captures the great story of FDR. In

addition, I really enjoyed another book by the same author: "Team of Rivals: The Political Genius of Abraham Lincoln."

Favorite spot you've visited?

The Isle of Capri. It's a little bit of heaven that's fallen from the sky. It's about 30 miles off the coast of Naples, Italy. We were there with the kids at the beginning of summer and we visit frequently.

What do you consider to be your crowning achievement?

My crowning achievement is being the father of triplets — AJ, Cubby, and Maryrose — with my partner, Jed.

The perfect family fun night includes

Our favorite family fun nights are pizza parties. We love them. We always end up with multiple pizzas.

Did you know...

- ✓ Uncle Albert "Cubby" Broccoli (of 007 fame) pointed Dr. D'Orta toward emergency medicine while he was completing his surgical residency. His cousin, Barbara Broccoli, has been a great supporter of EM as well, making sure the cast and crew of James Bond films have access to top health care on-set. "We took the residents from GWU to oversee many of the international locations for James Bond. We're getting ready to do the next James Bond due out in 2019, and Barbara will include emergency physicians in the making of that movie, too. We always involve both the residents and their attendings. We don't know what residency, but we always seek academic programs."
- ✓ He once spent time in a Moroccan jail after providing lifesaving care for the bodyguard of a Crown Prince of Bahrain.
- ✓ A 2007 Tony Award winner (and 3-time Tony Award nominee), Dr. D'Orta is a sometimes-Broadway producer and actor.
- ✓ He is the first volunteer firefighter/paramedic in New York to become a physician.
- ✓ He is the first board-certified emergency physician to serve as a trustee for a major hospital system. ★

You Made Us Proud!

CONGRATULATIONS

to the recipients of EMRA's fall 2017 awards — and thank you to everyone who participates in the process.

Your accomplishments reflect the strength of emergency medicine!

Joseph F. Waeckerle Alumni Award

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Melanie Watts, MD

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Gillian Schmitz, MD, FACEP

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Randy Sorge, MD

Augustine D'Orta Award

Ashley Alker, MD

Steve Tantama, MD, Award for Military Excellence

Capt. Joshua Krieger, MD

Clinical Excellence Award

Joshua Glick, MD

Be the Change Grant

Paul Ginart

Local Action Grant

Natalie Terao, MD

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Erik J. Blutinger, MD

International EM Scholar

Morgan Broccoli, MD

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Jennifer S. Love, MD

EMRA Simulation Research Grant

Lawrence Lau, MD

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Brian Ichwan, MD

EMRA ACEP17 Scholars

Erik J. Blutinger, MD

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Lawrence Lau, MD

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Brian McQuaide

EMRA EDDA Scholars

Olumide Akindutire, MD

Keith C. Hemmert, MD

Alex Koo, MD

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Rohit Sangal, MD

Leadership & Advocacy Conference Scholars

Olumide Akindutire, MD (EMDOCS Resident)

Caitlin Bonney, MD

Hannah Gordon

Jonathan Meadows, MPH, CPH

Arwa Mesiwala, MD (*EMDOCS Super Women of EMRA*)

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EMRA's mission is to be there for you at every stage of your training — and a key way we do that is by offering unparalleled on-shift resources. This fall we're bringing you 4 new books to tuck in your pocket!

NEW! EMRA EKG Guide

The inaugural *EMRA EKG Guide* will quickly become your go-to resource for on-shift EKG interpretation in the emergency department. It describes the diagnostic criteria and important clinical features for can't-miss EKG findings — all organized for fast and efficient referencing.



This book hails from the Christiana Care Health System in Delaware, home of the powerhouse *EMRA Antibiotic Guide*. Editor-in-chief Jeremy Berberian, MD, Associate Director of Resident Education, has teamed up with editors Brian Levine, MD, FACEP, Christiana Care's EM Residency Program Director, and William Brady, MD, FACEP, of the University of Virginia, as well as Christiana's emergency medicine residents and faculty.

The *EMRA EKG Guide* is not an instruction manual for learning how to read an EKG; rather, it's a resource to help you determine whether a finding is abnormal and/or clinically relevant, Dr. Berberian said. "The goal of this guide is to provide a list of potential EKG findings associated with a given pathology, as well as a list of potential pathologies associated with a given EKG finding, which is typically how we think when we interpret an EKG. It's distilled down to what's most important to us when evaluating a patient with a potential cardiac emergency."

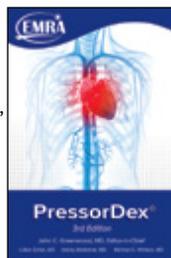
With an educational grant from Christiana's private democratic emergency medicine group Doctors For Emergency Services (DFES), EMRA is pleased to offer the *EMRA EKG Guide* to all resident members. The book exemplifies DFES's commitment to resident education, said Charles Reese IV, MD, FACEP, chair of the Department of Emergency Medicine at Christiana Care and vice president of the board of DFES.

"Education is a core responsibility we take very seriously," Dr. Reese said. "It's an almost sacred goal that has been part of our group's philosophy since it was founded more than 40 years ago."

Including residents in the book development adds another layer to that education. "They get to see the inner workings of medical education by being part of the writing, editing, and review process," Dr. Levine said. "It really puts any topic — whether that's antibiotic usage or EKG readings — in a different light when you know it's going to be used not only as a learning tool but also, and chiefly, as a resource on-shift."

PressorDex®, 3rd ed.

In *PressorDex*®, 3rd edition, editor-in-chief John Greenwood, MD, and a team of nearly 100 authors, editors, and reviewers bring you the latest clinical recommendations for vasoactive agents, pressors, continuous



infusions, and other drugs for the critically ill patient.

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Basics of Emergency Medicine, 3rd ed.

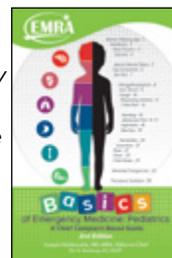
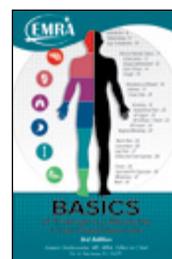
Editor-in-chief Joseph Habboushe, MD, MBA, and associate editor Eric Steinberg, DO, FACEP, have assembled a clinical guide that will help you handle the most common chief complaints efficiently and quickly throughout your shift. Use *Basics of Emergency Medicine* to ensure nothing is overlooked as you treat the adult patient population.

This pocket-size guide focuses on the 22 most common chief complaints you'll see on shift and is ideal for medical students, interns, off-service rotating residents, NPs, PAs, nurses — and anyone caring for patients in the fast-paced world of emergency medicine.

Basics of Emergency Medicine: Pediatrics, 2nd ed.

Pediatric patients can make for nerve-wracking cases. *Basics of Emergency Medicine: Pediatrics*, 2nd edition, aims to erase some of the stress of caring for our youngest patients.

Led by editor-in-chief Joseph Habboushe, MD, MBA, and associate editor Eric Steinberg, DO, FACEP, the team of authors and editors offers considerations for the most common pediatric complaints — along with considerations for child abuse, an overview of neonatal emergencies, and ultra-resourceful pediatric medication charts, normal vital signs, and likely diseases per age group. This reference is a must-have resource for the whole medical team involved in pediatric emergency care. ★



ABEM Online ITE

The 2018 In-training Examination (ITE) will be an online exam. This year, each residency program has the option of holding the exam during a single day, or over up to 5 days, beginning Feb. 27. As a result of the expanded testing window, the rules about discussing exam questions have been revised, so conversations about test questions cannot take place until after the entire 5-day testing window is over, no matter whether an individual program administers the test over 1 day or 5 days. Many residents have already experienced the online testing format, but for those who have not, a few highlights:

- The test can be taken using either Windows or Mac operating systems, as well as iPads.
- In the 2 weeks prior to the first day of the exam window (Feb. 27), programs and residents will use a portal to run final systems checks. If you or your program experience any difficulties, technical support will be available.
- In the interest of security, the ability to access the Internet or files on electronic devices will be disabled.
- At the end of the exam, you will have the opportunity to respond to a survey about your testing experience. Your input is valued, so we encourage you to respond. ★

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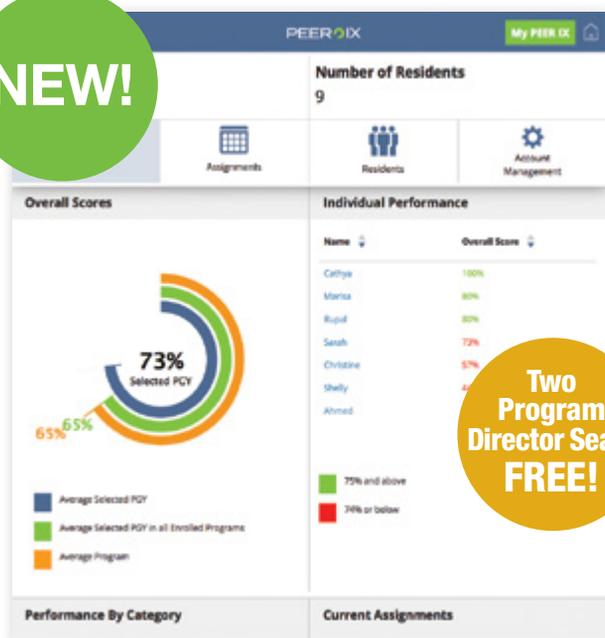
Funding for this initiative was made possible (in part) by grant nos. 5H79T1025595-03, 5U79T1026556-02 and 3U79T1026556-02S1 from SAMHSA. The views expressed in written conference materials or publications and by speakers and moderators do not necessarily reflect the official policies of the Department of Health and Human Services nor does mention of trade names, commercial practices, or organizations imply endorsement by the U.S. Government.

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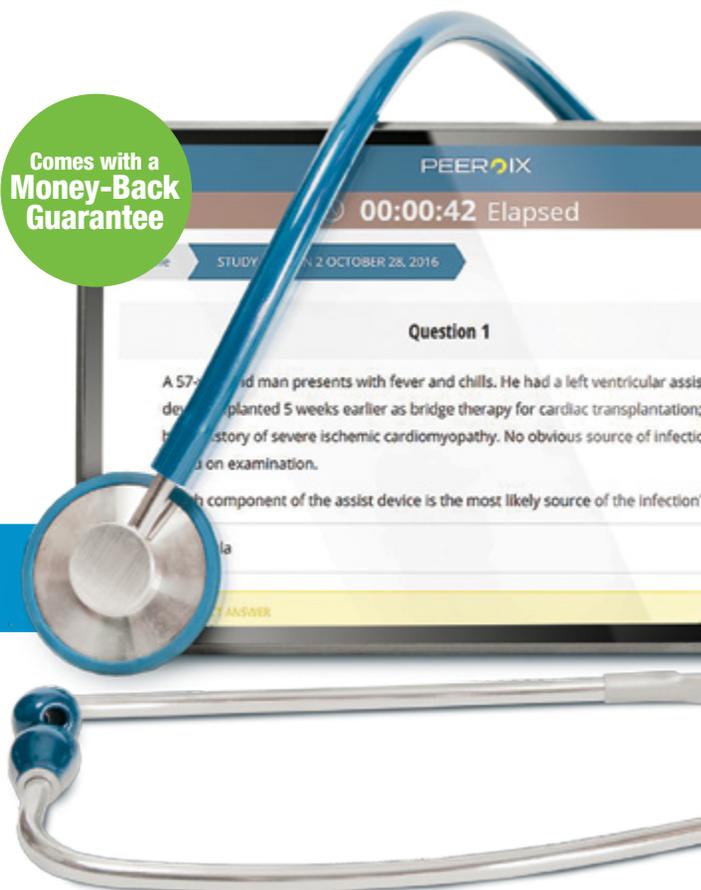
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Lawrence Lau, MD
Emergency Medicine Resident
Thomas Jefferson University
Philadelphia, PA



Hannah Mirzakhani, OMS IV
Lake Erie College of
Osteopathic Medicine
Erie, PA



Nicholas Governatori, MD
EMRA Director of Education
Assistant Residency Program
Director
Thomas Jefferson University
Philadelphia, PA



The Case

30-year-old male with no significant past medical history presents with 2 days of gradually worsening rash over the left nare, left upper lip, and inferior medial epicanthus. It is pruritic and mildly relieved with application of hydrogen peroxide and rubbing alcohol. Patient denies fever, eye pain or discharge, otalgia, headache, or blurry vision. He also denies exposure to any new hygiene, household cleaning products, or insects. He is up to date on his vaccinations and had an episode of heat exhaustion at work one week ago.

What is the diagnosis?

What is the treatment?

See the **DIAGNOSIS** on page 32

The Diagnosis

Herpes Zoster of the Maxillary Branch of the Trigeminal Nerve (V₂)

Herpes zoster is caused by reactivation of a latent infection of the varicella zoster virus (VZV), a member of the herpes virus family. During initial infection, VZV establishes a lifelong latency within the dorsal root ganglion of sensory neurons. Reactivation can occur due to many causes, such as immunosuppression, stress, or local trauma. The incidence also increases with age.¹

In this patient, reactivation was most likely due to the recent episode of heat exhaustion at work. During reactivation, the virus travels down the sensory nerve in the cutaneous distribution to produce the characteristic pruritus, paresthesias, burning, and rash. Pain can appear 48-72 hours prior to onset of rash, which is vesicular, unilateral, and limited to dermatomal patterns.^{1,2}

Ramsay Hunt syndrome (herpes zoster oticus) is a major otologic complication of reactivation within the V₂ and V₃ branches of the trigeminal ganglion (CN V), which may also lead to involvement of cranial nerves VII and VIII.³ The typical triad of symptoms includes ipsilateral facial paralysis, ear pain, and vesicles visible in the auditory canal or on the auricle.² Patients can also develop taste perception dysfunction on the anterior 2/3 of the tongue, tinnitus, hyperacusis, and lacrimation. If not treated, facial paralysis and hearing loss may become permanent.³ Treatment of herpes zoster oticus consists of a combination of antivirals (valacyclovir or acyclovir) and prednisone (5 days, without a taper).

The goals of therapy are to limit the extent, duration, and severity of pain in the primary dermatome; prevent disease dissemination; and prevent post-herpetic neuralgia. **Treatment of herpes zoster in immunocompetent patients should begin within 72 hours of onset of rash** and should only be considered after that time frame if the patient is developing new lesions.⁴

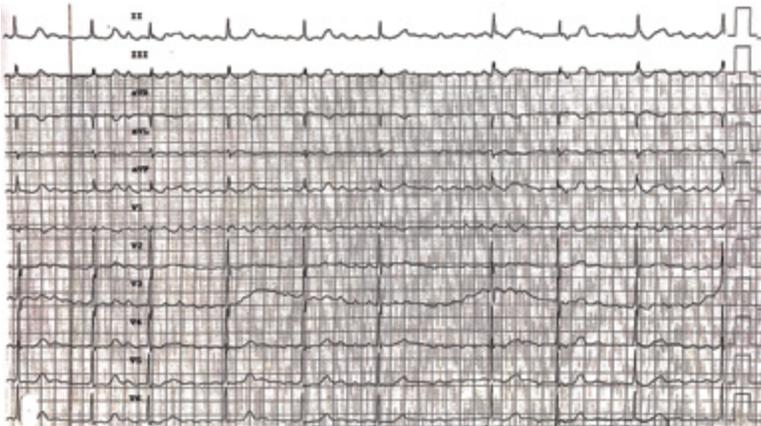
This patient had a single vesicle inferior to the medial epicanthus. Evaluation of the auditory canal revealed no lesions, and the patient did not have facial paralysis. A fluorescein stain of the eye was also performed and was negative for herpes keratitis. The patient was treated as an outpatient with acyclovir 800mg 5 times a day for 7 days with close primary follow up. ★



References available online.



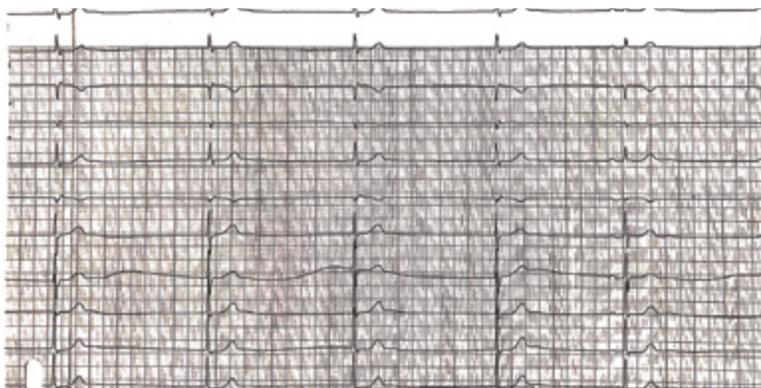
ECG Challenge



Shelby Catlett, MD
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Jeremy Berberian, MD
Associate Director of Resident Education
Dept. of Emergency Medicine
Christiana Care Health System
Newark, DE

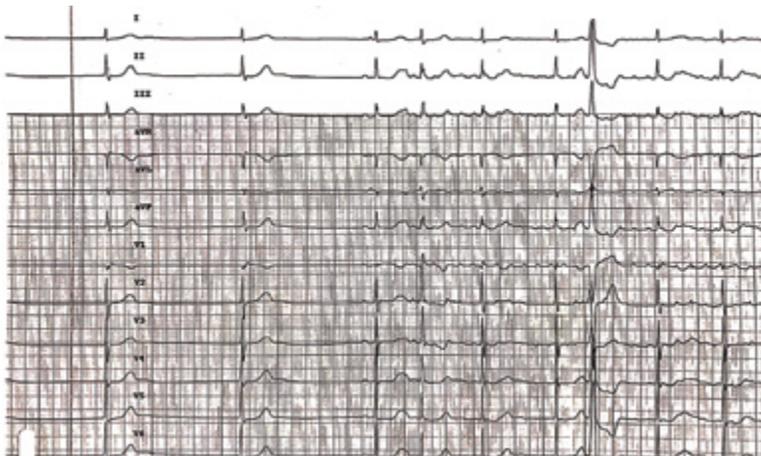


CASE.

An 81-year-old female with a history of hypertension presents with episodes of lightheadedness.

What do you see in this 12-lead rhythm strip?

Note: The 3 images are continuous.



**See the ANSWER
on page 34**

ECG Challenge



Case Resolution

Labs were unremarkable for any significant abnormalities. Shortly after this ECG was obtained, the monitor showed multiple 3- to 4-second pauses. The patient did not require external pacing and was admitted for placement of a permanent pacemaker. ★

ANSWER

Image 1. The initial rhythm is coarse atrial fibrillation (AFib) with an average ventricular rate ~60 bpm. It was initially mistaken for atrial flutter (AFlutter) with variable block because the large amplitude f-waves (fibrillatory waves) look like F-waves (flutter waves) and appear regular at ~300 bpm. However, AFlutter will demonstrate consistent F-wave morphology, duration, and timing with the absence of an isoelectric baseline in lead II. AFib is typically described as “coarse” when the majority of f-waves are easily seen and have an amplitude ≥ 3 -5 mm.

	ATRIAL FIBRILLATION	ATRIAL FLUTTER
General Features	<ul style="list-style-type: none"> Irregularly irregular rhythm with absence of any organized atrial activity Presence of f-waves of varying morphology, duration, and timing 	<ul style="list-style-type: none"> Caused by a re-entrant circuit initiated in the right atrium Stereotypical “sawtooth pattern” of F-waves best seen in the inferior leads
EKG Features	<ul style="list-style-type: none"> Absence of distinct repeating P-waves with atrial depolarization rate typically >300 bpm Ventricular rates typically 100-200 bpm Irregular RR interval when AV conduction is present (ie, in the absence of a 3rd degree AV block) 	<ul style="list-style-type: none"> Atrial rate is 250-350 bpm and typically fixed over time Ventricular rate is a fraction of atrial rate (2:1 \rightarrow 150 bpm, 3:1 \rightarrow 100 bpm) in the absence of a variable block Absence of isoelectric baseline (ie, TP segment) in lead II
Clinical Significance	<ul style="list-style-type: none"> Rate <100 bpm in untreated AFib suggests significant AV node disease Consider AFib with concurrent WPW when ventricular rate is > 250 bpm with wide QRS 	<ul style="list-style-type: none"> Consider AFlutter when ventricular rate is consistently around 150 bpm Vagal maneuvers or adenosine will slow ventricular rate but not atrial rate

Image 2. The rhythm changes to a junctional bradycardia at ~33 bpm.

There are likely retrograde P-waves after the QRS complexes in beats 1-4, best seen in V1 and aVR as upright deflections immediately following the QRS. Retrograde P-waves in these leads will usually be inverted (ie, upright, as they are typically inverted in normal sinus rhythm).

The 5th QRS complex is a sinus beat — narrow complex and preceded by a P-wave with a normal PR interval.

The 6th QRS complex is a junctional beat with a retrograde P-wave preceding the QRS with a PR interval <120 ms (best seen in inferior leads).

Image 3. Junctional bradycardia continues for 2 beats, followed by a sinus beat, then the rhythm returns to AF. The 7th beat is a wide complex premature beat with no preceding P-wave, and may be a PVC (arising from a ventricular focus) or an Ashman beat (an aberrantly conducted beat arising from a supraventricular focus)

Overall, these findings suggest sinus node dysfunction, also called sick sinus syndrome.

LEARNING POINTS

- Sinus node dysfunction (sick sinus syndrome) ECG findings:
 - Inappropriate sinus bradycardia:** persistent bradycardia unable to meet physiologic demands
 - Sinoatrial exit block:** depolarization fails to exit the sinus node resulting in a dropped P-QRS-T complex
 - Sinus pause/arrest:** depolarization fails to exit the sinus node resulting in a dropped P-QRS-T complex
 - Tachycardia-bradycardia syndrome:** alternating episodes of bradycardia and tachycardia (often PSVT)
- Junctional bradycardia ECG findings:
 - Regular narrow complex QRS in the absence of conduction abnormalities
 - Rate <40 bpm
 - May have retrograde P-waves before (with PR interval <120 ms) or after QRS
- Atrial fibrillation vs. Atrial flutter:
 - AFib:** f-waves with varying morphologies, duration, and timing
 - AFlutter:** f-waves with a uniform morphology, duration, and timing with no isoelectric baseline in lead II

Note: For more on sick sinus syndrome, see p. 17-18 of the EMRA EKG Guide.

Board Review

QUESTIONS

NEW! PEER IX QUESTIONS NOW AVAILABLE!

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 IX, which made its print debut in June 2017. For complete answers and explanations, visit the [Board Review Questions page under "Features" at emresident.org](#).

To order PEER IX, go to acep.org/bookstore.



1. A 61-year-old woman presents with vertigo. She says it starts every time she moves her head. She has no hearing changes or tinnitus and no previous medical problems. Her blood pressure is 178/85; there are no neurologic deficits. Bedside positional testing demonstrates nystagmus with a long latency and transient duration; it is suppressible with repeated testing. What is the most likely diagnosis?
 - A. Benign paroxysmal positional vertigo
 - B. Meniere disease
 - C. Transient ischemic attack
 - D. Vertebral basilar artery insufficiency
2. A 56-year-old man presents by ambulance, unresponsive and intubated, with stable vital signs. Paramedics report that he collapsed in a mall, and bystanders performed CPR and used an AED. "Shock advised" was noted on the AED, and bystanders said he showed signs of life. En route, a 12-lead ECG demonstrated an inferior wall STEMI. A repeat ECG shows continued inferior STEMI. Which of the following strategies for using therapeutic hypothermia is appropriate for this patient in the emergency department?
 - A. Consider starting it after the STEMI has been definitively managed
 - B. Start it with a target temperature of approximately 34°C (93.2°F)
 - C. Withhold it because of the patient's ECG abnormality
 - D. Withhold it since it was not initiated in the prehospital setting
3. Which of the following patients is at risk for health care–associated pneumonia?
 - A. Man with stable COPD who visits the clinic once monthly for 6 months
 - B. Nurse practitioner who recently underwent outpatient knee arthroscopy
 - C. Paramedic in an urban service area who is healthy but working extra shifts
 - D. Woman with end-stage renal disease who goes to dialysis three times a week
4. Which of the following aspects of the physical examination can best distinguish toxicity from an anticholinergic agent from that of a sympathomimetic agent?
 - A. Heart rate
 - B. Pupils
 - C. Skin
 - D. Temperature
5. Which of the following statements about diagnosing spinal cord injury without radiographic abnormality is correct??
 - A. Axial loading is the most common mechanism
 - B. Computed tomography can reveal occult fracture
 - C. It is more likely in younger children than in older children
 - D. Spinal column tenderness is common in the lumbar area ★

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



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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.



BROWN
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Emergency Medicine Fellowship Opportunities

The Brown Department of Emergency Medicine is proud to sponsor diverse fellowship training programs and is accepting applications for positions beginning July 1, 2017.

We offer ACGME and non-ACGME experience in:

International EM • Medical Simulation • Injury Prevention
Disaster Medicine • Pediatric EM • EM Ultrasound • EMS
Sex and Gender in EM • Medical Education Research
Emergency Medicine Health and Leadership Administration

Our fellows gain practical experience in a variety of academic and community settings. Rhode Island Hospital, our main clinical site, has an annual volume of 105,000 patients and serves as the region's only Level-1 Trauma Center.

Fellows are mentored by Brown University faculty and receive competitive salary, CME, and benefits through University Emergency Medicine Foundation. Most programs provide tuition support for master's degrees, including the Master's of Public Health through Brown University.

For more information please visit our website at:
www.brownemresidency.org/fellowships.html



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Arnot Health is currently interviewing for **ABEM/ABOEM-Certified Emergency Medicine physicians** to join the Emergency Department at Arnot Ogden Medical Center which is newly expanded and fully equipped.

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- Highly competitive hourly rate (\$215/hour) with an additional (\$20/hour) night shift differential.
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 - \$50,000 for candidates still in training
 - \$100,000 for experienced candidates
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 - up to a maximum of \$48,000
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Robert MacBlane
Director, Provider Recruitment
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rmacblane@arnothealth.org

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Cape Emergency Physicians is a small independent emergency medicine physician owned and operated practice that has been staffing Cape Regional Medical Center for over 20 years. It is a small community based hospital in Cape May County New Jersey with approximately 45k visits per year. The hospital is just minutes away from the beautiful beaches of Stone Harbor, Avalon and Cape May.

We are seeking BC/BE emergency medicine physicians for FT, PT, or per diem positions.

- Competitive hourly rates of \$175/200/225 per hour
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- CME allowance,
- 10 hour shifts
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- 11 bed acute care, 9 bed sub acute care, 9 bed fast track and 5 bed behavior health unit

If interested, please reply to Laura Ashley at staffing@urgentcarephysicians.org with your contact information and CV.

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NATIONWIDE

Looking for a Change? You have invested a lot of time and money in your future. The opportunity you choose should be the right fit for you both professionally and personally. TeedCo. would like to help you find your perfect fit. We currently have openings for **Core Faculty, Faculty, Community Practice, Residency Director and Director** positions nationwide. Stop by our **Booth #2407 at ACEP** or contact me today! **In confidence. Shawn Teed, TeedCo. Healthcare Recruiting, 877-901-0191, ext. 121.**

ARIZONA



Phoenix: Tired of the rain and cold? We are based in **Phoenix, Arizona**, which offers affordable living, sunshine, great schools, an urban environment, and endless options to enjoy a myriad of activities outside of work. Here you will find every major sports team, a golfers' paradise, a spa haven, thousands of venues for arts and culture, an urban vibe - the list of attractions is endless. Why not combine an exceptional career with the one of the most desirable cities to live in? There are no trade-offs here. By joining EPS you get the best of both worlds: working in world class emergency rooms while living in a city which has everything to offer. Openings in for full-time Emergency Physician with established physician group. We contract with four Banner hospitals in the Phoenix-metro valley. University Medical Center Phoenix - an academic tertiary care hospital located in downtown Phoenix with 9 residency and 8 fellowship programs. **New state-of-the art ED opened in June 2017.** Estrella Medical Center located in west Phoenix near the University of Phoenix stadium and Phoenix International Raceway. Ironwood Medical located in the San Tan Valley area. Goldfield Medical Center located in Apache Junction, in the shadows of the Superstition Mountains. We also partnership with MedAire Inc. to provide emergency medical support to commercial airlines, private jets and luxury yachts via a state-of-the-art global response center. We offer a comprehensive benefits package that includes: paid claims-made malpractice insurance/tail coverage included • group health insurance • disability insurance • CME allowance • paid licensing fees and dues • 401(k) plan. This compensation package is extremely competitive. Candidates must be EM residency trained or ABEM/ABOEM certified/eligible. Email CV to monica.holt@bannerhealth.com or visit us at www.emergencyprofessionalservices.com.

ALABAMA

Mobile: ACADEMIC EMERGENCY MEDICINE POSITION – The University of South Alabama, Department of Emergency Medicine is expanding its academic programs and is seeking full-time EM faculty. Responsibilities will include teaching students and housestaff, patient care, and participation in other academic activities. There are opportunities to initiate or contribute to new programs and services and an EM residency program is in development. Applicants are invited to submit CV and letter of interest to: Edward A. Panacek, MD, MPH, Chair of Emergency Medicine, University of South Alabama College of Medicine, USAMC 2451 Fillingim St., Mobile, AL 36617, or email eapanacek@health.southalabama.edu. Further information at www.southalabama.edu/departments/academicaffairs/resources/healthsciencepositions/medicine/USA.EM.%20Recruitment.notice_2015.pdf.

ALASKA

Fairbanks: New full-time position for a BC/BE Emergency Medicine physician to join a stable, democratic group of 10 physicians. This is a hospital practice based at Fairbanks Memorial Hospital. Annual visits exceed 36,000. Fairbanks Memorial Hospital is a JCAHO accredited 159-bed hospital that is the primary referral center for the 100,000 citizens of Alaska's interior. Fairbanks is a truly unique university community with unmatched accessibility to both wilderness recreation and urban culture. We aim to strike a balance between life and medicine, offering excellent compensation and benefits with a 2-year partnership track. 10 hour shifts with excellent mid-level coverage. For additional information please contact: Michael Burton MD, President (907) 460-0902 mrb5w@hotmail.com or Art Strauss MD, Medical Director (907) 388-2470 art@ghepak.com.

CALIFORNIA

San Francisco Bay Area – Pleasanton, Stanford ValleyCare Medical Center: Single hospital, democratic physician-owned group is seeking full and part-time Emergency Physicians. Our community hospital has 34,000 annual ED visits. We have double physician coverage 18 hours/day, with shift duration ranging 7-8 hours, and equitable distribution of night shifts. Pleasanton is a very desirable area with easy access to San Francisco, the mountains of Tahoe and Yosemite, as well as top-ranked schools. Candidates must be residency trained and EM board qualified or certified. For more information about this position, contact email: pleasantonemgroup@gmail.com.

San Francisco Bay Area – San Jose: EMERGENCY MEDICINE OPPORTUNITIES AT LEVEL 1 TRAUMA CENTER IN SAN FRANCISCO BAY AREA! VEP Healthcare is recruiting for EM trained board certified/prepared physicians to work at Santa Clara Valley Medical Center in San Jose, CA. Located in SF's south bay, in the heart of Silicon Valley and a short distance to all the amenities the San Francisco Bay Area offers. This medical center is affiliated with Stanford Emergency Medicine Program and offers a pathway to professorship. For more information contact Ben Aguilar at baguilar@vephealthcare.com or 925-482-8253.

Ventura: New hospital under construction and scheduled to open in the fall of 2017 with a state-of-the-art Emergency Department. Practice with a stable ER group on the central coast of California and only 70 miles from LAX. Positions available in two facilities for BC/BE emergency physician. Main facility is a STEMI Center, Stroke Center with on-



Yale University School of Medicine

DEPARTMENT OF EMERGENCY MEDICINE FELLOWSHIP PROGRAMS



For specific information including deadlines and requirements, visit: <http://medicine.yale.edu/emergencymed/>

The **Research** fellowship is a 2-3 year program focused on training clinician scholars as independent researchers in Emergency Medicine. Scholars will earn a Master of Health Sciences degree from Yale combining clinical experience with extensive training in research methods, statistics and research design. With the guidance of research content experts and mentors, the scholar will develop a research program, complete a publishable project and submit a grant application prior to completion of the program. The program is credentialed by the Society for Academic Emergency Medicine. **For further information, contact Steven L. Bernstein, MD, steven.bernstein@yale.edu.**

The fellowship in **Emergency Ultrasound** is a 1 or 2 year program that prepares graduates to lead an academic/community emergency ultrasound program. The 2-year option includes a Master of Health Sciences with a focus on emergency ultrasound research. This fellowship satisfies recommendations of all major societies for interpretation of emergency ultrasound and covers program development, QA, properties of coding and billing, and research. Fellows have structured time in the ED performing bedside examinations, QA and review, research into new applications, and education in academic/community arenas. We focus on emergency echo using state of the art equipment and wireless image review. **For further information, contact Chris Moore, MD, RDMS, RDCS, chris.moore@yale.edu, or apply online at www.eusfellowships.com.**

The fellowship in **EMS** is a 1-year program that provides training in all aspects of EMS, including academics, administration, medical oversight, research, teaching, and clinical components. The ACGME-accredited program focuses on operational EMS, with the fellow actively participating in the system's physician response team, and all fellows offered training to the Firefighter I or II level. A 1-year MPH program is available for fellows choosing additional research training. The fellowship graduate will be prepared for a career in academic EMS and/or medical direction of a local or regional EMS system, and for the new ABEM subspecialty examination. **For further information, contact David Cone, MD, david.cone@yale.edu.**

The **Administration** fellowship is a new 2-year program that will prepare graduates to assume administrative leadership positions in private or academic practice. The fellow will acquire experience in all facets of ED clinical operations, working with department and hospital administrative leaders. Fellows will complete the Executive MBA program at the Yale School of Management as part of their Administrative Fellowship. In addition, the candidate will assume a leadership role on one or more projects supporting departmental activities. The fellow will work directly with department administrative leadership in conjunction with the Vice Chair for Clinical Operations. **For further information, contact Arjun Venkatesh, MD, MBA, MHS, arjun.venkatesh@yale.edu.**

The **Global Health and International Emergency Medicine** fellowship is a 2-year program offered by Yale in partnership with the London School of Hygiene & Tropical Medicine. Fellows will develop a strong foundation in global public health, tropical medicine, humanitarian assistance and research. They will receive an MSC from LSHTM, a diploma in Tropical Medicine and complete the Health Emergencies in Large Populations course offered by the ICRC in Geneva. In addition, fellows spend 6 months in the field working with ongoing Yale global health projects or on an independent project they develop. **For further information, contact the fellowship director, Hani Mowafi, MD, MPH, hani.mowafi@yale.edu.**

NIDA K12: Partnering with Yale's Clinical and Translational Sciences (CTSA), Robert Wood Johnson Foundation Clinical Scholars Program, the Center for Interdisciplinary Research on AIDS (CIRA) and the VA Connecticut Healthcare we are offering the Yale Drug Abuse, HIV and Addiction Scholars K12 Research Career Development Program. The DAHRS K12 Scholars Program provides an outstanding 2-3 year research training experience that offers a Master of Health Science, a mentored research program as well as career and leadership development activities. **For further information, contact Gail D'Onofrio, MD, MS, gail.donofrio@yale.edu.**

The **Wilderness Medicine** fellowship is a 1-year program that provides the core content of medical knowledge and skills in being able to plan for and to provide care in an environment that is limited by resources and geographically separated from definitive medical care in all types of weather and evacuation situations. The fellow will be supported to obtain the Diploma in Mountain Medicine and other Wilderness Medical education. The fellow will become a leader and national educator in the growing specialty of wilderness medicine. **For further information, contact David Della-Giustina, MD, FAWM, david.della-giustina@yale.edu.**

The **Medical Simulation** fellowship is a 1-year program spanning all aspects of simulation education, including hi-fi mannequin simulation with computer program training, acquisition of debriefing skills and procedural simulation. Fellows participate in all educational programs for medical students, residents and faculty at the Yale Center for Medical Simulation and are trained in research methodology through the Research Division of the Department of Emergency Medicine and participate in the medical education fellowship through Yale Medical School. Fellows attend a 1-week Comprehensive Instructor Workshop at the Institute for Medical Simulation in Boston and may participate in an international exchange through the Yale-China Association Xiangya School of Medicine. **For further information, contact Leigh Evans, MD, leigh.evans@yale.edu.**

The **Clinical Informatics** fellowship, administered by the Yale Dept. of EM, is a 2-year program that provides ACGME-approved training in all aspects of clinical informatics. In the first year, fellows rotate between the Yale-New Haven Health and Veterans Affairs. Major blocks will be devoted to EHRs, clinical decision support, databases and data analysis, and quality and safety. Experiential learning will be combined with didactic classes and conferences. Fellows attend the American Medical Informatics Association annual meeting and prepare for the Clinical Informatics Board examination. **For further information, contact Cynthia Brandt, MD, PhD, cynthia.brandt@yale.edu or Richard Shiffman, MD, richard.shiffman@yale.edu.**

The **Educational Leadership** fellowship is a 1- or 2-year program that provides the training and education to equip academic emergency physicians with the skills, knowledge and experience to be strong educators and leaders in EM education, with the focus on developing leaders in EM residencies or in Undergraduate Medical Education. The fellow will be an Assistant Residency Program Director and an integral member of the education faculty. They will be supported to attend leadership training as well as using other internal resources, CORD and ACEP to further their education. **For further information, contact David Della-Giustina, MD, FACEP, FAWM, david.della-giustina@yale.edu.**

All require the applicant to be BP/BC emergency physicians and offer an appointment as an Instructor to the faculty of the Department of Emergency Medicine at Yale University School of Medicine. Applications are available at the Yale Emergency Medicine web page <http://medicine.yale.edu/emergencymed/> and are due by November 15, 2017, with the exception of the Wilderness Fellowship, which are due by October 15, 2017.

Yale University and Yale-New Haven Hospital are affirmative action, equal opportunity employers and women, persons with disabilities, protected veterans, and members of minority groups are encouraged to apply.



The Emergency Department at the University of Toledo Medical Center is seeking an energetic, highly motivated and talented physician to join the University of Toledo Emergency Medicine Department Residency Program as a curriculum/didactic Director and Core Faculty.

The Emergency Medicine Residency Program consists of 24 residents who rotate through The University of Toledo Medical Center and Toledo Hospital. Both are level one trauma centers in Toledo, with a very active Global Health Program. The core faculty position would be primarily at The Toledo Hospital with some clinical duties at The University of Toledo Medical Center.

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

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

The University of Toledo is an equal access, equal opportunity, affirmative action employer and educator.

For further information call the Department of Emergency Medicine Administrator, Hesham Youssef at 419-383-4439 or email him at Hesham.Youssef@utoledo.edu.

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call coverage of all specialties. This is a teaching facility with residents in Family Practice, Surgery, Orthopedics and Internal Medicine. Admitting hospital teams for Medicine and Pediatrics. 24-hour OB coverage in house and a well-established NICU. Annual volume is 48K patients with nearly 70 hours of coverage daily and 12 hours of PA/NP coverage. All shifts and providers have scribe services 24/7. Affiliated hospital is a smaller rural facility 20 minutes from Ventura in Ojai. Malpractice and tail coverage is provided. New hires will work days, nights, weekends and weekdays. Come work with a well-established high caliber group with expected volume growth potential at our new facility. Enjoy the life style of a beach community yet outside the hustle of the LA area. Please send a resume to Alex Kowblansky, MD, FACEP, at kowblansky@cox.net.

FLORIDA

Jacksonville: St. Luke's Emergency Care Group, LLC — Jacksonville, Florida. Independent Physician group at St. Vincent's Medical Center-Southside in beautiful Northeast Florida. Great area/community with river and ocean access. Good schools, sports, and entertainment. Emergency Medicine residency trained BC/BE physicians. FT/PT available. Low physician turnover. Flexible scheduling with overlapping shifts. Holiday pay, shift differentials, competitive base salary, quarterly RVU bonus pool. Sign-on bonus and moving stipend. Corner EMR. In house hospitalists and ICU coverage, L&D/Neonatal ICU. Supportive Medical Staff back-up and consultation coverage. 37,000 ED visits/year. Please contact us and send CV to: Katherine Considine, MD, Katherine.considine@ascension.org or (904) 296-3885.

GEORGIA

Atlanta: EmergiNet, a progressive, well-established physician owned emergency group, has positions available for BC/BP, EM residency trained physicians at multiple facilities in the Atlanta area. We work as a team emphasizing quality emergency care, dedicated customer service, professional and personal growth. Fee-for-service based compensation, plus benefits, in the \$350K range. Malpractice and tail coverage are provided. Flexible scheduling, no non-compete, and much more. Email CV to Neil Trabel, ntrabel@emerginet.com; fax 770-994-4747; or call 770-994-9326, ext. 319.

ILLINOIS

Peoria, Pekin: Join our team today! 1-844-4EPSSMD email: Hublerepss@aol.com www.epsserdoc.com. **Emergency Physician Staffing Solutions (EPSS)** is seeking FT/PT Emergency Medicine Physicians to join our team today! **Facilities: UnityPoint Hospitals: annual volume of 20,000 – 27,000 patients per/yr.:** Conveniently located in Central Illinois for *travel* from all facilities with *flexible block scheduling*; ABEM, ABPS or IM, FP Board certified, physicians with EM experience; Exceptional rates based on location and volume: \$185-\$230. **UnityPoint Proctor Hospital, Peoria, IL:** Volume: 20,000- avg 1.7 patients per/hr; EMR: EPIC; Physician coverage: 8/9hrs; Midlevel/ Scribe coverage: 12hrs 7 days per week; Qualifications: ABEM/AOBEM/ABPS or board eligible with ER experience. **UnityPoint Pekin Hospital, Pekin, IL:** Volume: 27,000 volume ED plus 10,000 urgent



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of our employees.
Improving Health,
Enriching Life*

altru.org/careers/physicians



**Jennifer Semling,
Manager,
Physician Recruitment**
800.437.5373, ext. 6607
701.741.0330 cell
jsemling@altru.org

What is it about Altru?

See our booth at ACEP 2017 Scientific Assembly Washington D.C.

Altru Health System is a non-profit integrated health system located in northeast North Dakota and northwest Minnesota. Altru is a 277-bed, Level II Trauma Center with more than 200 physicians representing 44 specialties and serving a primary care population of over 220,000.

Join our Emergency Medicine Team

Altru Health System, a not for profit, integrated health system in Grand Forks, North Dakota is seeking an additional BC/BE Emergency Medicine physician to join a team of ER physicians in a 20 bed unit.

- » Emergency Department averages 30,000 visits per year
- » 1500 hours per year (extra shifts are available)
- » Generous compensation package and sign on bonus with an extensive benefit package

Grand Forks is a community with an excellent school system, safe neighborhoods, affordable housing and an abundance of cultural and recreational activities. Our community has over 50 miles of bike trails and many beautiful parks and golf courses. The University of North Dakota School of Medicine located in Grand Forks offers teaching opportunities with residency programs in family practice and general surgery.

Photo Credit: Greater Grand Forks Convention & Visitors Bureau

TOP TEXAS LOCATIONS



AUSTIN & THE WOODLANDS



As an emergency medicine physician, **where** you practice medicine is almost as important as **why** you practice medicine.

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We are aligned with TriHealth, the regional leader in integrated healthcare delivery. Our staff of 45 Physicians and 33 Advanced Practice Clinicians provides care for 5 Emergency Departments and 2 Clinical Decision Units.

We offer a lucrative production based compensation structure, full partnership with no buy-in, full benefits, equitable scheduling and the opportunity to have a voice in your new practice.



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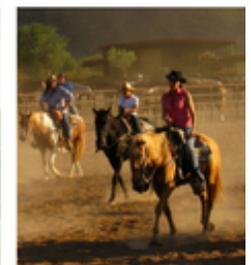


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Earn over \$500,000 working just outside of the Tucson metro area and live in a place known for outstanding hiking and outdoor adventures, rich cultural traditions, a vibrant arts scene, world-class golf and great dining; and a thriving home to more than 1 million residents.

Schedule an interview now or during ACEP (Booth #1107) email your CV to FEP@EMrecruits.com or call 877-379-1088 today.



RUTGERS

New Jersey Medical School

Academic Emergency Physician Rutgers New Jersey Medical School, Newark, NJ

The Department of Emergency Medicine at Rutgers New Jersey Medical School in Newark, NJ, is recruiting highly qualified, full-time BC/BE Emergency Medicine Faculty at the Assistant or Associate Professor level.

Join a diverse, enthusiastic faculty of academic Emergency Physicians in an expanding and dynamic department committed to scholarship, education, research, and outstanding clinical care. Clinical services are provided at University Hospital in Newark, NJ, a Level I trauma center.

Optimal candidates will have a desire for clinical, academic, or administrative excellence. Subspecialty of other training desired, but anyone with clinical and academic aspirations is strongly encouraged to begin or enhance your career at Rutgers NJMS. The salaries are competitive, the institutions and leadership are very supportive, and the patient population is highly in need of quality healthcare.

Live nearby in beautiful suburban or urban New Jersey or within a short commute from New York City. The medical school is blocks from the New Jersey Institute of Technology and the Rutgers Newark Campus, as well as the rejuvenating downtown Newark area, and is close to Newark Liberty Airport and Newark Penn Station Amtrak.

For more information or to submit a CV/cover letter please contact:

Lewis S. Nelson, MD
Chair, Department of Emergency Medicine
185 South Orange Avenue, MSB 609
Newark, NJ 07103
Email: Lewis.Nelson@njms.rutgers.edu

Rutgers University is an AA/EEO employer. All applicants will receive consideration for employment without regard to race, color, religion, sex, sexual orientation, gender identity, national origin, citizenship, disability or protected veteran status.

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White Plains Hospital is defined by our culture of excellence and high standard of care. If you are passionate about providing quality patient care and want to grow in a supportive and professional environment, we invite you to join our dynamic healthcare team. Our Emergency Department treats nearly 60,000 patients annually. **Physicians must be BC/BE in Emergency Medicine.**

- Newly remodeled ED
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- Competitive salary including incentive bonus programs
- Comprehensive world-class benefits

For consideration, please send your CV to:

David Bigham, Human Resources Director

E-mail: dbigham@wphospital.org

White Plains Hospital, 41 East Post Road, White Plains, NY 10601

Fax: 914-681-2910



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care. Physician coverage: 8/9 hrs; double physician coverage; Midlevel and Scribe coverage: 20 hrs 7 days per week; Qualifications: ABEM, ABPS or IM/FP boarded physician with ER experience.

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. E-mail CV to mschenkel@emipg.com or call 260-203-9607.

South Bend: Memorial Hospital. Very stable, Democratic, single hospital, 23 member group seeks additional Emergency Physicians. 60K visits, Level II Trauma Center, double, triple and quad physician coverage. Equal pay, schedule and vote from day one. Over 375K total package with qualified retirement plan; group health and disability insurance; medical, dental and CME reimbursement, etc. Very favorable Indiana malpractice environment. University town, low cost of living, good schools, 90 minutes to Chicago, 40 minutes to Lake Michigan. Teaching opportunities at four year medical school and with FP residency program. Contact Joseph D'Haenens MD at southbendemergency@gmail.com.

NEW YORK

Saratoga – Practice in the Perfect Place: Vibrant Saratoga Springs, NY! Saratoga Emergency Physicians, P.C. (SEPPC) seeks enthusiastic, BE/BC Emergency Medicine Physicians to join our comfortable, physician-owned practice in the small, but vibrant Upstate New York city of Saratoga Springs, near Albany, at the edge of the Adirondacks. This is an exceptional opportunity to join a stable practice at Saratoga Hospital, with annual volume of 40,000 visits, in a spacious, state-of-the-art, 41-bed ED, constructed six years ago. SEPPC has staffed the hospital for 28 years. We offer comprehensive benefits and locally competitive compensation. There is a two-year shareholder track with no financial buy-in. Check out our website at www.seppc.com. Contact: Denise Romand, Saratoga Hospital (518)583-8436, email: docfind@saratogacare.org. Famous venues locally include Saratoga Race Course, Saratoga Spa State Park, and the Saratoga Performing Arts Center. View us: www.saratogahospital.org, www.saratoga.org, <http://discoversaratoga.org>, and <http://www.ilovesaratoga.us>.

NORTH CAROLINA

Asheville – Stable, long-term democratic group looking to add new partners. Have the best of all worlds – work in a busy Level II trauma center that sees 100k pts/year and live in an awesome small city in the mountains. We are a fee-for-service model with competitive compensation. Employment model available in nearby regional hospitals. Looking for motivated full-time Physicians to join our team. Send CV to Chris Flanders at Chris.Flanders@msj.org.

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 II 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, then send your CV, cover letter, and a recent photo to sepspc@salemhealth.org or call us at 503-814-1278.

SOUTH CAROLINA

Upstate: Seeking Emergency Medicine Physicians, PAs, & NPs. Independent, democratic group offering partnership for BC/BE emergency physicians with exceptional daily coverage, equal pay and scheduling from day one; occurrence malpractice insurance; Level II Trauma Center and area referral center; Emergency department with adjacent fast track facility have combined annual volume of 85k visits. Affordable, lakefront property on beautiful Lake Hartwell; Short drive to mountains and beaches. Contact: Brandy Vaughn at brandy.vaughn@anmedhealth.org or (864) 512-3897.

TEXAS



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Seeking Emergency Physicians to join our Academic Department of EM

ACADEMIC POSITIONS

Emergency Medicine Faculty (all ranks)

- Clinical
- Critical Care (ACCM pathway preferred)
- Director of Medical Simulation
- Director of Ultrasound
- Research
- Ultrasound

Fellowships

- Administration, Operations & Quality
- Climate & Health Policy
- Critical Care-Anesthesia
- Emergency Medical Services
- Research
- Toxicology
- Ultrasound
- Wilderness Medicine

COMMUNITY POSITIONS

Chief of Emergency Services

at UHealth Highlands Ranch Hospital

Community Practice Physicians

The academic Department of Emergency Medicine at the CU School of Medicine is dedicated to excellence in clinical care, teaching and mentoring, research and scholarship, and innovation. We have 75 faculty emergency physicians and are looking to grow our faculty.

The University of Colorado Anschutz Medical Campus is among the top institutions nationally in clinical care, education and research. More than 4,000 students learn alongside faculty members who also make meaningful medical discoveries and provide expert clinical care. We teach residents in the Denver Health Residency. A hub for research and innovation, CU Anschutz receives over \$400 million in research awards each year and has filed 1,300 patent applications and formed 53 new companies since 2002. University of Colorado Hospital sees over 100,000 inpatient visits, over 2.5 million outpatient visits, and employs over 15,000 providers and staff. The Emergency Department at Anschutz sees over 100,000 patients annually and our regular faculty primarily staff this location. UHealth, our large hospital-based health system, is expanding along the Rocky Mountain front range. Our community-based physicians will primarily staff these locations at new hospitals and freestanding EDs.

Denver is a highly desirable place to live, work, and raise a family. We offer salaries commensurate with qualifications, relocation assistance, physician incentive program and a CME allowance, and a comprehensive benefit package.

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For additional information, please contact:

Frances Schulz, HR Manager, Emergency Medicine

frances.schulz@ucdenver.edu



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Visit ketteringdocs.org for more information.



DEPARTMENT OF EMERGENCY MEDICINE FELLOWSHIP PROGRAMS

WASHINGTON, DC — The Department of Emergency Medicine at the George Washington University is offering **Fellowship** positions beginning July 2018:

*Emergency Management
Medical Leadership & Operations
Emergency Ultrasound
Telemedicine/Digital Health
Extreme Environmental Medicine
Simulation in Medical Education*

*International Emergency Medicine
Medical Toxicology
Operations Research
Health Policy
Clinical Research*

Fellows receive an academic appointment at George Washington University School of Medicine & Health Sciences and work clinically at a site staffed by the Department. The Department offers Fellows a common interdisciplinary curriculum, focusing on research methodologies and grant writing. Tuition support for an MPH or equivalent degree may be provided, as per the fellowship's curriculum.

Complete descriptions of all programs, application instructions, and Fellowship Director contacts can be found at:

<https://smhs.gwu.edu/emed/education-training/fellowships>



The GW Medical Faculty Associates

Department of Emergency Medicine



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EMERGENCY MEDICINE PHYSICIAN OPPORTUNITIES

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Roy.B.Hernandez@kp.org

(510) 625-2731

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Glenn.Gallo@kp.org

(800) 541-7946

Georgia

Laurie Wehunt

Laurie.Wehunt@kp.org

(800) 877-0409

Mid-Atlantic

Cooper J. Drangmeister

Cooper.J.Drangmeister@kp.org

(301) 816-6532

Washington

Nancy Longcoy

Longcoy.N@ghc.org

(206) 630-4345



Clinical Associates/EMED Scholars

The University of Chicago's Department of Medicine, Section of Emergency Medicine, is pleased to offer the opportunity for qualified candidates to receive training in medical education, medical operations and leadership, or global health as an Emergency Medicine Scholar. These positions offer protected time for professional development while working clinically as an attending in our emergency department at a reduced effort. Applicants must have a medical degree, be board certified or board eligible in Emergency Medicine by the time of appointment and be eligible for medical licensure in Illinois.

Those interested must submit a cover letter and CV online at academiccareers.uchicago.edu/applicants/Central?quickFind=55205. Compensation is dependent upon qualifications. A generous package of fringe benefits is provided. Review of applications will continue until all available positions are filled.

The University of Chicago is an Affirmative Action/Equal Opportunity/Disabled/Veterans Employer and does not discriminate on the basis of race, color, religion, sex, sexual orientation, gender identity, national or ethnic origin, age, status as an individual with a disability, protected veteran status, genetic information, or other protected classes under the law. For additional information please see the University's Notice of Nondiscrimination at http://www.uchicago.edu/about/non_discrimination_statement/. Job seekers in need of a reasonable accommodation to complete the application process should call 773-702-0287 or email ACOppAdministrator@uchicago.edu with their request.

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Department of Emergency Medicine Fellowship Opportunities

The Department of Emergency Medicine at University Hospitals Cleveland Medical Center is currently seeking ABEM/ABOEM certified or eligible physicians for the following fellowships in July 2018:

- **Global Emergency Medicine Fellowship**
Program Director: Dr. Justin Yax
- **Ultrasound Fellowship**
Program Director: Dr. Vicki Noble
- **Administrative Fellowship**
Program Director: Dr. Christopher Miller
- **EMS Fellowship (ACGME-Accredited)**
Program Director: Dr. Jeffrey Luk

University Hospitals Cleveland Medical Center (UHCMC) is a 1,032-bed Magnet facility on the campus of Case Western Reserve University (CWRU) located in the cultural heart of Cleveland: University Circle. UHCMC is a verified Level I Adult Trauma Center, Comprehensive Stroke Center, and STEMI Center. The Department of Emergency Medicine hosts a three-year emergency medicine residency training program with 10 residents/year. UHCMC also includes Rainbow Babies and Children's Hospital, which is a verified Level I Pediatric Trauma Center. UHCMC is a teaching affiliate of the CWRU School of Medicine.

Visit our website to learn more:
<https://www.uhdoctor.org/center-for-emergency-medicine>

Salary and academic rank will be commensurate with accomplishments and experience.

Qualified candidates should email a letter of interest to the appropriate fellowship director c/o Ms. Dildred Houston, Education and Practice Coordinator, Department of Emergency Medicine, at Dildred.Houston@UHhospitals.org



{ Job Opportunities }

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PEDIATRIC EMERGENCY MEDICINE LEADERSHIP OPPORTUNITIES

ASSOC PROGRAM DIRECTOR

VICE CHAIR, RESEARCH

EMERGENCY MEDICINE RESEARCHER POSITIONS



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® 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:



PennState Health



Susan B. Promes, Professor and Chair, Department of Emergency Medicine, c/o Heather Peffley, Physician Recruiter, Penn State Health Milton S. Hershey Medical Center, 500 University Drive, PO Box 855 Mail Code A595, Hershey PA 17033, Email: hpeffley@pennstatehealth.psu.edu

OR apply online at: <http://hmc.pennstatehealth.org/careers/physicians>



Department of Emergency Medicine Yale University School of Medicine



Advancing the Science and Practice of Emergency Medicine

The Department of Emergency Medicine at the Yale University School of Medicine has a total of 4 clinical sites: Adult Emergency Services at York Street Campus; Shoreline Medical Center; Saint Raphael's Campus; and the West Haven VA Emergency Department with a combined ED volume of 195,000 visits per year. We are seeking faculty at all ranks (Clinician, Assistant Professor, Associate Professor, Professor, etc.) with interests in clinical care, education or research to enhance our existing strengths. Interest and/or experience in observation medicine is a plus. The successful candidate may be a full-time clinician committed to excellence in patient care and emergency medicine education or one who would want to join the academic faculty promoting scholarship to enhance the field of emergency medicine. We offer an extensive faculty development program for junior and more senior faculty. We have a well-established track record of interdisciplinary collaboration with other renowned faculty, obtaining federal and private foundation funding, and a mature research infrastructure supported by a faculty Research Director, a staff of research associates and administrative assistants. Eligible candidates must be residency-trained and board-certified/-prepared in emergency medicine. Rank, protected time and salary will be commensurate with education, training and experience.

Yale University is a world-class institution providing a wide array of benefits and research opportunities.

To apply, please visit: apply.interfolio.com/43754 to upload your CV and cover letter. Specific inquiries about the position may be sent to the chair: Gail D'Onofrio, MD, MS, Chair, via email: jamie.petrone@yale.edu.

Yale University is an affirmative action, equal opportunity employer. Yale values diversity among its students, staff, and faculty and strongly welcomes applications from women, persons with disabilities, protected veterans, and underrepresented minorities.



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Emergency Medicine Fellowship Opportunities

The UMass Medical School Department of Emergency Medicine invites qualified candidates to consider our fellowship training opportunities. Nationally-renowned fellowship directors and faculty oversee intensive, focused curricula that prepare fellows to assume leadership roles in their chosen areas.

Our department's nationally-recognized track record in leadership, clinical care, education, and research, coupled with a strong stature within our medical school and 5-hospital health system, as well as the opportunity for pursuing UMass master's-degree education when applicable, makes our institution an ideal place to gain exceptional sub-specialty expertise and launch highly successful careers.

Our fellowship opportunities include:

- Administration/Leadership
- Disaster Medicine (may be taken in sequence with EMS)
- Emergency Medical Services (may be taken in sequence with disaster medicine)
- Emergency Ultrasound
- International EM & Global Health
- Medical Toxicology
- Research (PhDs also considered)

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Fellows will assume limited clinical responsibilities at one or more of our Emergency Departments. Prior to starting, fellows must have completed an ACGME-accredited EM residency program, must be EM board-certified or eligible, and must be eligible for full medical licensure in the Commonwealth of Massachusetts.

For more information, please refer to our website and contact our Fellowship Coordinator:

<http://www.umassmed.edu/emed/>
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THE DEPARTMENT OF EMERGENCY MEDICINE

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Exciting Emergency Medicine Opportunities Academic Faculty & Clinical Faculty Opening

The Department of Emergency Medicine at Baylor College of Medicine is looking for Faculty who are interested in a career in Academic Emergency Medicine. We are currently hiring faculty of all ranks commensurate with prior experience and seeking applicants who have demonstrated a strong interest and background in medical education, simulation, ultrasound, or research. Clinical opportunities are also available at our affiliated hospitals.

The Department of Emergency Medicine at Baylor College of Medicine, a top medical school, is located in the world's largest medical center, in Houston, Texas. The Baylor Emergency Medicine Residency was established in 2010, and we recently received department status in Jan 2017. Our residency program has grown to 14 residents per year in a 3-year format. We offer a highly competitive academic salary and benefits commensurate to academic level and experience.

Our academic program is based out of Ben Taub General Hospital and Baylor St. Luke's Medical Center. Ben Taub General Hospital is the largest Level 1 trauma center in southeast Texas with certified stroke and STEMI programs that sees nearly 100,000 emergency visits per year. Baylor St. Luke's Medical Center is home to the Texas Heart Institute and with freestanding Baylor St. Luke's Emergency Centers offers multiple additional practice sites for Baylor faculty. BCM has a collaborative affiliation with eight world-class hospitals and clinics in the Texas Medical Center. These affiliations, along with the medical school's preeminence in education and research, help to create one of the strongest emergency medicine experiences in the country.

Those interested in a position or further information may contact Dr. Dick Kuo via email dckuo@bcm.edu or by phone at 713-873-7044. Please send a CV and cover letter with your past experience and interests.

ASSISTANT/ASSOCIATE PROGRAM DIRECTOR OPENING

The Department of Emergency Medicine at Baylor College of Medicine in Houston, TX is seeking outstanding candidates for the position of **Assistant/Associate Program Director**.

Applicants should have a strong background in medical education with a career path directed towards graduate medical education. Duties of this position will include a focus on developing and implementing innovative educational strategies in the CLER pathways (Patient Safety, Health Care Quality, etc.) that meet and exceed the ACGME accreditation standards. In addition, we are searching for applicants who will contribute to our missions of promoting academic excellence, diversity, and teamwork in service to our patients.

Interested applicants should submit a CV, letter of intent, and 1 letter of recommendation to the Program Director, Dr. Tyson Pillow (pillow@bcm.edu).

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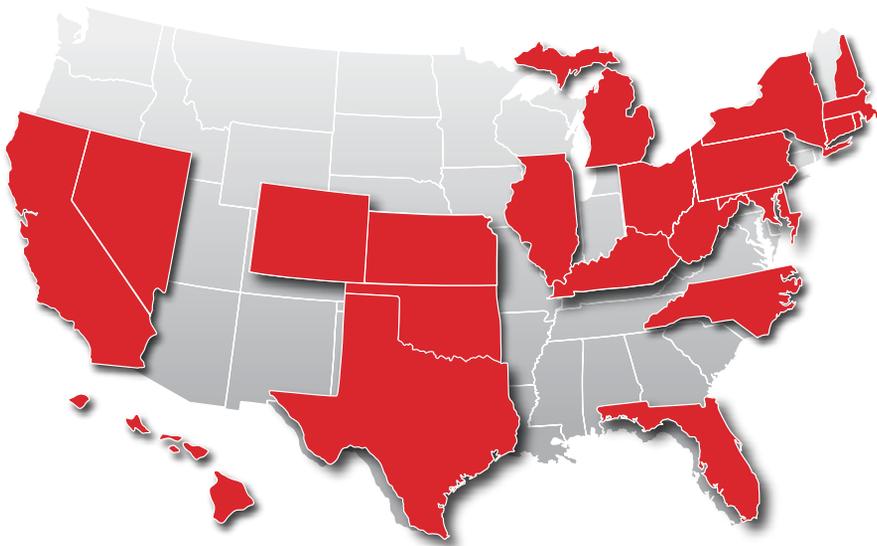


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*Tulsa, OK | 10-99,000 pts./yr.

Providence Health Center

Waco, TX | 73,000 pts./yr.

Valley Baptist Medical Center

Harlingen, TX | 30,000 pts./yr.

Peterson Regional Medical Center

Kerrville, TX | 29,000 pts./yr.

CHI St. Joseph Health Regional Hospital

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Meritus Medical Center

Hagerstown, MD | 78,000 pts./yr.

LifeBridge Health

* Baltimore, MD | 64-72,000 pts./yr.

Lake Health System

*Cleveland, OH | 12-35,000 pts./yr.

Summa Health System

*Akron, OH | 10-100,000 pts./yr.

Mercy Health

*Cincinnati, OH | 14-60,000 pts./yr.

Florida Hospital

*Tampa/Heartlands, FL | 13-45,000 pts./yr.

University Medical Center

*Las Vegas, NV | 17-81,000 pts./yr.

Carolinas HealthCare System

*Charlotte, NC | 17-69,000 pts./yr.

CarolinaEast Medical Center

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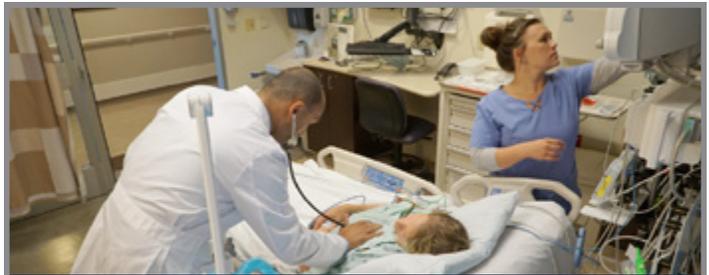


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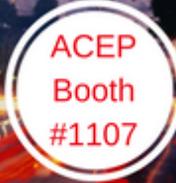
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- Houston Methodist West Hospital
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Academic Emergency Medicine Physicians

The University of Chicago's Department of Medicine, Section of Emergency Medicine, is seeking full-time faculty members to serve as Emergency Physicians as we prepare to open a new adult emergency department and establish an adult Level 1 Trauma Center. Academic rank is dependent on qualifications. Applicants are required to be board certified or board eligible in emergency medicine and to be eligible for Illinois licensure by the start of appointment. Responsibilities will include teaching in the educational programs sponsored by the Section and participation in scholarly activity. We seek candidates looking to develop an academic niche that builds upon our faculty expertise in basic and translational research, health equity and bioethics research, geriatric emergency care, global emergency medicine, medical education, prehospital medicine, aero-medical transport, and ultrasound. We host one of the oldest Emergency Medicine Residency programs in the country and serve as a STEMI receiving hospital, a Comprehensive Stroke Center, a Burn Center, and a Chicago South EMS regional resource hospital. The Adult ED has an annual volume of 65,000 and our Pediatric ED cares for 30,000 patients per year, including 1,000 level 1 trauma patients.

This position provides competitive compensation and an excellent benefits package. Those interested must apply by uploading a cover letter and current CV online at academiccareers.uchicago.edu/applicants/Central?quickFind=55160. Review of applications will continue until all available positions are filled.

The University of Chicago is an Affirmative Action/Equal Opportunity/Disabled/Veterans Employer and does not discriminate on the basis of race, color, religion, sex, sexual orientation, gender identity, national or ethnic origin, age, status as an individual with a disability, protected veteran status, genetic information, or other protected classes under the law. For additional information please see the University's Notice of Nondiscrimination at http://www.uchicago.edu/about/non_discrimination_statement/. Job seekers in need of a reasonable accommodation to complete the application process should call 773-702-0287 or email ACOppAdministrator@uchicago.edu with their request.



Beautiful Historic Williamsburg Location

Williamsburg Emergency Physicians, Inc. – a well established, highly regarded democratic ED group - is looking for BC/BP ED physician to join their practice. Sentara Williamsburg Regional Medical Center is a state of the art hospital located in historic York County, VA recently named one of the nation's 100 top hospitals by Truven Health Analytics. ED sees 32,000 visits per year with a 6 bed Fast Track. Staffing is supported by ED trained full time/part time PAs along with a strong Scribe program affiliated with the College of William and Mary.

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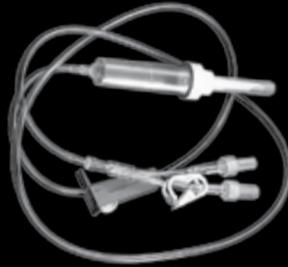
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This ED serves a high acuity patient population with 28% annual admission rate. There are over 90 hours of adult physician coverage daily and over 110 hours mid-level coverage daily. It is a Level III Trauma Center with robust hospitalist service, interventional cardiology 24/7, cardiac surgery, neurosurgery, etc. The facility is Chest Pain and Stroke accredited. The EMS system is hospital-owned and managed, with an award-winning paramedic program. Of note, the Pediatric ED is separate and has 17 dedicated beds with an additional 24 hours of physician coverage and 20 hours of mid-level coverage. We welcomed our inaugural class of EM residents in July 2017.

Opportunities exist for both clinical and academic emergency physicians.

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

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

Fayetteville is known for its many golf courses with the Home of Golf, aka Pinehurst, located only 30 minutes from the city. Our central location provides easy access to some of the most beautiful beaches in the country to our east and the majestic Blue Ridge Mountains to our west.

In addition to our central location, our mild climate, low cost of living, and patriotic spirit makes it an ideal city for rising healthcare professionals and families. As the sixth-largest city in North Carolina - and growing - both Fayetteville and Cape Fear Valley Health's healthcare needs are on the rise.

Please contact Physician Services for more details at (910) 615-1891 or adowl@capefearvalley.com.

Fayetteville, NC

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Come see us at booth #2611 at ACEP and visit us at the EMRA job fair during the conference!

For more information, visit geisinger.org/careers or contact Miranda Grace, Talent Management, at 717-242-7109 or mlgrace@geisinger.edu.



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