As medical students we have a nice, stable position on the bottom of the totem pole. We have no real authority in the hospital and frankly, the shortness of the white coat is slightly embarrassing. We all know what rolls downhill, and we often find ourselves at the bottom of that hill.

It can be very easy to succumb to the negativity and cynicism that can be pervasive among over-worked, sleep-deprived, type A colleagues. It can be frustrating to be sent on the seldom successful, but always important, old medical record hunt or to invest so much time in preparing the perfect daily progress note that never gets read. So what are we little guys to do? You can choose to tuck your tail under your short white coat, but I'd like to challenge you to take a step back and readjust your perspective.

During my months on internal medicine rotations, I would arrive at the hospital at an unspeakable hour to see my patients and have my notes in the chart before the residents came in. It was the end of my third year and my ‘give a damn tank’ was running dangerously low.

Needless to say, I was not thrilled about the demented patient awaiting nursing home placement who I was assigned to see every day. The first morning that I walked into this man’s room, he sat up in bed and with the biggest smile yelled “Good morning! Hallelujah! How you doing doc?”

This patient was not in the best of health and had been abandoned by his caretakers, but he enthusiastically approached his day. The first morning that I walked into this man’s room, he sat up in bed and with the biggest smile yelled “Good morning! Hallelujah! How you doing doc?”

The first day, I attributed his cheeriness to the dementia. But after a few days of the consistent positivity, I found myself looking forward to going in to see him first thing in the morning and

continued on page 20
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For the sake of consistency, the use of the terms “ED,” “emergency department,” and “emergency physicians” are preferable to using “ER” or any such derivation.

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EM Resident is published six times per year. Ads received by January 3 will appear in the February/March 2011 issue.

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

An interesting question was posed to me recently. “How do you define an emergency physician?” The question seems fairly straightforward, but the more I thought about it, the more I realized I couldn’t pin down a firm answer.

Maybe the answer is that we are the physicians ready to take care of the sickest patients in their greatest time of need. Or maybe we are there for those patients who have nowhere else to turn. Or maybe we are the docs that are trained to tackle any problem at any time – as a colleague of mine says, “we can do it all!”

Even if it is hard to define, it seems that each of us knows what it means to be an emergency physician. One thing I have noticed – and this becomes more evident with every emergency medicine doc I meet – there is no one definition for all emergency physicians. We each come with our own specific interests, fields of expertise, and passions.

As you read this, take a moment to think about how you would define your own career. Which patients do you feel particularly drawn to in the department? Is the best setting for you to practice in an urban center, a rural community, or the international scene? Will your career be defined by a dedication to the care of the underserved or to ground-breaking research? Will you find your area of expertise in pediatrics, toxicology, EMS, or administration?

Residency is the perfect time to start exploring what sets you apart from the rest of your colleagues. Find mentors now to guide you into your field of choice and support you along the way. Take advantage of every opportunity you can find.

It has been one of the central tenets of EMRA to promote the professional development of emergency medicine residents. To that end, we have expanded the opportunities we offer to our members and will continue this in the years to come.

If research is a particular interest of yours, apply for an EMRA/EMF research grant. Excited about politics and the legislative process? Apply for our Health Policy Mini-Fellowship, and attend the ACEP Leadership and Advocacy Conference in Washington, D.C. Do you find yourself drawn towards the world of medical education? Apply for the ACEP Teaching Fellowship or travel grants to the CORD Academic Assembly.

These opportunities, among many others, are provided to help residents develop those unique skills that will help pave the way to their future career and the future of our specialty. Take some time today to think about what the future holds for you and how you would define your own practice as an emergency physician.
Board Update

The EMRA Board of Directors hard at work at ACEP’s Scientific Assembly in Las Vegas.

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Mission Statement

EMRA promotes excellence in patient care through the education and development of emergency medicine residency-trained physicians.

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MEET EMRA’S
New Board Members

Don Stader, MD
EMRA President-Elect
Carolinas Medical Center
Charlotte, NC

Don Stader is the son of Bruce Stader, a retired American Diplomat and Thuy Stader, his lovely wife of over 35 years. As a result of his father’s work, he was born in Philippines and lived a peripatetic life growing up in the Philippines, Kenya, Panama, Nicaragua, Botswana, Switzerland, and Eritrea.

Don moved to the U.S. after high school and attended Mary Washington College in Virginia. In college he played rugby, was an officer for Best Buddies and an EMT-B with the Fredericksburg Volunteer Fire Department and Rescue Squad. He graduated from Mary Washington in 2004 and promptly moved to Switzerland.

In Switzerland, Don worked at the Leysin American School in Switzerland, as a high school science teacher and men’s basketball coach during the week and avid ski bum come weekends. After two years of teaching, he left the Alps and headed for the warmer, swampier and larger metropolis of Houston for medical school.

Don attended Baylor College of Medicine, graduating in 2010. Early in medical school, he decided upon a career in emergency medicine (the greatest specialty known to man). While at Baylor, he actively promoted the specialty of emergency medicine and began many initiatives to improve medical school education. While president of his school’s EMIG, he became interested in organized medicine and working with EMRA.

Currently, Don is a resident at Carolinas Medical Center in Charlotte, North Carolina. As part of the board, he looks forward to passionately serving the membership of EMRA. In this capacity Don plans to apply himself to the goals of growing EMRA’s membership, creating new resources to improve resident education, and providing strong representation of EM resident interests. If you have any questions, ideas, suggestions, or comments please email him at presidentelect@emra.org.

Jordan Celeste, MD
ACEP Representative
Brown University
Providence, RI

Jordan Celeste was born and raised in Harrisburg, Pennsylvania – where her childhood was filled with sports, studying, and lots of support. She held many leadership roles during these formative years—including student council president in junior high, class president in high school, and captain of the soccer and tennis teams. After high school, Jordan moved slightly south and graduated summa cum laude from the University of Maryland in 2004 with a B.A. in Anthropology.

Jordan stayed in Maryland for medical school, graduating from the University of Maryland with her M.D. in 2010. As a medical student, Jordan served as Vice President of Talks and Mentoring for her school’s EMIG. She then also became involved with Maryland ACEP’s Public Policy Committee. During her fourth year, she wrote an elective for her medical school entitled “Legislative Medicine,” while also serving as a Regional Representative for EMRA’s Medical Student Council.

Currently, Jordan is a resident in the Brown Emergency Medicine program in Providence, Rhode Island. She is a Resident Representative to the Rhode Island Medical Society, and she is also a member of RI ACEP. Jordan lives with her encouraging husband, Peter, and her faithful dog, Flint. She enjoys running, cooking, and watching TV on the couch with her guys—in what free time she can find.

In her new role as ACEP Representative, Jordan is looking forward to making an impact on both the EMRA and ACEP boards. She would like to foster communication between EMRA and ACEP committees and keep the membership fully informed about ACEP’s current projects. Jordan believes that it is important for emergency medicine residents to become actively involved—we are, after all, the future of the specialty. Jordan can be reached at aceprep@emra.org.

Alison Haddock, MD
Legislative Advisor
University of Michigan
Ann Arbor, MI

Alison Haddock was raised in the suburbs of Seattle, then moved East to attend college at Duke University. While completing her pre-medical coursework there, she developed an interest in A.C.C. basketball, as well as politics, enrolling in several public policy and political science courses prior to graduating with a B.S. in Biolinguistics.

Looking for big-city glamour, she moved to New York City and completed medical school at Weill Cornell Medical College. Between her first and second year, she received funding from the American Medical Association to serve as a Government Relations Intern in the office of Congressman Jim McDermott, MD (D-WA). Later on in medical school, she organized the American Medical Students Association’s largest regional conference in Brooklyn, NY.

Her involvement in EMRA began as a program representative for her residency program at the University of Michigan. She started as a member of the Health Policy Committee, then was awarded the ACEP-EMRA Health Policy Mini-Fellowship. During her elective month at ACEP’s Washington D.C. office, she studied how health care reform will affect emergency physicians and helped organize a recruitment drive to increase resident membership in ACEP’s 911 Network.

During her tenure as Legislative Advisor, Alison hopes to expand EMRA’s advocacy programming and develop tools to improve education in health policy and advocacy within emergency medicine residency programs nationwide. She looks forward to channeling the energies of EMRA’s thousands of members toward the goal of improving legislation to empower physicians so that we may provide the highest quality of emergency care for our patients. Contact Alison at legislativeadvisor@emra.org.
Hamad Husainy, DO is a resident at the University of Mississippi in Jackson, MS, as well as your newly elected Vice-Speaker of EMRA. He is very excited to be involved in leading EMRA members and continually working to improve EMRA over the next two years.

Dr. Husainy hails from Vero Beach, FL where he attended elementary and high school at St. Edward’s School. He was a three-sport athlete and decided to take his athletic and academic talents to Salisbury University in Salisbury, MD, lettering each of the four years and serving as captain of the football team. He decided to become an EMT after his first year of college and dove head first into the medical profession, serving as a volunteer EMT and ED tech.

After college came medical school in Lewisburg, WV at the West Virginia School of Osteopathic Medicine. After his second year there, he married his wonderful and supportive wife, Kristin. After five years of marriage, they have three beautiful children—Ashland James (4), Kathryn Ann (2), and Bryan Oliver (3 months). After matching at the University of Mississippi, Dr. Husainy completed a surgical internship at the University of Tennessee-Knoxville, which he feels prepared him to hit the ground running during EM residency. After he has completed residency, he will take his talents to Tacoma, Washington to work at the Franciscan Healthcare System.

Dr. Husainy’s passion in the specialty of EM is administration and organized medicine. He hopes to increase EMRA’s membership and improve the services offered by the organization over the next two years. He is confident that the leaders on the EMRA Board of Directors are a great group who work diligently to lead the membership. You may contact him at vicespeaker@emra.org with any questions or concerns that can be addressed to improve your experience as a resident and our standing within the house of medicine.

Jonathan Heidt is representing the Gateway city of St. Louis, MO! He is currently a fourth year resident at Washington University in St. Louis. Jonathan began his education as an undergraduate at the University of Missouri – Columbia. After completing his degree in biochemistry, Jonathan returned home to St. Louis where he attended medical school at Washington University. During medical school, Jonathan met his wife, Elizabeth. Elizabeth and Jonathan were married after he finished his second year of medical school. They have two children – a four-year-old boy, and a sixteen-month-old girl.

Jonathan’s interest in health policy began during his first year of residency after working with two inspiring mentors who have had a significant involvement with ACEP. Since his intern year, Jonathan has worked on the SAEM Program Committee, on the Missouri Chapter Board of Directors, and as an EMRA regional representative. Upon completion of residency, he hopes to continue his training with further work in health policy and healthcare administration.

During his free time, Jonathan enjoys traveling with his family. He especially enjoys the Caribbean and Costa Rica. Jonathan is excited to have this opportunity to serve as a member of the EMRA Board of Directors as the resident representative to the RRC-EM. If you have any questions or need assistance, please do not hesitate to contact him at rrcelemrep@emra.org.

Jonathan Heidt
Director-at-Large/RRC-EM Rep
Washington University
St. Louis, MO

Hamad Husainy, DO
Vice Speaker of the Council
University of Mississippi
Jackson, MS

Swearing in of the 2011 EMRA Board of Directors during Scientific Assembly in Las Vegas.
EMTALA and the emergency physician

One of the most important legal issues for an emergency department is compliance with the Emergency Medical Treatment and Labor Act (EMTALA). Well, what is it? Quite simply, it requires any emergency department in a hospital that receives federal funding to provide health screenings to anyone who walks in the door. But like all laws, compliance with EMTALA presents a unique set of challenges.

Historically, EMTALA, passed in 1986, sought to remedy reports that the poor and uninsured were being turned away from life saving treatment at hospitals because of their inability to pay. The campaign to pass EMTALA even had a term for this: patient dumping.

Patient dumping has two aspects. First, hospitals were simply refusing to treat people. The other aspect was a private hospital would get a patient with a severe injury (i.e., gunshot wound) and place the patient immediately into an ambulance to the public hospital. Patient would usually arrive at public hospital D.O.A.

So who must comply with EMTALA? Any emergency department in a hospital that receives federal funding such as Medicare (hint: this is most of them) must comply with EMTALA.

As an emergency department physician, there are two steps to insure compliance with EMTALA. First, you (or someone on staff) must perform “an appropriate medical screening examination... to determine whether or not an emergency medical condition exists.” Second, if the screening examination indicates that an emergency medical condition does exist, the hospital ordinarily must “stabilize the medical condition” before transferring or discharging the patient.

There are other issues to keep in mind as well. An emergency department is broader than just the four walls of your hospital. An emergency department includes the entire campus of the hospital and a 250-yard radius from the main buildings. In short, if you see someone dying on the side of the road by the hospital, don’t keep driving to your “Physician Only” parking spot.

For quick reference, an emergency physician should also understand exactly what qualifies as an emergency. An emergency medical condition is a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of...
“Any emergency department in a hospital that receives federal funding such as Medicare (hint: this is most of them) must comply with EMTALA.”

Immediate medical attention could reasonably be expected to result in placing the health of the individual (or, if pregnant, to the unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. With respect to a pregnant woman who is having contractions, it is an emergency medical condition if there is inadequate time for a safe transfer to another hospital before delivery or if the transfer may pose a threat to the health or safety of the woman or her unborn child.

If you don’t comply with EMTALA, the threatened penalties can be quite severe—you hospital could even lose its federal funding. This, like an avalanche in Louisiana in July, is unlikely. For you personally, if you are the on-call physician and fail to respond to an emergency condition, you could be subject to a civil monetary penalty, which is not covered by your malpractice insurance. Also, don’t sign off on a transfer that you know to be false or should know to be false.

EMTALA is an element of health care regulations that really focuses on hospitals. But as an employee or independent contractor of a hospital, you are in the position to best insure the hospital complies with EMTALA.

Rene Louapre graduated from LSU School of Law with a JD/BCL. He then received an LLM in Health Law from St. Louis University. Mr. Louapre’s practices healthcare law at Milling Benson Woodward, LLP in New Orleans.

Rene Louapre graduated from LSU School of Law with a JD/BCL. He then received an LLM in Health Law from St. Louis University. Mr. Louapre’s practices healthcare law at Milling Benson Woodward, LLP in New Orleans.
Advocacy education

Where did you learn what you know about our political system? Elementary school viewings of “I’m Just A Bill” on Schoolhouse Rock? A high school civics class? A college course in political science or public policy, squeezed in between premedical prerequisites? And when did you most recently discuss how policy is made, and more importantly, how you might influence that process?

In order to effectively advocate for our patients and our professions, all physicians must understand the political process. We are dramatically impacted by changes in health policy. Just a few months ago, the Patient Protection and Affordable Care Act was passed. This law, which was created with limited input from physicians, will enact significant changes in US health care over the next decade.

Our professional obligation as physicians goes beyond the provision of high-quality care for individual patients. We are also obligated to consider the health of the communities that we serve and the ability of all of our patients to access care. As emergency physicians, we provide care to all patients, regardless of their ability to pay.

The limited ability of many patients to access the remainder of our excellent medical system becomes a part of our challenge as we strive to provide comprehensive care. When we care for uninsured and underinsured patients on every shift, we act as advocates as we help them fill prescriptions and establish follow-up care.

The most complete physician will be empowered to expand their advocacy efforts beyond a single disenfranchised patient. The best trained and most dedicated physicians will take their efforts to a higher level, advocating for systemic reform to improve care for all patients.

The many administrative bodies contributing to residency guidelines know that patient care and medical knowledge are only a part of what we must learn as residents. We also must understand the system in which we work and develop the skills to advocate for our patients. The ACGME calls on residents in all specialties, under the core competency of “Systems Based Practice,” to “demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value.” The 2009 Model of the Clinical Practice of Emergency Medicine includes “advocacy” as a component of professionalism.

Yet despite these curricular imperatives, a recent survey of EM residency program directors revealed that only 33 percent include advocacy in their residency’s educational curriculum.

In response to these limited offerings, EMRA has taken action. At the Spring 2010 Representative Council meeting, your delegates passed a resolution encouraging EM residencies to integrate formal education in health care systems and advocacy training as official components of their residency’s education programming. A similar resolution was co-authored by members of the EMRA board and was passed by the ACEP Council at their annual meeting in Las Vegas.

As your newly elected Legislative Advisor, I will work to expand education on health policy and advocacy issues in all EM residencies. The EMRA Emergency Medicine Advocacy Handbook provides an introduction to these important topics, and we will be releasing a new edition in the spring of 2011. In addition, EMRA hopes to work with fellow organizations within emergency medicine to move towards the creation of efficient and effective educational tools to help residencies improve their policy and advocacy training. Through these efforts, we can build future generations of physician-advocates nationwide.

Reference
The road ahead for ACEP

Just two days after my term as ACEP Representative began, I had the opportunity to attend my first ACEP Board Meeting. I was not the only new face at the table, as Dr. Paul Kivela and Dr. Robert O’Connor were just elected to the ACEP Board of Directors during Scientific Assembly in Las Vegas. In addition, Dr. Sandra Schneider transitioned into her role as President of ACEP. During the board meeting, Dr. Schneider spoke briefly about four areas of focus for ACEP in the year ahead:

Healthcare reform
Now that the Patient Protection and Affordable Care Act of 2010 has been passed, the next step is implementation. While ACEP did not take an official position on the law, ACEP has been very vocal about topics pertinent to emergency physicians. ACEP recently sent a letter to Health and Human Services Secretary Kathleen Sebelius highlighting priorities for healthcare reform implementation. Included were such topics as extending the prudent layperson standard, making the emergency department more efficient, and increasing emergency medicine residency slots. The overall focus for ACEP at this time is to not simply be satisfied that the legislation made it through, but to remain strong advocates for emergency medicine as the reforms actually start to take shape. EMRA members also provide an important voice in these discussions, as we are the future of emergency medicine.

Emergency medicine workforce
In 2009, the Future of Emergency Medicine Summit was held, and it included representatives from across the field of emergency medicine. In addition to ACEP and EMRA, delegates from AAEEM, SAEM, CORD, and the American College of Osteopathic Emergency Medicine (ACOEP) were also present, as well as members of the Emergency Nurses Association (ENA) and the Society of Emergency Medicine Physician Assistants (SEMPA). The focus was on workforce issues, and this first summit defined the problem of emergency physician shortages and elucidated the need for residency-trained emergency physicians to ensure patient safety. In addition, shortages in rural areas were discussed, as was the reliance on providers with other levels of training in the emergency department.

The next summit will be held at the end of January 2011, and the goal of this meeting will be to further explore potential solutions to the emergency physician workforce shortage. The development of a minimum skill set – comprised of basic procedural and cognitive skills – for emergency care providers is one aspect that will be receiving further discussion.

Medical liability
This has been a long-standing challenge for ACEP, dating back well over 20 years. ACEP’s Reform of Tort Law Policy endorses legal reforms designed to limit the liability for economic damages, reduce term lengths for statutes of limitation, control attorney’s contingency fees and so on. To this end, ACEP is working to compile data on medical liability at the state level, and someday when the political climate is correct, they will be prepared for national liability reform. The medico-legal environment in which we practice is too often forcing the focus of patient care to be on the legal aspect of medical decision making.

Boarding in the emergency department
ACEP has long called for the cooperation of physicians, administrators, elected officials, the public, and other stakeholders to address the continued problem of boarding admitted patients in the ED. Clearly this practice is a patient-safety issue, and ACEP is working with the American Society of Hospital Risk Managers to develop an educational program for their members to highlight these issues. While ACEP continues to emphasize the importance of finding real-world, long-term solutions to boarding, they have realized that an important step in that process is making people aware of the facts.

These have been only brief summaries on the areas where ACEP will focus this coming year – and all four are certainly hot topics. EMRA members should explore those that interest them and then look for ways to become involved. ACEP’s Leadership and Advocacy Conference, as well as both EMRA and ACEP Committees, provide avenues for education, participation, and contribution – thus allowing everyone to travel on the road ahead.

References
3. ACEP Policy Statement: Reform of Tort Law; Approved by the ACEP Board of Directors August 2009
4. ACEP Policy Statement: Boarding of Admitted and Intensive Care Patients in the Emergency Department; Revised and approved by the ACEP Board of Directors April 2008
Resolutions, apple pie...and the Tea Party

The fall is my favorite season. Thanksgiving dinner, foliage, the smell of impending winter, football, the cornucopia (a very underappreciated form of abstract art), and of course, Election Day. The fall is such a politically charged time, with policy changes occurring at every level of government. In order to keep you on the cutting edge, I have summarized the key developments so that you can spend more time making apple pies and protecting your significant other from crazy Uncle Eddie.

**EMRA**

In an unprecedented legislative power play, EMRA forwarded two resolutions to the ACEP Representative Council, both of which were passed during September’s Scientific Assembly. The first resolution instructs ACEP to work with EMRA, CORD (Council of Residency Directors), and other appropriate entities to continue the development of resources that deliver advocacy education to emergency medicine residents. Furthermore, the resolution urges ACEP to encourage all emergency medicine residency programs to integrate formal advocacy and healthcare system education into the official residency curricula.

The second resolution establishes ACEP policy. The resolution states that ACEP believes in maximum legal penalties for verbal threats, physical assault, or any other form of violence against healthcare providers working in the emergency department. The resolution urges ACEP to advocate for heightened national awareness for this problem and increased safety measures in all emergency departments. In addition, ACEP is asked to encourage all states to sign into law that violence against healthcare providers in the emergency department have a maximum elevated category of offense and subsequently, maximum criminal penalty. At this time, only six states have passed such laws making emergency department healthcare workers a protected class, similar to police officers or public transit officials.

**ACEP**

Thirty five resolutions were discussed at ACEP’s Scientific Assembly Council meeting in Las Vegas. The Council Officers, Arlo F. Weltge and Marco Coppola, commanded the attention of the 350 councilors present, and with wit and charm, navigated both parliamentary procedure and the electronic voting system.

The resolution topics varied from the definition of an emergency physician to the use of web-based prescription monitoring programs and databases. The Council also voted to widen the breadth of representation by adding one councilor position for the Council of Residency Directors (CORD). By far the most spirited debate centered around two resolutions addressing the classification status of marijuana and endorsement for the legalization and taxation of marijuana. The final outcomes of all resolutions are listed on the ACEP website.

ACEP’s Political Action Committee, NEMPAC, reported record fundraising efforts during the ACEP Scientific Assembly. This enthusiasm was likely buoyed by the upcoming November elections that could change the political landscape in Washington, DC, and also perhaps by a few lucky streaks at the craps tables.

A political action committee, or PAC, is a private group, regardless of size, organized to elect political candidates or to advance the outcome of a political issue. NEMPAC is well on its way to exceeding the previous annual fundraising record of $1,167,342 set in 2009. To set that goal last year, the ACEP Board of Directors and Councilors donated more than $155,000 at Scientific Assembly. NEMPAC is currently the fourth largest physician-specialty PAC behind the anesthesiologists, orthopedic surgeons and radiologists.

**National**

By the time you read this article in print, the November 2nd elections will have occurred, and Congress will be preparing to return on November 15th with many potential changes. One unique difference this year is that the Senators elected in Delaware, Illinois, and West Virginia will be seated immediately after the election because they are replacing Senators who were appointed to fill vacancies (as opposed to waiting for inauguration in January).
There are several emergency medicine-pertinent issues we expect the Congress to address before the end of the year. These include an extension of Medicare physician payment rates, so as to avert the 23 percent cut scheduled to take effect on December 1. If history is any predictor of the future, Congress will elect to extend current rates and a new temporary postponement will be in place until the beginning of the new calendar year. Additionally, the Congress will need to establish budgets and funding for federal agencies for the remainder of fiscal year 2011 since no regular appropriations bills were enacted this year, and the government is currently operating at FY 2010 levels on a temporary basis through December 3.

The Tea Party

These days, what political summary is complete without a tribute to the Tea Party? The Tea Party movement emerged in 2009 through a series of locally and nationally coordinated protests, partially in response to several new federal laws and a series of healthcare reform bills. The movement’s self-proclaimed, primary concerns include adherence to the Constitution, cutting back the size of government and lowering taxes and wasteful spending. However, with a disproportionate number of Tea Party members dependant on Medicare, it seems ironic that the group is constantly criticizing the unfair nature of the ‘welfare state’ and advocating for less government spending.

Regardless of your personal opinion of the Tea Party, their vision of a revolution is refreshing, and I applaud their degree of grassroots organization and commitment. However, despite being pitched in the media as a threat to the GOP, there is a suspicious amount of overlap between the Tea Party and the Republican Party. This common interest threatens the genuine nature of this uprising and may leave many early supporters jaded. The complicated system of multi-tiered checks and balances in the U.S. prevents rapid, large-scale political change and I anticipate the same outcome from November’s elections.

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

EMRA’s Representative Council working through proposals and voting on resolutions presented at the 2010 ACEP Scientific Assembly.
Having recently rotated on the orthopedics service, I realized the importance of being able to describe hip fractures – specifically femoral neck fractures – as this determines how they are managed. These can often be very subtle on radiographs. It is important for the emergency medicine physician to have a sound understanding of these, as femoral neck fractures are very common and the incidence is increasing as the population ages.

During the initial management of femoral neck fractures, it is important to adequately control the patient’s pain, and prompt consultation with an orthopedic surgeon is necessary. It is also the responsibility of the emergency medicine physician to differentiate between a mechanical and non-mechanical fall. Syncope or any other non-mechanical etiology of a fall must be worked up thoroughly. Additionally, examination for other injuries is warranted.

The femoral neck is a highly vascular region, and when fractured, significant complications – including avascular necrosis – can occur. To avoid further disruption of the blood supply to the femoral head, immobility of the extremity in question is necessary.

The Garden classification was developed to describe femoral neck fractures. Orthopedic surgeons would appreciate a description of a femoral neck fracture that incorporates the Garden classification, as it determines management in the operating room and risk of avascular necrosis. The risk of avascular necrosis increases as the Garden number increases.

The major risk factor for femoral neck fractures is osteoporosis. Accordingly, these fractures are often called “insufficiency fractures,” as they tend to occur after minimal or no trauma; the bone simply has weakened over time.

It should initially be determined if the fracture is displaced. Displacement simply describes whether or not the segments of a fracture maintain their normal position. About 20 percent of femoral neck fractures are nondisplaced. Garden I and II femoral neck fractures are nondisplaced. Conversely, Garden III and IV femoral neck fractures are displaced.

Femoral neck fractures can be very subtle and difficult to find on x-rays. Shenton’s lines can be drawn (Figure 2). When searching for a fracture, drawing Shenton’s lines can be helpful. Any disruption of this line might indicate a fracture of the femoral neck.

The convex outline of a normal femoral head smoothly joins the concave outline of the femoral neck. This will produce an S curve and a reverse S curve (Figure 3). Lowell suggested that a fracture produces a sharp angle, representing a disruption of the normal anatomy.

In summary, femoral neck fractures are an important clinical entity of which the emergency medicine physician must have a solid understanding. They often can be challenging to discover on radiographs. Immediate orthopedic consultation is necessary for all femoral neck fractures. An accurate description of the fracture is extremely important – including the Garden classification – and should be conveyed to the orthopedic surgeon.
Welcome to five new EM programs and a new EM subspecialty!

Semiannually, the Residency Review Committee for Emergency Medicine (RRC-EM) meets to review both core emergency medicine and emergency medicine subspecialty programs. The purpose of the reviews is to ensure that all residents graduating from an ACGME-accredited program receive equivalent and adequate training. Results from the September 2010 RRC-EM meeting in Chicago, IL are as follows:

Two new core EM programs were approved:
1. Dartmouth-Hitchcock Medical Center Program
   • Lebanon, NH
   • Program Director: Kevin M Curtis, MD
2. Carilion Clinic – Virginia Tech Carilion School of Medicine Program
   • Roanoke, VA
   • Program Director: Jennifer J Casaletto, MD

Two new Medical Toxicology programs were approved:
3. SUNY Upstate Medical University Program
   • Syracuse, NY
   • Program Director: Michael Hodgeman, MD
4. Virginia Commonwealth University Health System Program
   • Richmond, VA
   • Program Director: Brandon K Wills, DO

One new Pediatric EM program was approved:
5. Health Partners Institute for Medical Education Program
   • Minneapolis, MN
   • Program Director: Manu Madhok, MD

Currently in the 2010-2011 Academic Year there are 155 ACGME accredited emergency medicine programs. One hundred and twenty-three of these are three years in length (five of the three-year programs require an internship to be completed first – PGY2-4) and the other 32 are four years in length. Eighty-eight percent of the resident positions within these programs are filled.

In the EM subspecialties, of the 24 accredited Medical Toxicology Programs, 51 of the 88 approved positions are filled. In Pediatric Emergency Medicine, there are 65 of 75 positions filled in the six Undersea and Hyperbaric Medicine programs. Sports Medicine has seven of eight positions filled in five programs. For Sports Medicine and other multidisciplinary programs (Hospice and Palliative Medicine, Sleep Medicine, Neuromuscular Medicine), a separate RRC provides accreditation review. For programs visited after July 1, 2011, the Family Medicine RRC will review those programs.

Lastly, Emergency Medical Services (EMS) has been accepted as a new subspecialty by the ACGME with a tentative effective date of July 2013.

The next RRC-EM meeting will be held in Jackson Hole, WY February 11-13, 2011.

If you have any questions, please refer to the ACGME website and the Emergency Medicine RRC newsletter which can be found on the ACGME website (http://www.acgme.org).

Congratulations and welcome to all the new programs!
Pin-point pupils...let’s give 2 of Narcan!

**Case presentation**

A 25-year-old man with no known past medical history is brought in by Emergency Medical Services (EMS) for unresponsiveness. EMS reports that they were called by a neighbor who found the patient comatose. The patient was hypoventilating at three breaths per minute and cyanotic, with miotic pupils. EMS also noted track marks on the arms, as well as an empty syringe at the scene. The patient was ventilated by bag-valve-mask during transportation.

Upon arrival, the patient was placed in the critical care bay during which time preparations for endotracheal intubation were being made. Two mg of naloxone was administrated intravenously, the patient became alert with a respiratory rate of 18 breaths per minute. At this time, the patient was clearly uncomfortable with piloerection, diaphoresis, hyperactive bowel sounds, and bilateral rales on lung exam. He soon developed respiratory distress with pink foam at the mouth and desaturation. The patient was intubated with a chest radiograph that revealed bilateral diffuse patchy infiltrates.

**Discussion**

A case many clinicians witness is the opioid toxidrome. Many may also have witnessed complications of an opioid antagonist when not properly used. The diagnosis of an opioid toxidrome relies on clinical acumen as opposed to laboratory testing. Patients often will present with a constellation of symptoms that include hypoventilation, depressed mental status and miotic pupils. Many patients often require immediate ventilation and oxygenation to avoid death; however, judicious use of an opioid antagonist such as naloxone may avoid prolonged bag-valve-mask or intubation.

While many clinicians understand that naloxone is the “antidote” of choice when managing a patient with a suspected opioid poisoning, few understand proper dosing as well as the desired outcome. Perhaps the most important teaching pearl is that the goal of naloxone treatment is the restoration of sufficient spontaneous respirations and not complete arousal.

There are primarily three opioid antagonists currently available in the United States—naloxone, nalmefene, and naltrexone. Naltrexone is a long-acting opioid antagonist that has good oral bioavailability, often used for opioid detoxification as well as maintenance of opioid abstinence. Nalmefene is an intravenous agent whose duration of action is between that of naloxone and naltrexone. All three are competitive antagonist at various opioid receptors such as delta (δ) and kappa (κ) receptors, with the mu (μ) receptor being the most clinically relevant.

Naloxone has poor oral bioavailability, but is well absorbed by other routes of administrations such as intravenous, subcutaneous, and endotracheal. It has a rapid onset of action when administrated intravenously measured in minutes, with duration of action falling between 20 and 90 minutes.

Naloxone, when given to healthy human subjects resulted in no adverse effects, even when very large amounts were given. With the exception of resedation and induced withdrawal, adverse effects from naloxone are rare. The problems...
associated with naloxone use are apparent when it is improperly given to a patient who is not opioid naïve. A potential complication is resedation, which occurs when naloxone—a short-acting opioid antagonist—is given to a patient who ingested a long-acting opioid agonist such as methadone. Use of longer-acting opioid antagonists, such as naltrexone, may avoid resedation but has a substantial risk for prolonged withdrawal syndrome, which can be difficult to manage.

Another complication when an improper dose of an opioid antagonist is given is inducing opioid withdrawal. While a natural-occurring opioid withdrawal (such as lack of access to an opioid agonist in prison) is not life-threatening, an iatrogenic-induced opioid withdrawal may result in pneumonitis from emesis, acute lung injury, cardiac dysrhythmias, and hypertension. Also, many patients with induced opioid withdrawal are often difficult to manage from a behavioral standpoint.

The initial dose of naloxone in a patient who is opioid tolerant should be much lower than what is typically given. With the exception of an opioid-naïve patient, doses in the one to two mg (or even 0.4 mg) range would be considered large and most certainly will induce opioid withdrawal. The primary goal is to reverse respiratory depression while avoiding precipitating withdrawal, therefore 0.04 or 0.05 mg is a practical starting dose. It is important to observe the patient for resedation, in particular if a long-acting opioid agonist is in effect which may then require re-administration or a naloxone infusion.

Case conclusion
The patient was diagnosed with acute lung injury related to an iatrogenic induced opioid withdrawal from the large dose of naloxone use. The patient was admitted to the intensive care unit where he had a complicated course of ventilator-associated pneumonia and acute lung injury. The patient was discharged eight days later after his prolonged hospital course.

References
The “aVR” sign: A potential medical emergency

Case

A 64-year-old man with a history of type II diabetes, carotid artery and peripheral artery disease, and no known cardiac disease was hospitalized for multilobar pneumonia and respiratory failure. He was subsequently intubated for worsening respiratory status. The patient remained hemodynamically stable. Later, ST elevation was noted on the monitor, which prompted the recording of the 12-lead ECG below (Figure 1). Troponins in the next 24 hours were 0.86 → 1.65 → 1.66 ng/mL (upper limit of normal: 0.06 ng/mL). A bedside echo revealed normal chamber sizes and LV function, with an estimated ejection fraction (EF) of 55 to 60 percent.

What is your interpretation of the ECG, and what would you do at this time?

The ECG (Figure 1) shows diffuse ST depression and ≥ 0.5 mm ST elevation in aVR and V1. Coupled with the troponin elevation, this is suggestive of diffuse subendocardial ischemia from proximal left anterior descending artery (LAD) or left main (LM) disease. More than one mm ST-elevation in aVR or ST elevation greater in aVR (Figure 2) than in V1, has an 80 percent positive predictive value for left main disease. Conversely, the absence of ST elevation in aVR has a high negative predictive value for LM disease.

With an anterior ST elevation MI (STEMI), elevation in aVR indicates proximal rather than distal LAD occlusion. Pooled data show this “aVR sign” has 96 percent specificity and a 91 percent positive predictive value for proximal LAD occlusion (Figure 3). While the absence of ST elevation in aVR may exclude LM stenosis as the underlying cause in NSTEMI, its presence indicates a culprit lesion in the proximal segment of the LAD in an anterior STEMI.
Ischemic left main disease with an aVR sign is not considered a STEMI, as evidenced by the modest troponin elevation and normal LV function in the echo of our patient. However, these patients are at very high risk for subsequent STEMI and death. Therefore, in the absence of contraindication, they should undergo urgent cardiac catheterization (Figure 4).

Lastly, in patients with ST elevation in leads aVR and V1, there are additional diagnoses to consider, especially in the critical care setting. These include pulmonary embolism, isolated RV infarct, RV stress, stress-induced ischemia, myocarditis, pericarditis, and hyperkalemia. All of these conditions can be associated with diffuse ST depression, ST elevation in aVR or V1, or mild troponin elevation and should be part of the differential diagnosis.

In our case, the patient was not considered to be a good candidate for cath. Five days later, he developed shock. The ECG at that time showed signs of extensive anterior MI with abnormal Q waves in V1-V5 (Figure 5). The echo demonstrated anteropapical akinesis and an EF of 30 to 35 percent. Cardiac labs peaked as follows: troponin 102.5 ng/mL, total CK 2,860, MB fraction 60.9. Two days later the patient dies following refractory shock.

References
“Remember that there is always something for you to learn, even if it’s how you are going to treat medical students when you are a resident.”

Good morning! Hallelujah!

would stop by for a visit if my day was getting particularly trying. His positivity was contagious, and I left his room each day with my tank refilled, ready to share that with my team.

As medical students, it’s easy to think that we are of little value to our team. Our H&Ps have to be repeated. We can’t obtain consent for a procedure, and we have a tendency to slow down the flow of our experienced senior residents. But remember that your job is to learn; it is your responsibility to take this time to see and do and learn as much as you can while you still have the freedom of the limited responsibility that often frustrates us. So while you are busy taking, what is it that you can give to your team? Your best attitude.

Attitude, good or bad, is contagious. Even at the bottom of the totem pole, you have the opportunity, and perhaps responsibility, to have a very contagious, positive attitude. Find what it takes for you to be positive, whether that’s jamming out to your favorite song in the car before you go in, visiting the happy patient before you put your bag down, or knocking out some jumping jacks. Being able to find your happy place is a skill that you will use throughout your career. It can even help you from getting sued, since the majority of malpractice claims are based on a patient’s perception of the physician’s attitude.

Take the time during medical school to practice being nice. You should never argue with your residents and never approach your encounters with negativity or hostility. Remember that there is always something for you to learn, even if it’s how you are going to treat medical students when you are a resident.

A positive attitude has a beneficial impact on patient care, and if you, as a medical student, are able to take part in setting the tone for your team each day, then you really are making an impact on your team, your career, and most importantly, your patients. I challenge you to wake up every day at that ridiculous hour, and say to yourself, “Good morning, Hallelujah!” to yourself. Embrace all of your learning opportunities, the fun, and the less-than-fun with a positive attitude, and you will be a much happier medical student!
Why is my surgery rotation important for EM?

After dragging myself out of bed at 4:30 a.m., my suspicions were confirmed the first day of my rotation, surgery was going to be the longest, hardest, and most strenuous rotation of my third year. The long hours and physical pain from prolonged standing in the same spot, combined with the lack of sunlight, food, and relaxation, reminded me that surgery was simply not my calling.

But despite my general exhaustion and initial lack of interest, I quickly realized that many skills important to the practice of emergency medicine could be acquired during my days spent masquerading as a surgeon. Among the most important of these skills are:

1. Management of the Surgical Patient. During your EM residency, you will most likely rotate through trauma surgery, SICU, or another surgical specialty service. Learning how to manage surgical patients, including the ability to properly assess their condition, is a skill that you will use throughout your career as an emergency physician. Take the time to learn how to write a solid SOAP (Subjective, Objective, Assessment, and Plan) note now, so you’re ready to jump right in during your first surgical rotation.

2. Suturing. Basic suturing skills are essential to the practice of emergency medicine, as lacerations are a common emergency department presentation. Suturing skills are also important to mastering central line placement, arterial line placement, and other common EM procedures. If you have already learned how to suture, then you are one step ahead of the game. It will also impress your emergency medicine residents and attendings if you have mastered this skill in time for your medical school rotations in the ED.

3. Team Dynamics. Pay attention to how your surgical team functions during trauma resuscitations and in the operating room.

4. Placing Lines. During your surgery rotation, you will be presented with many opportunities to learn common EM procedures, such as nasogastric tube, intravenous line, or Foley catheter placement. Make sure that you take full advantage of these opportunities. You will have similar opportunities for line placement on your emergency medicine rotations, but why not already have them mastered? You will refine your procedural skills each time that you perform a procedure, so do as many of them as you can.

5. Surgical Decision-Making. While you may not get to make the big decisions intra-operatively, you should observe to learn how your attending surgeons decide whether or not to pursue a particular course of action. Learning the thought processes behind the quick and tough (but educated) decisions made by surgical attendings during surgery can help you to make similar quick, challenging decisions about patients in the ED. There is often little time to sit down and formulate a plan in the emergency department, especially with critically-ill patients.

Learning how to formulate a plan of action, understanding team dynamics, mastering suturing and other basic procedural skills, and making tough decisions quickly are all vital skills for any doctor, not just surgeons or emergency physicians. By focusing on learning these skills, you will get the most out of your medical school rotation in surgery. More importantly, you will be well prepared for some of the many challenges that you will face as an emergency medicine physician.

“The long hours and physical pain from prolonged standing in the same spot, combined with the lack of sunlight, food, and relaxation, reminded me that surgery was simply not my calling.”

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Combined EM/IM residency training: Benefits and perspectives

Have you ever considered applying to a combined emergency medicine – internal medicine (EM/IM) residency program? You may wonder why anyone would want to spend more time in residency. But there are advantages, as well as disadvantages, to dual training. This article outlines some of the factors that you should consider before you apply, including how current residents view their decision to pursue combined EM/IM training.

Background
The American Boards of Emergency Medicine (ABEM) and Internal Medicine (ABIM) approved the concept of combined emergency medicine (EM) / internal medicine (IM) training in 1989. Since that time, 11 allopathic EM/IM programs have been developed in the United States, with a 12th program scheduled to open in July 2011. These programs are modeled on a five-year curriculum, with residents eligible for board certification in both specialties after graduation. Three programs also offer an optional sixth year of critical care training, leading to board eligibility in critical care medicine.

Why EM/IM?
Dually-trained EM/IM physicians are well-positioned to care for patients with both acute illness or injury and chronic disease in a variety of settings, including the emergency department, the ICU, the wards, and the clinic. They have a unique opportunity to integrate the knowledge base and skill sets of both specialties into their daily practice. Many “combined” residency graduates feel that their internal medicine exposure helps them to better understand the pathophysiology of common medical conditions seen in the emergency department. Conversely, their emergency medicine training allows EM/IM physicians to confidently perform many minor surgical procedures and to expertly manage high-acuity situations that may arise on the wards or in the clinic.

EM/IM physicians are uniquely equipped to be problem solvers and leaders within healthcare systems because they have trained in virtually every hospital setting and have been exposed to a wider variety of specialists than most physicians. Their extended training period highlights a deep commitment to medicine and enhanced leadership abilities, both essential elements of a successful career in academic medicine or administrative leadership. Collaborating with residents in different programs and learning how to share the skill sets unique to both specialties help EM/IM graduates to be successful educators and mediators.

Critical care medicine is the most common fellowship pursued by EM/IM program graduates, as the high acuity of care provided in the ICU complements their emergency medicine training. EM/IM physicians are also ideal candidates for leadership roles in the growing field of observation medicine, where efficiency and continuity of care must be balanced.

International medicine is another specialty that is well-suited to the EM/IM graduate. In areas with limited resources, skilled physicians are needed to manage both acute and chronic medical problems. The unique perspective of EM/IM physicians allows an adaptive and innovative approach to healthcare that is particularly useful in the difficult, and often makeshift, conditions faced by international and disaster medicine specialists.

Applicants
Applicants to combined EM/IM residency training programs, like categorical EM
applicants, are typically among the best in their class. EM/IM applicants have diverse personal backgrounds with a wide variety of experiences. Many of them express a strong interest in academic careers, international health, or research opportunities. Others are interested in combining their work in the emergency department with hospitalist medicine, or in pursuing subspecialty training in fields such as critical care medicine.

Whatever their career aspirations or personal background, applicants to EM/IM programs should certainly love both emergency medicine and internal medicine and be willing to spend five years training in both. Applicants should be prepared for a demanding five-year training program that integrates a large volume of knowledge and skills from both specialties. Additionally, applicants should have a plan for incorporating both components of dual training into their career. EM/IM training is probably not the best choice for applicants who simply cannot decide between emergency medicine and internal medicine training or envision practicing in only one field in the future.

Dual training enables physicians to work in a variety of settings, especially within the world of academic medicine. About half of recent EM/IM graduates work primarily in an emergency department, while ten percent work only in internal medicine or a medical subspecialty, and one-third practice both emergency medicine and internal medicine. Although more than two-thirds of EM/IM grads go on to practice in an academic setting, approximately one in four pursue formal fellowship training after residency (Kessler CS et al., 2009).

Current residents

We asked several “combined residents” why they chose to pursue dual training and how they view this decision after completing at least part of their residency training. We found that most residents pursued a combined EM/IM path because of their interest in both specialties, in addition to an interest in academic or international medicine. One EM/IM resident found dual training to be a good fit because, “I felt like a true generalist when I was still a medical student.” These residents valued their experiences in both emergency medicine and the internal medicine subspecialties during their fourth year of medical school, prompting their decision to pursue combined training.

While some residents appreciated the extended spectrum of potential fellowship options, others felt like dual training offered numerous satisfying career options without the need to complete an additional fellowship. Overall, residents felt that dual training was a good intellectual and personal fit for them because of the wide variety of patients, pathology, and practice settings they hoped to see after graduation.

Critical care rotations were frequently cited by current residents as the ideal EM/IM experience, where the procedural backgrounds and knowledge bases of both specialties merge. As one resident put it, “In the ICU, I feel that I am a true combined resident.” EM/IM residents referenced their ability to better anticipate the needs of consultants while in the emergency department and their greater comfort interacting with consultants on the wards as another major benefit of dual training. Because of their broad training, combined residents often develop strong working relationships with residents from other programs. These relationships can lead to greater cooperation and improved interaction between residents from multiple disciplines.

How can I learn more?

A fourth-year medical school rotation at an institution with an EM/IM program is highly recommended for interested students. These rotations provide students with an opportunity to interact directly with EM/IM residents, and can lend credibility to your EM/IM residency application and personal statement. More importantly, they enable both the applicant and the program leadership to identify a “good fit.”

If you are interested in EM/IM residency, you should also stay involved with EMRA and consider joining ACEP’s Emergency Medicine – Internal Medicine Dual Training Section (www.acep.org). Participating in the section’s activities is a great way to network with current residents and graduates of dual training programs. The section is also a good place to learn about ongoing and upcoming research projects. Best of all, EMRA members can join one ACEP section for free!

Further reading


December/January 2011 23
Priapism is “a pathological condition of a penile erection that persists beyond or is unrelated to sexual stimulation.” 1-4 This article describes a unique case of non-ischemic priapism that converted to ischemic, followed by a brief overview on the diagnosis and latest advances in treatment available in the ED.

Case report

The patient, a 22-year-old, African American male taking no medications, presented to the ED with a chief complaint of “groin pain.” He received an injury to his groin between the base of his penis and testicles during a basketball game four days prior. The injury was initially painful but subsided quickly. He returned home with no other complaints or deficits.

Over the next day, he developed a painless erection that failed to resolve spontaneously. After three days, the painless erection became intensely painful, prompting his visit.

The patient denied tobacco or drugs but admitted to occasional alcohol. Physical exam showed a fully erect priapism (Fig.1, 2), which was tender to palpitation. He was able to void normally.

Initial management consisted of narcotics and subcutaneous terbutaline with no effect. A penile blood gas pH of 6.8 necessitated rapid drainage in the ED.

Next, one 18 gauge catheter was inserted into each cavernosa, with several sterile saline flushes alternating sides to allow drainage. Direct irrigation of the cavernosa with phenylephrine diluted in normal saline was applied during continuous BP monitoring to assess for systemic vasoconstriction (Fig.4). Despite these interventions, the priapism continued to fill in a pulsatile fashion, so the patient was sent to interventional radiology for imaging and embolization.

Radiology discovered and embolized a pseudoaneurysm filling the left penile artery. The patient was discharged to home with urology follow-up. The patient’s hemoglobin electrophoresis was normal.

Etiology of priapism

Ischemic priapism is a medical emergency, presenting as an acutely painful, fully erect phallus. It is linked to many etiologies including sickle cell anemia (SCA), drugs, malignancy, and spinal cord stenosis. SCA has a reported prevalence of priapism as high as 42 percent. 5-7 Drugs linked to ischemic priapism include hydralazine, prazosin, chlorpromazine, trazodone, risperidone, sildenafil, sildenafil, and cocaine.

Non-ischemic priapism—on the other hand—presents as a painless, semi-erect phallus. It results secondary to trauma and is not a compartment syndrome. 3,4

Current therapeutic guidelines

As treatment for ischemic versus non-ischemic priapism differ greatly, proper diagnostic evaluation is essential. For ischemic priapism, a careful history is essential to seek triggering medications, hemoglobinopathy, or malignancy, followed by hemoglobin testing, rectal exam, and prostate-specific antigen.
The American Foundation for Urological Disease (AFUD) recommends a penile blood gas and Doppler sonography to assess blood flow into the cavernosa. Initial measures include local anesthesia using a dorsal nerve block, circumferential penile block, and subcutaneous local penile shaft block.3,4

The management of ischemic priapism in SCA parallels that of non-SCA patients but also requires supplemental IV hydration, oxygen, narcotic analgesia, and possibly transfusion.3,4,8 Initial treatment for any ischemic priapism begins with either direct corporal injection or irrigation with sympathomimetics (e.g. phenylephrine). The advantages of irrigation over direct injection include reduced risk of corporeal contamination, plus the capacity to perform extended irrigation without repeated injections.9,10 Patients must be under constant monitoring during either treatment method to monitor systemic blood pressure.4,9-10 Most patients treated within 12 hours respond within 20 minutes; treatment failure may indicate irreversible changes in the vasculature.3,9

Following failure of conservative treatment, surgical intervention is recommended by the AFUD. A number of surgical shunts are available, but there are no guidelines outlining the preferred choice. While these procedures are generally done by urology, it is important for ED physicians to have knowledge of these techniques for use in the absence of a timely urology consultation.

Three of most commonly used shunts include the Winter, AL-Gorab, and T-shaped. The Winter shunt encompasses creation of small channels between the corpora cavernosa and spongiosum.11 The AL-Gorab shunt is a larger communication between the corpora cavernosa and spongiosum.3,4

Use of the T-shaped shunt is a technically simple procedure involving direct incision and passage of a 20 French dilator down through the glans on either side of the corpus spongiosum. The priapism is then milked and closed. This technique thus creates open channels in both cavernosa, preventing fibrosis and scarring. Several authors have reported very favorable results even forgoing the need for penile prostheses.12 This technique “is easily performed with the patient under local anesthesia and, thus, is well-suited in the emergency department...the T-shunt with tunneling combines the appealing features of the distal and proximal shunts in that it reliably creates a large diameter shunt...it is technically simple and easy to perform and...seems to facilitate recanalization of corporal circulation.”12

The treatment options for non-ischemic priapism consist of conservative measures including external compression and topical application of ice. If these initial approaches fail, selective emboislation under direct fluoroscopy is recommended.3,4,14 Embolization is associated, however, with a very low but very serious incidence of perineal abscess formation, necessitating long-term follow-up.15

Priapism represents a medical emergency that requires prompt treatment in the ED. This report outlines the various presentations of priapism, their most common etiologies, respective treatments and the most up-to-date literature on surgical options while highlighting an unusual case of priapism.1

Resources

Bouncebacks!

The case of a 45-year-old man with a cough and a sore throat

The August/September issue’s case was easy... a knuckle lac is always a fight bite... right? Well, this case will be a bit more challenging. Not necessarily because of the diagnosis, but more specifically because of the atypical presentation. This is my favorite case from the Bouncebacks! book, as it demonstrates how good care can become great. I suspect many physicians would have handled the evaluation of this patient in an identical manner, but with a few extra minutes of time, disaster could have been adverted.

Ever feel like you’re living on the edge? Working night shifts, hanging with the salt of the earth? We are also for searching for patients on the edge; sick appearing patients who appear well. No worries about the code or routing ankle sprain, these deceptively healthy patients are who we are after.

On the surface, the evaluation below seems well thought out, but a closer look reveals some serious documentation and patient safety issues - see how many you can spot.

Let’s get started… remember that patient you saw last night…?

Initial visit

Note: The following is the actual documentation of the providers, including punctuation and spelling errors.

Chief complaint (00:39): Sore throat

Vital signs
Time 00:39; Temp (F) 97.8; Pulse 110; Resp 16;
Syst 110; Diast 82; Pos. S; O2 Sat 98; O2% RA

History of present illness (physician assistant)
45 year old male c/o cough and throat pain x 1 month. Admits to past hx of GERD. States he has been taking Zantac for a week. His PCP prescribed a cough medicine and an antibiotic, but the cough has not improved. Denies known fever. Admits to feeling hot and having intermittent chills. Denies n/v/d, abdominal pain, ear pain, chest pain, peripheral edema, calf muscle pain, shortness of breath, rhinorrhea. The history is provided by the patient. He refuses an interpreter.

Past medical history/triage (at 00:26)
Medication, common allergies: No known allergies.
Current meds: Zoloft and Tramadol hcl and Zantac and Lipitor
Past medical/surgical history: Depression, Headache. No significant surgical history.

Physical exam (physician assistant):
General: Well-appearing; well-nourished; A&O X 3, in no apparent distress
Neck: No JVD or distended neck veins
Resp: Normal chest excursion with respiration; breath sounds clear and equal bilaterally; no wheezes, rhonchi, or rales
Card: Regular rhythm, without murmurs, rub
Abd: Non-distended; non-tender, soft, without rigidity, rebound or guarding
Skin: Normal for age and race; warm and dry without diaphoresis
Extremities: No peripheral edema or calf muscle pain
Results (01:43): PA and lateral CXR. The heart size is enlarged. The pulmonary vasculature is within normal limits. No acute infiltrates or evidence of CHF is seen.

Impression: Cardiomegaly

Progress note (03:23) – (physician): I spoke with his PCP and discussed the case including getting a cardiac ECHO and to ensure follow up. I do not feel that he needs admission as there is no peripheral edema, crackles on exam, or pulmonary edema on CXR.

DIAGNOSIS: Cough, Gastritis

FOLLOW UP: Prescriptions for prilosec and hydromorphone. Follow up with primary physician in 3 days. Outpatient testing for cardiac ECHO ordered with results to be sent to PCP. Discharge time was 03:44

Author’s note: This patient is one we see every day…cough, sore throat, heartburn; but is that all there is? How do we catch the needle in the haystack – the well appearing patient who is sick…

Discussion of documentation and risk management issues

Error #1: The doctor questions the accuracy of his own documentation.

Discussion: It is documented in the HPI “He refuses an interpreter.” This statement calls our whole history into question; did he need an interpreter, and if he did, then how was he able to refuse one? It is easy to lapse into a game of yes/no questions: String together a long list of symptoms and the patient will often answer ‘no’ to all of them… even if one was the actual chief complaint! This brief sentence calls into question the reliability of the entire history.

If there is a question about the patient’s ability to adequately communicate, try to find other ways to obtain their history such as using an interpreter (or language phone line), family members, or writing questions and answers (hearing impaired). Document their understanding of the risks of refusing an interpreter.

Teaching point: If the patient is not able to communicate an accurate history, you will not be able to make an accurate diagnosis.

Error #2: The chief complaint is not addressed in the history. The physical exam does not have a throat exam.

Discussion: When the CXR showed cardiomegaly (an unanticipated finding as the CXR was likely ordered to look for infiltrate) the doctor records a progress note and speaks with the PCP about setting up an ECHO, but does not return to the ‘ace in their hand’: the history. Returning to the bedside and questioning the patient specifically about symptoms of heart failure such as dyspnea with exertion, orthopnea, paroxysmal nocturnal dyspnea as well as risk factors for heart failure could have yielded important information.

How important is the history? Multiple studies have shown the diagnosis can be determined 73 to 92 percent of the time from the history alone. The documentation of the nurse and physician need to be consistent. If this chart would have been reviewed before the patient left the ED, this major discrepancy may have been detected and addressed.

Teaching point: Complete the history before moving to the ROS.

Error #3: The patient was not questioned about symptoms specific for heart failure.

Discussion: When the CXR showed cardiomegaly (an unanticipated finding as the CXR was likely ordered to look for infiltrate) the doctor records a progress note and speaks with the PCP about setting up an ECHO, but does not return to the ‘ace in their hand’: the history. Returning to the bedside and questioning the patient specifically about symptoms of heart failure such as dyspnea with exertion, orthopnea, paroxysmal nocturnal dyspnea as well as risk factors for heart failure could have yielded important information.

Why the cardiomegaly?
Teaching point: This is the most important lesson to be learned from this case: When evaluation or testing reveals unexpected findings (in this case cardiomegaly), return to the bedside and address these findings with further questioning or testing.

Error #4: Elevated pulse not addressed.

Discussion: Just as abnormal findings on testing need addressed, abnormal vital signs need to be rechecked and addressed by discussion in a progress note (unless obvious; i.e. tachycardia in a young patient with dehydration which resolves with IV fluids). Sklar localized four main themes in patients who died an avoidable deaths within seven days of ED visit:

1. Atypical presentation of unusual problem.
2. Chronic disease with decompensation. (ex. CHF)
3. Mental disability, psychiatric problem, or substance abuse making it less likely patient will return for worsening problems
4. Abnormal vital signs. Note: tachycardia occurred in 25 out of 35 (71 percent) of ‘possible error’ cases

Whereas the first three are predictable, the last is surprising and an opportunity to catch the ‘ticking time bomb’. Just as fever and weight loss are ‘red flags’ of back pain, tachycardia is a red flag for impending catastrophe. When a patient has unexplained tachycardia, consider returning to the bedside to confirm the story then recording your thoughts in a progress note. Testing is not required, a repeat bedside evaluation is. Tachycardia is prevalent and nonspecific, but is a ‘flashing yellow light in a school zone’ which says: look both ways before you cross.

Teaching point: Abnormal vital signs need to be rechecked and explained.

Error #5: Surprise diagnosis!

Discussion: Who says doctors are boring; this doctor came up with a diagnosis out of left field. The patient was diagnosed with gastritis and prescribed prilosec, but the history and exam do not support this diagnosis. In fact, the only allusion to gastritis is a diagnosis by the primary care doctor… talk about diagnosis momentum…

If the thought process is not clear by reading the chart, then the medical decision making needs to be explained in a progress note. For example, if you have a young patient with sharp chest pain and you document an extensive review of symptoms (ROS) for DVT/PE and document reproducible chest pain with palpation, then a diagnosis of ‘muscular strain’ is supported in the H&P, and a progress note is probably not necessary. In this case, the chief complaint is not reflected in the H&P, the H&P does not support the diagnosis, and the diagnosis is only helpful for a coder.

Teaching point: It is hard to justify a diagnosis if there is nothing in the history and physical exam to support it.

Summary of case and risk management principles

It would be interesting to know the patient’s understanding of the phrase ‘shortness of breath;’ I have often had a patient answer ‘no’ when asked about chest pain, but later learned he has chest pressure (or even an elephant on their chest). Our patient had no SOB when seated on the gurney in the ED, but did he have dyspnea with exertion or orthopnea? – we will never know for sure.

The most common radiologic finding of heart failure is cardiomegaly; other findings may include interstitial or alveolar edema, dilated upper lobe vessels, pleural effusion, and Kerley-B lines. Cardiac enlargement is defined as a cardiothoracic ratio (CTR) ≥0.5, but the heart size may be normal (CTR < 0.5) in up to 1/3 of patients with HF. An enlarged heart may not indicate HF. One study (Coronary Artery Surgery Study investigators) found a normal left
ventricular EF in 66 percent of 1,397 patients with CTR > 0.5\textsuperscript{6}.

The initial physician did seem to be concerned about heart failure (HF). A progress note was written before discharge to justify outpatient testing. If HF was a concern (using our ‘retrospect-o-scope’), it may have been helpful to confirm that the history was correct. If the patient had been re-questioned about dyspnea or orthopnea prior to discharge, the evaluation, and outcome, may have been different. In addition, an ECG could have been performed; a recent study showed that 96 patients with HF, none had a normal ECG. In 1996 Davie et al. examined 534 patients age 17-94 of which 96 were found to have HF. ECG findings in those with HF included atrial fibrillation, previous MI, left ventricular hypertrophy, bundle branch block or left axis deviation. In this study, none of the patients with HF had a normal ECG. (The remaining 438 patients had normal LV systolic function, though 169 had major ECG changes\textsuperscript{7}).

Unfortunately, our patient was sent home, decompensated quickly, and ended up in a nursing home on tube feedings. Most likely, the defendant’s case would stand up if brought to trial, but our goal is to take good care of patients, not merely to avoid lawsuits.

**Suggested readings**

1. Personal experience of the author
I pod jacks, heated seats, and bluetooth® technology are just a few upgrades available on new cars these days. bluetooth® allows the multitasking driver to focus on the road instead of holding a cell phone. Similarly, emergency medicine scribes allow busy emergency medicine physicians to see more patients and do paperwork relatively hands free.

I am a former scribe and the experience I had was life changing since it led to my career choice to be an emergency physician. Scribes are valuable assets to an emergency department team, and it is important to understand their role and how to work well with them so that efficiency can be maximized.

Scribes increase emergency department efficiency by serving a myriad of roles for their assigned physician. During a shift, a scribe will work with a physician and help them document on every patient that the physician sees that day. A scribe’s job includes recording the subjective and objective findings, helping with orders, tracking down lab results, and helping with disposition paperwork. Just like the physician that the scribe is working for, they need to be hard working, energetic, and able to multitask.

Scribes will also work with many different physicians and need to be able to adapt to different personalities and different attending styles. Scribes are typically college students who are interested in pursuing a medical career in the future. They usually have some form of training that includes training shifts with more experienced scribes. Once a scribe is trained they work as an important part of the emergency medicine team.

A symbiotic relationship exists between a physician and their scribe if the relationship is working properly. Scribes are looking for education, and physicians are looking to increase throughput and do less paperwork. A strong physician-scribe relationship can result in increased education, productivity, and profitability in the emergency department.

A recent study by Rajiv Arya, MD, Danielle M. Salovich, Pamela Ohman-Strickland, PhD, and Mark A. Merlin, DO showed how scribes benefit emergency department flow and finances. Their article was published in *Academic Emergency Medicine* in 2010. It was a retrospective study that looked at over 3,500 clinical hours over an 18-month span at a university-based academic medical center. Their results showed that a physician can see an additional 0.8 patients per hour and generate an additional 2.4 RVUs per hour by using a scribe. Although it clearly pays to use a scribe, it is important for the physician to take time to teach medical pearls when time allows. A scribe that is learning medicine will be a happier scribe and be more knowledgeable when it comes to documenting as well.

I worked as a scribe in college to get hospital experience and make sure that medicine was the career I truly wanted. The job was overwhelming at first because everything was happening so fast. I didn’t know medical terminology, where anything was, or how a hospital worked. After my training shifts I was capable of doing a fair job, but it took about six months before I really knew how to be a good scribe.

I appreciated the physicians who took the time to explain physical exam tests and procedures I had just seen. The job allowed me to see over thirty different physicians’ working style and the opportunity to see what life would be like as an emergency medicine physician. The attendings I met as a scribe were, and continue to be, my mentors and because of them, I am happily pursuing a career in emergency medicine.

Scribes in the emergency department prove that cars are not the only place that you can multitask and go hands free. As long as respect and communication exists, scribes can provide much needed help in efficiency for their physicians. My experience as a scribe allowed me to see how great working in the ED could be, and I hope to mentor scribes in the future.

Reference

How do you define an emergency physician?

During this year’s ACEP council meeting, a resolution was proposed which offered a definition of an emergency physician. Initially the answer to this question seems obvious. However, this resolution was one of the most debated topics at the council meeting. As organizations such as the American Board of Physician Specialties (ABPS), challenge our identity as a primary specialty, it is important to take time and reflect on how we would answer this question ourselves.

For our patients, the answer is easy. The emergency physician is the person who:

- takes care of their infant with a fever at 2 am
- Treats their husband with chest pain
- Resuscitates their daughter after a motor vehicle accident
- Gives the medication to their grandmother that will help her recover from her stroke

In order to help answer this question for ourselves, it is helpful to review where we have been as a specialty. The notion of emergency medicine began during the Korean and Vietnam wars when physicians realized that lessons learned in both pre-hospital and hospital settings could be applied at home. Concepts such as triage and time dependent treatment and resuscitation were introduced. However, initial “emergency rooms” were staffed mostly by nurses, interns, and residents from varied specialties without much supervision.

In response to the exponential increase in emergency department visits in the 1950’s and 1960’s, the National Academy of Sciences published a historical report, “Accidental Death and Disability, the Neglected Disease of Modern Society.” After this report, some physicians began to realize that practicing emergency care required specific training and skills.

In 1968, a group of eight physicians formed ACEP in an attempt to improve emergency care through education and to promote new standards in the delivery of emergency medicine. In 1973, ACEP received permission from the AMA to form a provisional section in emergency medicine. The Emergency Medicine Residents’ Association was formed in 1974 and remains as the only independent resident organization in the house of medicine. Emergency medicine finally became recognized as the 23rd medical specialty in 1979.

Emergency medicine remains as the youngest specialty, with the average age of a board certified emergency physician of approximately forty. As a result, we continue to fight for the recognition from our colleagues that we have developed a unique skill set that allows us to most appropriately care for emergency patients. The importance of our specialty will only continue to grow as the number of emergency department visits continue to increase with the aging of the “baby boom” generation and with the evolution of our health care system.

Unfortunately, as a result of our young age, there are simply not enough residency-trained board-certified physicians to staff every emergency department. As a result of our past, our current reality, and our goals for the future, the question of “how do you define an emergency physician?” is not an easy question to answer. When asked this question by a colleague in another specialty, how would you answer?
A look back at the 2010 ACEP Scientific Assembly

EMRA's Past Presidents honored with life membership.
EMRA promotes excellence in patient care through the education and development of emergency medicine residency-trained physicians. For those residents interested in learning more about the nuts and bolts of resident education or considering a career in medical education, EMRA has partnered with the Council of Residency Directors (CORD) to offer two fantastic opportunities for residents this coming spring.

The first opportunity is the Resident Track at the CORD Academic Assembly from March 2-5, 2011 in San Diego, CA. This must-attend conference for aspiring clinician educators showcases the newest educational material for emergency medicine residents and an amazing faculty development program for upper level residents and junior faculty. This year’s conference theme is “Residency 2.0: Integrating Technology into Practice.” In addition to conference programming, EMRA has helped organize a resident-specific track on Friday, March 4.

EMRA offers three faculty development scholarships of $500 each for interested senior residents to help defray the costs of registration and travel. You can apply for the EMRA Faculty Development Scholarship by submitting your CV and a letter of interest in emergency medicine resident education by January 3, 2011 to emra@emra.org. For more information about the offerings at CORD Academic Assembly, visit their website at www.cordem.org.

The second offering is a new opportunity to participate directly on CORD committees focused on resident education. Interested residents may choose to join the remediation committee, resident evaluation methods committee, national program planning committee, or the electronic resources committee. The commitment for participation involves regular communication via e-mail and scheduled conference calls. Attendance at national meetings such as the CORD Academic Assembly in the spring and ACEP Scientific Assembly in the fall is encouraged but not required. Interested residents should email Todd Guth, EMRA Academic Affairs Representative, at academicaffairsrep@emra.org with a short description of their reasons for wanting to participate in a CORD committee by January 15, 2011.

EMRA Resident Track Offerings at CORD Academic Assembly

2:00 pm - 2:45 pm Exploding Out of the Gates: A Primer for Transitioning to Junior Faculty
Back by popular demand, this lecture details the “do’s and don’t’s” of your initial years out of residency with particular focus on making a terrific first impression, faculty development opportunities, managing your career, and passing your boards. It’s a must-attend lecture for aspiring senior residents and first-year faculty.

2:45 pm – 4:00 pm Saving Lives with Cutting Edge Evidence-Based Emergency Medicine
Welcome to EBM on the Fly!! This interactive online teaching workshop provides you with need-to-know EBM concepts and walks you through a number of online EBM resources in real time. Please bring your computers to this interactive session.

4:00 pm - 5:15 pm Sweet Talkin’: A Case-Based Difficult Communication Workshop
This choose-your-own adventure small group session provides participants with interpersonal communication pearls for difficult conversations with consultants, disclosing medical errors, death telling, and more. An overview of the curriculum is provided to participants for use in their own institution by making the content available online.

5:15 pm – 6:00 pm Fellowship or Not? A Critical Decision for the Aspiring Academic Physician
This panel will provide an overview of all fellowships offered in emergency medicine with a focused discussion on the recently ABEM-certified fellowships in critical care and emergency medical services (EMS). Panelists include individuals having completed or currently enrolled in toxicology, ultrasound, simulation, EMS and education fellowships.

6:00 pm – 7:00 pm EMRA Resident-Faculty Mixer and Social Networking
This second annual social event is open free to all interested participants in the conference. Attendees of the resident track will receive free drink tickets.
Congratulations to the 2010 EMRA Resident Sim Wars Competition winners

Winners pictured left to right: University of California, San Diego - Davut Savaser, Dr. Leslie Oyama (team coach), Angie Pham, Anthony Salazar and Alfred Joshua.

**Participating Teams**

**Defending Champions**
University of Florida Jacksonville, FL
David Caro, MD, Program Director

**Northeast Teams**
Thomas Jefferson University Hospital, PA
Ronald Hall, MD, Program Director
St. Luke’s/Roosevelt Hospital Center, NY
Mark Clark, MD, Program Director

**South**
Medical College of Georgia, GA
Steve Shiver, MD, Program Director
Texas A&M/CHRISTUS Spohn Emergency Medicine, TX
Thomas J. McLaughlin, MD, Program Director

**West**
University of California San Diego, CA
Binh Ly, MD, Program Director

**Midwest**
Cook County Hospital Emergency Medicine, IL
Steven Bowman, MD, Program Director

**Alphabet Soup** Benjamin Lawner, DO, University of Maryland

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The 2010 Final CPC competition was held at the ACEP Scientific Assembly in Las Vegas. Congratulations to all the 2010 CPC participants!
Appendix I Procedures and Skills

For a complete reference and answer explanation for the questions below, visit www.emra.org.

1. A 49-year-old man presents after he fainted while running on his treadmill at home. He has been having exertional dyspnea and angina for the past several months. Which of the following cardiac diseases is most likely to cause these symptoms?
   A. Aortic stenosis
   B. Atrial septal defect
   C. Mitral incompetence
   D. Pulmonary stenosis
   E. Tricuspid incompetence

2. The hypertensive emergency that is most easily reversible with pharmaceutical management is:
   A. Acute coronary syndrome
   B. Aortic dissection
   C. Eclampsia/preeclampsia
   D. Encephalopathy
   E. Intracranial hemorrhage

3. Which of the following statements regarding posterior wall infarction is correct?
   A. Associated with ST-segment depression in V1
   B. ECG shows an inverted T wave in V1
   C. ECG shows large S waves in V1
   D. Occurs in 5% of all acute MIs
   E. Results from occlusion of the left anterior descending artery

4. Regarding treatment of heart failure in patients with diastolic rather than systolic dysfunction:
   A. Aggressive therapy with diuretics is more effective
   B. β-Blocking agents might improve cardiac output
   C. Both are associated with impaired cardiac contractility
   D. Most patients with CHF have diastolic dysfunction
   E. Ventricular filling pressures are higher in systolic dysfunction than in diastolic dysfunction

5. Which of the following statements regarding the use of continuous positive airway pressure therapy in pulmonary edema is correct?
   A. Decreases left ventricular preload and increases afterload
   B. Decreases mortality rates
   C. Increases the effective FIO2 delivered
   D. Lowers intrathoracic pressure
   E. Reduces the work of breathing
EMRA Research Committee series part 5: Submitting a paper for publication

As your manuscript nears completion of the drafting process, the hard work may seem over; however, publishing a manuscript is far from guaranteed. In Part 5 of the EMRA Research Committee Series, we summarize the most crucial steps in this process, from choosing the right journal for publication to giving your manuscript the best possible chance for acceptance.

This process can be broken down into five discreet steps:

A. Organize
B. Select a publication type
C. Write
D. Select the right journal
E. Revise

A. Organize
Create a timeline for completing the above milestones. The time it takes to draft the actual paper (Step C) will depend on the publication type. See Part 4 of the EMRA Research Committee Series for a useful checklist to help you avoid common pitfalls in organization and preparation of your publication. If your project is a literature search, randomized controlled trial, or systematic review, the STARLITE, QUORUM, and CONSORT websites, respectively, detail formal guidelines for each study type.

If you have not yet discussed authorship, start now. The earlier your team can negotiate this potential sticking point, the more fruitful your manuscript preparation will be.

B. Select a publication type
Choose the publication type that is most appropriate for your manuscript. Discuss with your coauthors the potential impact your results may have on the field and for which audience you are aiming. Consider publishing an original paper if the findings are indeed unique. Otherwise, don’t be afraid to start small with a simple case report, clinical image, or short communication. Some article types are more suited to research performed by emergency medicine residents. Given the volume of interesting presentations seen daily in the ED, case reports are a great option for residents seeking to introduce themselves to the publication process.

C. Write
Time to write! Gather old research materials from colleagues and mentors: initial grant applications, study design notes, previous literature reviews, and source references. Next, focus on the pillars of a scientific paper using the mnemonic IMRAD: Introduction, Methods, Research, and Discussions. You do not need to write the manuscript in sequential order, as the introduction and methods sections can often be written before the study has even started.

Avoid plagiarism for the sake of your credibility, scientific integrity, and ultimately, patient safety. Organize your results, such as primary and secondary outcomes, by paragraph. Make reasonable and precise recommendations in the discussion. Openly acknowledge the limitations of your study, which will add to the veracity of your paper. Consider the audience and write to inform, rather than to impress.

D. Select the right journal
Read the journals you are considering for submission: note their style, content, and format. Each of the emergency medicine journals has a certain Science Citation Index score, or impact factor, and a corresponding difficulty for paper acceptance. Review the online tutorials and submission process unique to each. These rules are not standardized, even within our specialty, so pay close attention.

Submit all documentation at the same time. Be polite when communicating with the editor, and respond to revision requests in a timely manner. Allow all authors the opportunity for input prior to each revision. Finally, give your manuscript the greatest chance of acceptance by including a well-written cover letter.
Focus on the pillars of a scientific paper using the mnemonic IMRAD: Introduction, Methods, Analysis, Discussion, and Conclusion.

E. Revise
If the editor deems your article to be of sufficient quality for possible publication, then it will be forwarded to the journal’s peer reviewers. The names of you and your authors may be blinded or unblinded, depending on the journal. Manuscripts not selected for peer review will be returned immediately to the authors, who then must decide where to submit the article next.

Based on the reviewer comments, the editor will place your publication in one of four dispositions: acceptance without revision, possible acceptance after minor revisions, possible acceptance after major revisions, or rejection. If granted provisional acceptance, carefully address each of the criticisms to ensure the best chance of final acceptance for your paper.

Keep a logbook of where and when you submitted a manuscript for review. Be polite with revisions and demonstrate you are willing to respond to editor requests in a timely and professional manner. Typically one or two exchanges will result in acceptance if you have taken the appropriate steps to produce a quality product.

Stay positive. Don’t give up! Remember that scientific writing is a skill, and you can learn a tremendous amount about the process even if your research does not get accepted in a peer-reviewed journal. By following this organized approach, however, you can maximize your chance of becoming a published author in the field of emergency medicine.

References

### TABLE 1. TYPES OF PUBLICATIONS

<table>
<thead>
<tr>
<th>Type</th>
<th>Description</th>
<th>Time commitment</th>
<th>Pros</th>
<th>Cons</th>
</tr>
</thead>
<tbody>
<tr>
<td>Original article</td>
<td>Major paper – based on original observations that form a coherent story</td>
<td>(++++)</td>
<td>greatest potential impact</td>
<td>multi-year time commitment</td>
</tr>
<tr>
<td>Original report</td>
<td>Focused description of unique symptoms or previously undescribed diagnostic findings</td>
<td>(+++)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Review</td>
<td>Detailed analysis of a specific topic, highlighting important recent literature, with no new opinions or experiences of the author</td>
<td>(++++)</td>
<td>all-inclusive, does not require gathering new data</td>
<td>significant time and experience required</td>
</tr>
<tr>
<td>Technical note</td>
<td>Focused description of an existing procedure, modification of an existing technique, or presentation of new equipment</td>
<td>(+)</td>
<td>entry level publication, may draw on diverse background of interdisciplinary trainees</td>
<td>traditionally low impact</td>
</tr>
<tr>
<td>Clinical image</td>
<td>Text limited to description of high quality figures/pictures of a recognized disease with emphasis on teaching points and recognition</td>
<td>(+)</td>
<td>entry level publication, excellent for medical student co-authors</td>
<td>traditionally low impact</td>
</tr>
<tr>
<td>Case report/Case series</td>
<td>One or more descriptions of previously underreported observations of a recognized disease</td>
<td>(+)</td>
<td>limited conclusions can be drawn by anecdotal findings</td>
<td>traditionally low impact</td>
</tr>
<tr>
<td>Correspondence</td>
<td>often takes the form as letter to the editor, can be written on any subject of interests to journal reader, comments are objective and constructive</td>
<td>(++)</td>
<td>less time commitment, can be specific to an area of interest</td>
<td>traditionally low impact</td>
</tr>
<tr>
<td>Other</td>
<td>Short communication information technology historical article poetry/artwork health policy evidence based studies</td>
<td>(+)</td>
<td>entry level publication, =/&gt; 2000 words</td>
<td>traditionally low impact</td>
</tr>
</tbody>
</table>
When is a pediatric headache a medical emergency?

**History and presentation**

A 13-year-old girl presents to the emergency department with a headache (HA). She describes it as frontal in nature, with pain radiating around the sinuses and both eyes. The pain started approximately three months ago. She describes the pain as constant, with severity ranging from 6/10 to 10/10. She is unable to describe the character of the pain, stating that it “just hurts.” She also complains of photophobia, nausea, and vomiting over the past six days.

Further investigation reveals that she had fallen off a horse approximately three months ago. At that time, she was seen in an emergency department and was diagnosed with a concussion. A head CT immediately after the fall was normal. An MRI was performed due to persistent headaches, which was also read as normal. She is currently taking hydrocodone/acetaminophen, dimenhydrinate, ibuprofen, and caffeine with minimal relief. Today, she is sent in by her pediatrician for migraine treatment. This is her third emergency department visit for continued HA.

**Background**

Pediatric headaches are very common; occurring in more than 90 percent of school-age children. One retrospective series from a busy children’s emergency department demonstrated that one percent of visits were for a chief complaint of HA. The etiology of HA can range from benign to life-threatening; from muscle tension, visual strain, or stress to life-threatening infections and brain tumors.

Many use the classification system of primary versus secondary HA. Primary HA is self-limited, a diagnosis based on symptomatology and patterns of pain. This includes migraine, tension, and cluster headaches. Secondary HA have an underlying etiology. The most common etiology seen in pediatric emergency departments is related to a viral illness or upper respiratory illness such as an otitis media and sinusitis.

The goal of the emergency physician is to distinguish secondary, life-threatening etiologies, from non-life-threatening causes based on a thorough history and physical examination. Occasionally, this requires the use of ancillary testing for prompt diagnosis and treatment.

Life-threatening causes of secondary HA include infectious etiologies such as bacterial meningitis, certain types of viral encephalitis, orbital abscess, brain tumors, intracranial hemorrhages, or carbon monoxide poisoning. Studies have been performed to help the EP scrutinize symptomatology in order to flag life-threatening causes of headaches. Among HA features, children who are unable to localize pain are more likely to have a life-threatening HA.

Those with a history of trauma, an abrupt onset of pain, pain that awakens them from sleep, or chronic progressive pain should clue the physician in to a more worrisome cause. Associated symptoms including emesis, photophobia, or phonophobia were not statistically associated with life-threatening causes.
of HA, but objective neurological signs including papilledema, ataxia, or abnormal eye movements were highly associated with life-threatening etiologies.\(^3\)

**The emergency department visit**

Although a complete physical exam is required for all those presenting with HA, a detailed neurologic exam is of utmost importance. The pediatric physical exam can be difficult and should be tailored to the age of the child. Elements of a pediatric neurologic exam include: mental status, funduscopic exam, thorough cranial nerve exam, fine motor coordination, gait function (which includes walking or crawling), sensation, and reflexes. Younger children are more likely to be cooperative if the physician starts at the feet and works towards a cranial nerve exam, saving the funduscopic exam for the end.

Neuro-imaging should be considered in those with chronic progressive headaches, thunderclap HA, abnormal neurologic examination, or skin lesions consistent with any of the neurocutaneous syndromes.\(^4\) Computed tomography (CT) is typically the standard imaging used in the ED and can identify conditions that would require immediate treatment.

**Case conclusion**

The patient discussed above was seen previously in two different EDs and treated for pain after having a normal CT and MRI. Her symptoms could be attributed to a primary cause with this work-up history, but she has clues that indicate potentially life-threatening cause. These include progressive symptoms and a history of head trauma. In addition, she was found to have papilledema on physical examination. A repeat CT scan was then obtained (Figure 1). She was found to have a near pan-hemispheric left subdural hematoma with midline shift and early left uncal herniation.

She was admitted to the Pediatric ICU and required emergent craniotomy by neurosurgery. She developed post operative swelling causing diplopia from a left lateral rectus palsy and broad based gait, which slowly resolved. She also developed episodes of slurred speech and subjective numbness and tingling requiring seizure prophylaxis. After a long hospital course, she was discharged with a nearly intact neurologic exam and mentation.

**References**

Which way will you go?

As the calendar points towards December, the EMRA job fair is behind you, and the next choice for many will be which type of practice to choose? The three most common are working as an independent contractor, working with a democratic group, or being a faculty member in an academic institution.

Each carries separate considerations from a financial standpoint. This article is intended to highlight some basic differences as you evaluate future opportunities.

I recommend that you consider the following factors:

Clinical faculty/academic institution
This is commonly the easiest financial position to understand. Income is typically paid as it is during residency. All taxes and other deductions are withheld by the hospital. You will commonly be provided health insurance paid by the hospital, basic life insurance and basic disability insurance. You should not have to qualify for any of these from a medical perspective. (If you have a challenging medical history, this is very important.) Most hospitals have a 403(b) retirement plan that will allow you to contribute up to $16,500 per year (2010) before taxes and will often have supplemental programs to allow greater contributions. In some cases you will also have a relationship with a private hospital practice that provides additional benefits.

- **Pros:** Benefits are automatically provided. Retirement matching is common, and the contract is stable. Teaching opportunities are available.
- **Cons:** Salaries are typically more limited than other arrangements. Retirement funding may not provide the opportunities of private practice. Tax deductions are limited. State, local, and hospital political considerations can impact your practice.

Independent contractor
As an independent contractor, you take on the responsibilities of being self employed. You will likely contract with one or more staffing groups at a fixed hourly rate. There are not commonly any benefits provided (with the exception of malpractice) and you will be responsible for understanding your tax liability and scheduling appropriate payments. You will want to establish a separate checking and credit account for your business and either become proficient with an accounting software program or hire a bookkeeper/practice manager. You will need to understand and qualify for your own health insurance, disability insurance, and life insurance. You will need to establish your own retirement plan and fund it with your own money.

- **Pros:** Maximum flexibility in scheduling, health insurance, and retirement funding to reduce taxable income. Many common expenses can become tax deductible. **BIG OPPORTUNITY:** Create your own business entity (S-Corp, LLC, PLLC, C-Corp). Employ your spouse with a valid job. Establish a solo 401(k) plan.
“When you can articulate your own objectives, you can understand how your future practice will allow you to reach them.”

Taking these steps will allow you to sock close to $100,000 away pre-tax per year! Please note that this reduces personal income pro-rata and may not work in all states and situations.

- **Cons:** You pay an extra 7.5 percent in tax as a self employed physician. All benefits must be qualified for and paid for. Personal medical history can make some benefits prohibitively expensive or unavailable.

**Democratic group**

This often provides the best of both hospital and independent contract work. A decent sized group will provide health insurance, basic life insurance, and may provide basic disability insurance. Commonly, a 401(k) plan will allow you to defer $16,500 per year (2010) towards retirement and will often be matched up to the maximum federal contribution (+/- $49,000 in 2010). The group shift schedule often provides greater flexibility than a hospital can offer. There is often a partnership track allowing greater income potential through ownership of the practice and a percent of the profit. As an employee, you are taxed the same as hospital faculty. As a partner, you are probably taxed as an independent contractor.

- **Pros:** Camaraderie of peers/partners. Ownership potential. Tax management. Income potential of IC with benefits of hospital.

- **Cons:** Contract with hospital(s) can be lost. Decisions made by group consensus. Group revenue and expenses determine profitability and ultimate income.

As you explore potential practices, take the time to consider your personal retirement, debt repayment needs, and family and lifestyle objectives. Use them to determine which type of practice will best allow you to accomplish your goals. When you can articulate your own objectives, you can understand how your future practice will allow you to reach them. This should become your guide for an efficient and effective transition plan, allowing you to confidently take advantage of opportunities and avoid common mistakes.

Please note that this article contains brief guidelines only, and you should always discuss your individual situation with your tax, legal, and financial council.

*M. Shayne Ruffing, CLU, ChFC, AEP® is the creator of the Confident Transition Plan™ for medical residents, the Physician Disability Income Analyzer™ and the Physician’s Financial Navigator™. Shayne specializes in executive benefit planning for physicians and medical practices. He can be reached at 800.225.7174, via e-mail at shayne@mybpginc.com or on the web at www.IntegratedWealthCare.com.

Shayne is an Financial Advisor offering Securities and Advisory Services through NFP Securities, Inc., a Broker/Dealer, Member FINRA/ SIPC and Federally Registered Investment Advisor. The Benefit Planning Group is not an affiliate of NFP Securities, Inc.

Emergency Medicine Foundation is pleased to announce several grant opportunities due January 5, 2011.

**Emergency Medicine Foundation/Emergency Medicine Residents’ Association Resident Research Grant,** up to 3 available, $5,000 each

**Emergency Medicine Foundation/Medical Toxicology Foundation Resident Research Grant,** one available, $5,000.

This grant will focus on toxicology research. Although not mandatory, proposals utilizing the American College of Medical Toxicology (ACMT) ToxIC (Toxicology Investigators Consortium) Registry are particularly encouraged.

**Emergency Medicine Foundation Research Fellowship,** one available, $150,000 over two years.

The EMF Fellowship is intended to provide the opportunity for formal education in research methodologies, and experience in research in preparation for an academic career as a research scientist.

Other grant opportunities include EMF Career Development, EMF Health Policy, EMF/ENA Foundation Team, EMF/SAEM Medical Student, EMF/Baxter Directed Grant on Rehydration, and EMF/EMPSF on Patient Safety—all due Jan. 5, 2011. EMF is also pleased to announce the EMF/Genentech Directed Grant on Regionalization and Stroke Care for $100,000 due Feb. 1, 2011.
Members requested...

EMRA delivers

2011 EMRA Antibiotic Guide

NOW AVAILABLE AS YOUR FAVORITE MOBILE APP

For Palm OS
Pocket PC/Windows Mobile
Apple iPhone/iPod touch
Droid and Blackberry Platforms

With convenient search feature and everything you’ve come to love about the printed guide including the Antibiogram.

Ordering instructions

Palm/Pocket PC
visit the bookstore on www.emra.org
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Webster’s definition of an epidemic is “A dramatic increase over the expected rates for any kind of health outcome.” Between 2004 and 2008, there was a 111 percent increase in emergency department visits for complaints involving non-medical use of narcotic pain relievers. According to the CDC, one in five high school students report abuse of a prescription medication. Nationally, opioid overdose is second only to motor vehicle accidents as the most common cause of unintentional death. Couple that with a 400 percent increase over the past decade to outpatient substance abuse treatment centers, and we can safely say that there is a national prescription drug abuse epidemic.

Why prescription drugs? The Partnership Attitude Tracking Surveyed 7,218 adolescents and found the main reasons to be that they are “not illegal,” “easy to get from others prescriptions,” and are “safe and cheap.” The top two sources are free from a friend or relative (60 percent), followed by a physician (17 percent). In 2008, there were over 121 million prescriptions for Vicodin written in the U.S. Nationwide, 40 percent of opioid prescriptions originate in the emergency department.

We as emergency physicians are in a difficult situation. The 2000 JAHCO mandate on pain management coupled with the negative connotations associated with mislabeling a patient as “drug seeking” have a tremendous impact on emergency department practice. To address these issues, many EDs utilize statewide prescription monitoring databases or implement lists to track patients that frequent their departments. The use of these tools is not without consequence. ACEP President, Dr. Angela Gardner, makes a very valid point in a USA Today Op-ed: “Emergency physicians should not be forced to become the ‘pain police,’ mandated to search for a patients prescription history. Knowing that any pain prescription will be entered into a large public database might prevent patients from being truthful, or in the worst case from seeking needed care. Mandating that a physician search a database before writing a prescription will add to an overload of tasks keeping us from our patients.”

In the past, I would rather give nine drug-seekers pain medicine to avoid missing the one genuine patient; however, after seeing a 24-year-old girl to whom I had given 12 Percocet a week before come in as an DOA from on overdose, I began to rethink my prescribing habits. Maybe, if I had taken the five minutes to call the pharmacy and find out that she had filled three Percocet prescriptions that same week, we could have avoided this tragic outcome.

So what can we do? An article in Pain Physician detailed a screening tool to detect the risk of inappropriate opioid use. Six identified criteria were: focus on opioids, other drug use, low functional status, exaggeration of pain, unclear etiology of pain, and a history of opioid overuse. If more than three of these factors were present, there was a 77 percent likelihood of inappropriate opioid use.

Most screen these behaviors during a patient encounter, but a few other historical items can prove very helpful to screen potentially abusive patients. Simply ask a patient when were they seen for the same issue, by whom, and how much medication was provided. Then, document these responses on the chart and make a quick call to the pharmacy or primary care physician to determine their validity.

Admittedly, these steps can be a real burden. Being on hold for five minutes to talk to a family doctor is a real pain especially when a patient with two gun shot wounds to the chest is rolling into the trauma bay. But keep in mind, you’re doing this for the right reasons. When you speak with your patients regarding this issue, explain to them that you have concerns about prescribing a dangerous medication and have their safety at the forefront. The simple phrase, “it is clearly not in your best interest for me to give you what you want and send you on your way without any cares.” Any patient that can’t relate to that should not be receiving controlled substances.

Knowing your department or hospital polices regarding the use of lists, prescription databases, or outreach programs to help address the epidemic of prescription drug abuse is paramount when practicing in the emergency department. If you feel compelled to initiate a program or policy to address your departments issues with this extremely important health risk, speak with your program director or department chair and realize that it can start with one physician caring about the consequences of the medicine they are prescribing.
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1. “The epinephrine auto-injector is self-explanatory and I’m busy. They’ll figure it out if they ever need to use it.”
Physicians frequently neglect to counsel patients on epinephrine auto-injector use. Studies show that many patients don’t know how to use their auto-injectors properly. Time spent teaching a patient how to use the auto-injector may be life-saving during a future episode of anaphylaxis.

2. “The nurse is questioning my intramuscular epinephrine order because he’s always given epinephrine subcutaneously.”
Traditional teaching was to administer epinephrine subcutaneously, but onset appears to be faster with intramuscular administration. Expert guidelines recommend intramuscular, rather than subcutaneous administration.

3. “The patient doesn’t have cutaneous findings, so it couldn’t be anaphylaxis.”
The diagnosis of anaphylaxis does not require cutaneous findings. Acute onset of any 2 of the systems listed in Table 1 (on page 2 of the complete article, available at www.ebmedicine.net/emra) or hypotension after exposure to a known allergen is sufficient for the diagnosis of anaphylaxis. In one study, the majority of patients with fatal anaphylaxis lacked cutaneous signs, so treatment should not be delayed because the patient doesn’t have urticaria.

4. “This patient said she felt short of breath after eating a cookie which may have contained peanuts. She is extremely anxious. Her physical examination is completely normal with the exception of a rapid respiratory rate.”
Patients with a history of allergy or anaphylaxis may have a panic attack if they think that have come in contact with a trigger. Consider panic attack in patients who have no objective evidence of anaphylaxis.

5. “Two patients arrived from the same restaurant with anaphylaxis. Is that a coincidence.”
Scombroid poisoning presents with similar signs and symptoms to those of anaphylaxis. It is the likely diagnosis if multiple patients present with anaphylaxis-like symptoms after eating the same fish.

6. “I won’t prescribe an epinephrine auto-injector because the patient will follow up with the pediatrician tomorrow. The pediatrician can write for it.”
Even if patients have prolonged observation in the ED, biphasic reactions after discharge are possible. All patients with anaphylaxis should be discharged with an epinephrine auto-injector.

7. “My 18-month-old patient had anaphylaxis, but he only weighs 12 kg so I can’t prescribe him an epinephrine auto-injector.”
A clinical report published by the American Academy of Pediatrics recommends prescription of the 0.15 mg auto-injector to otherwise healthy children weighing from 10 to 25 kg.

8. “My patient has wheezing and diffuse urticaria and flushing after eating a peanut butter sandwich. He’s not hypotensive so epinephrine would be overkill. I’ll give an albuterol treatment and diphenhydramine and see if he improves.”
Delay in epinephrine treatment has been identified as a risk factor for biphasic reactions and fatal anaphylaxis. All guidelines emphasize early treatment with epinephrine.

9. “Paramedics are calling for an order to give epinephrine to a 5-year-old with a history of bee sting anaphylaxis who now has stridor, diffuse wheezing, and an oxygen saturation of 92% after a bee sting. It sounds like anaphylaxis, but I’d rather examine the patient myself before giving any medications.”
Again, all guidelines emphasize early treatment with epinephrine.

10. “My patient had an anaphylactic reaction with syncope, urticaria, and shortness of breath at home. The mother gave epinephrine and her symptoms completely resolved before she arrived. I’m not sure why they even came to the ED.”
There is a risk of biphasic reactions after symptom resolution. Guidelines vary in their recommendations, but all recommend some period of observation. The patient will also need a prescription for a replacement epinephrine auto-injector.
Risk management pitfalls for APAP toxicity

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1. “The patient presented with nausea, vomiting, and abdominal pain for several days and he said he’d been taking some OTC pain pills. I didn’t even think to check an APAP concentration.”
   Symptoms of APAP toxicity are vague. Remember that APAP is a common constituent of prescription pain relievers and OTC analgesics. In fact, it is so widespread that its toxicity has become the most common cause of hepatic failure in the US. It must remain part of the differential diagnosis for any patient presenting with vague abdominal pain, especially if there is also a history of self-medicating.

2. “His APAP level was drawn as soon as he came in, only 2 hours after his ingestion, so I can’t plot it on the nomogram.”
   An APAP concentration drawn between 0 and 4 hours after an acute ingestion is neither informative nor prognostic in determining the level of toxicity or the need for treatment, since the body’s absorption is erratic until this time and likely has not reached peak serum concentration. The concentration must be remeasured between 4 and 24 hours after the ingestion (preferably between 4 and 8 hours) and then plotted on the Rumack-Matthew Nomogram in order to plan treatment.

3. “The ingestion was about 8 hours ago, but I wanted to get the results of the APAP concentration back to see if I even needed to start treating with NAC.”
   In suspected cases of acute toxic ingestions when the timing is known and the patient is evaluated close to 8 hours post ingestion, NAC should be initiated before the serum APAP concentration is available. NAC is most effective when started in the first 8 hours, and any delay can lead to worse outcomes. If, after starting NAC, the APAP concentration is found to be nontoxic, the antidote can be discontinued. The safety profile of either formulation of NAC is excellent, and serious adverse reactions are rare.

4. “He felt flushed and itchy after starting IV NAC so we had to stop the infusion.”
   Roughly 15% of patients have some form of mild reaction to NAC. The antidote should not be stopped because of anaphylactoid reactions; instead, the infusion should be diluted and given more slowly. If needed, diphenhydramine can be administered. Properly administered IV NAC is very safe. The risk of a serious adverse effect from NAC is very low.

5. “I started the patient on NAC after getting an elevated 4-hour APAP concentration, but I didn’t think I needed to check any other follow-up blood work.”
   Transaminase concentrations start to rise within 24 hours after an acute ingestion, and the presence of RUQ or epigastric pain could suggest hepatic injury. Laboratory tests of liver and kidney function as well as tests of coagulation should be performed to better understand the extent of the hepatotoxicity. This information is also helpful in understanding a patient’s prognosis and may alert the emergency clinician to contact a regional transplant center.

6. “She’d been taking one of those over-the-counter allergy medications in addition to APAP and seemed kind of sleepy. I thought it was just the diphenhydramine.”
   APAP is part of many combination cold and sinus medications. When a patient presents taking 1 of these medications, he or she must be monitored for the effects of the other components of the pills, as well as for APAP toxicity. A patient who presents with altered mental status after an APAP overdose should be assessed for hepatic encephalopathy or cerebral edema.

7. “The baby had had a viral syndrome for a few days and his mom was giving him APAP. She said she was using the dosing instructions on the box. She brought him in because his vomiting worsened.”
   Pediatric toxic ingestions are often the result of dosing miscalculations or unintentional ingestions. Weight-based dosing has the potential to lead to more medical mistakes. These ingestions should be handled in the same manner as an adult APAP overdose, since the risk for hepatotoxicity and potential long-term repercussions exists in the pediatric population as well.

8. “She’d been taking APAP over the past few weeks, but only occasionally over the dose recommended on the package. I didn’t think that could cause toxicity.”
   Repeated supratherapeutic ingestions of APAP can result in a cumulative APAP toxicity. Often, when added up, these ingestions fall above the recommended daily dose. Roughly 30% of patients admitted for APAP overdose have taken the analgesic in exactly this pattern in order to alleviate pain and not as a suicide attempt. Some studies suggest that these individuals have a worse prognosis than those admitted after an acute ingestion, so this type of ingestion must be taken seriously. Repeated supratherapeutic ingestions do create a diagnostic challenge, since values cannot be plotted on the APAP nomogram. Other laboratory values and physical examination findings must be relied upon more heavily in these cases.

9. “He was a known alcoholic with cirrhosis who’d been taking APAP for a couple weeks but under the maximum recommended dose printed on the box. I didn’t think he’d be in the toxic range.”
   Patients with a history of baseline hepatic dysfunction or chronic alcohol use may have a more severe and rapid onset of hepatic damage after lower doses of APAP than patients without these underlying disorders. In addition, patients who are taking medications that activate the same enzyme pathways as APAP are at higher risk for problems, and they should undergo a complete work-up for toxicity.

10. “She wouldn’t look me in the eye, but she told me that she wasn’t trying to kill herself by taking all those pills at once. I didn’t think she needed to see a psychiatrist and I discharged her.”
    Whenever a patient presents after a toxic APAP ingestion, the motivation behind the ingestion must be explored. If there is any concern in the emergency clinician’s mind that a patient might have intentionally taken a toxic dose of APAP, that patient should be assessed for suicide risk and a possible psychiatric cause for their presentation. This is particularly true if the patient is being discharged and will no longer be under the direct observation of healthcare professionals.
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For more information, contact Sharon Hirst: 800.369.8397 or email shirst@questcare.net
DISTRICT OF COLUMBIA—The Department of Emergency Medicine of the George Washington University is seeking physicians for our academic practice. Physicians are employed by Medical Faculty Associates, an independent, University-affiliated, not-for-profit multispecialty physician group. The Department provides staffing for the Emergency Units of George Washington University Hospital, Prince Georges Hospital Center, the National Naval Medical Center and the DC Veterans’ Administration Medical Center. The Department sponsors an Emergency Medicine Residency and many student programs.

We are seeking physicians who will participate in our clinical and educational programs and contribute to the Department’s research and consulting agenda. Applications from physicians with interest in medical informatics, bedside diagnostic imaging and emergency public health are encouraged.

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

**Application Procedure:** A CV is considered a completed application. Review of applications will begin on October 10, 2010 and continue until all positions are filled.

Please submit CV by mail to Robert Shesser MD, Chair, Department of Emergency Medicine. University faculty rank will be commensurate with experience.

**Application Procedure:** A CV is considered a completed application. Review of applications will begin on October 10, 2010 and continue until all positions are filled.

Please submit CV by mail to Robert Shesser MD, Chair, Department of Emergency Medicine, George Washington University Medical Center, 2150 Pennsylvania Avenue NW, Suite 2B-417, Washington DC 20037 or by email at: rshesser@mfa.gwu.edu

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**Ohio, Cincinnati:** EM Physician opportunity with Democratic group north of Cincinnati. This ED has an annual volume over 60,000 with excellent coverage and great physical plant. Very appealing package includes multiple incentive opportunities plus family medical plan, employer-funded pension, expense account, malpractice, and shareholder opportunity with no buy-in; Contact Kim Rooney, Premier Health Care Services, (800) 726-3627, ext. 3674; krooney@phcsday.com.

**Ohio, Columbus:** The Ohio State University Department of Emergency Medicine seeks physician to work clinically in our 20 bed comprehensive ED observation unit. The physician will work with a team of experienced mid-level providers and deliver care to over 500 patients/month on more than 30 observation protocols. EM and IM experience preferred. For qualified applicants, flexibility available to split shifts in the ED and observation medicine. Compensation commensurate with qualifications, experience and academic appointment. Send CV to: Douglas A. Rund, MD, Professor and Chairman, OSU Emergency Medicine, 456 W. 10th Avenue, 4510 Cranbook Hall, Columbus, OH 43210; mary-jayne.fortney@osumc.edu; (614) 293-8176. AAEOE.

**Ohio, Columbus:** Choose city or small-town living 25 minutes NW of Columbus. Excellent opportunity in 22,000 volume ED with fast-track. Enjoy the advantages of a democratic, physician led group including equity ownership and incentive opportunities, malpractice, family medical plan, CME, employer-funded pension and more. Contact Amy Spegal, Premier Health Care Services, (800)726-3627, ext 3682, aspegal@phcsday.com fax (937) 312-3683.

**Ohio, Columbus:** Jump Start Your Leadership Career at The Ohio State University Medical Center Administrative Fellowship. The Department of Emergency Medicine at The Ohio State University is seeking EM residency trained or Board certified candidates for a competitive two year Fellowship in Administration beginning July 2011. Fellows will learn operational and financial skills necessary to lead any Emergency Department and develop key executive skills to become future leaders in the health care industry. Fellows also earn a fully funded MBA at the prestigious OSU Fisher College of Business. Contact: Mark Moseley, MD, MHA, Administrative Fellowship Program Director, at 614-293-
Exceptional opportunity to join a cohesive team of Emergency Physicians at a prestigious healthcare system located in Hartford, CT. We are presently expanding our group as we prepare to move into our newly constructed state-of-the-art 70 bed Emergency Department in May of 2011. We, therefore, have immediate opportunities as well as positions in 2011. Saint Francis Hospital and Medical Center is a Level II trauma and tertiary referral center with 70,000 emergency department visits per year.

We desire that one of the physicians be trained as a toxicologist in order to contribute to our Emergency Department Toxicology Program.

Successful candidates should be Board Prepared or Board Certified in Emergency Medicine and may be eligible to hold an academic appointment at the University of Connecticut School of Medicine.

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OHIO - Lodi: Directorship opportunity for new contract! Lodi Community Hospital is designated as a fully accredited Critical Access Hospital with top patient satisfaction scores. Annual ED patient volumes average 10,000 visits per year. EPMG offers directors strong administrative support through quality improvement measurements, training & implementation of clinical tools promoting patient safety, and advocacy of proper ethical behavior. Qualified candidates will be BC/BE EM with leadership experience. Contact Tyrus Arnold at 800-466-3764, x335 or tarnold@epmgpc.com. Visit www.epmgpc.com for more details.

OHIO - Wadsworth and Barberton: SUMMA Health System-Barberton Hospital is a full-service community hospital in southern suburban Akron with 38,000 ED visits/yr. WRH Health System in Wadsworth sees 21,000 patients per year. Work at one site or combination of both. Outstanding partnership opportunity includes equal profit sharing, equity ownership, funded pension, open books, full benefits and more. Contact Steve Rudis, MD (careers@emp.com), Emergency Medicine Physicians, 4535 Dressler Rd, NW, Canton, OH 44718. 800-828-0898 or fax 330-493-8677.

OKLAHOMA - Tulsa: Modern 800+ bed community hospital sees 75,000 ED patients per year. Broad pathology, high acuity, modern facilities and supportive environment. Outstanding partnership opportunity includes equal profit sharing, equity ownership, funded pension, open books, full benefits and more. Contact Steve Rudis, MD (careers@emp.com), Emergency Medicine Physicians, 4535 Dressler Rd, NW, Canton, OH 44718. 800-828-0898 or fax 330-493-8677.


PENNSYLVANIA - Northwestern: Join Pennsylvania’s Leader in Emergency Medicine. UPMC Northwest is Emergency Resource Management’s newest site. UPMC Northwest is a state-of-the-art facility located in Seneca, PA, halfway between Erie and Pittsburgh. The ED sees approximately 30,000 patients with excellent coverage. The surrounding community is situated in the foothills of the Allegheny Mountains, offering a great lifestyle with plentiful outdoor activities and a low cost of living. We offer an outstanding compensation/benefits package including: paid malpractice insurance with tail, employer-funded retirement plan, paid health insurance, CME allowance, and more. Board certification/prepared in EM. Contact Dr. Robert Maha at 888-647-9077/Fax 412-432-7480 or e-mail mahar@upmc.edu. EOE.

PENNSYLVANIA - Pittsburgh: Join Pennsylvania’s Leader in Emergency Medicine. UPMC East Pittsburgh Hospital is located in an affluent suburban area with excellent housing and schools, and is a short commute from the amenities of Pittsburgh. The newly expanded ED sees 35,000 patients annually with 39 hrs of physician coverage and 20 hrs of mid-level provider coverage daily. An outstanding compensation/benefit package includes paid malpractice with tail, employer-funded retirement plan, paid health insurance, CME allowance, and much more. EM board-certification/preparation required. Contact Dr. Robert Maha at 888-647-9077/Fax 412-432-7480 or e-mail mahar@upmc.edu. EOE.

WASHINGTON - Tacoma: TACOMA EMERGENCY CARE PHYSICIANS. Looking for one more excellent emergency physician to join our group in the beautiful Northwest. Need another emergency physician for FT position (12-14 eight hr shifts/mo). Practice high acuity emergency medicine in a supportive environment with highly competitive compensation & a quick transition to full shareholder status. Brand new ED at Tacoma General Hospital opened April 2010! Visit our website www.tecp.net or contact Jaime Delcampo, MD at delcampo@tecp.net.

WEST VIRGINIA - Bluefield: EM physician opportunity with democratic group. This 36,000 volume ED is on the WV/VA border. Excellent coverage of 36 physician hours plus 20 PA/NP hours daily. Benefits include shareholder opportunity, family medical plan, malpractice, pension, incentive income. Scenic location with appealing sports/recreational opportunities. Contact Rachel Klockow, Premier Health Care Services, (800)406-8118, e-mail rklockow@phcsday.com, fax (954) 986-8820.

WEST VIRGINIA - Wheeling (near Pittsburgh, PA): Wheeling Medical Center offers easy access to desirable residential areas and amenities in WV and PA. The ED treats 40,000 patients annually. Outstanding partnership opportunity includes equal profit sharing, equity ownership, funded pension, open books, full benefits and more. Contact Steve Rudis, MD (careers@emp.com), Emergency Medicine Physicians, 4535 Dressler Rd, NW, Canton, OH 44718. 800-828-0898 or fax 330-493-8677.

WEST VIRGINIA - Wheeling: Full time position available at 36,000 visit ED located just one hour from Pittsburgh. Wheeling Hospital was recently named among the top 10 best hospitals in the nation for quality healthcare. BC/BE EM. EPMG offers paid family health, prescription, vision, dental, life, LTD, flexible scheduling, 401(k) employer contribution, paid malpractice, and much more. Contact Sarah Hysell at 800-466-3764, x327 or shysell@epmgpc.com.
ESP is a democratic physician-owned group with over 20 hospital partners across Central and East Texas. Our partner sites include D/FW, Austin, Bryan/College Station, San Antonio area and the Texas Hill Country, and we will work to find the right position for you. With compensation models to maximize income, fair scheduling, paid malpractice and tail, mentoring/leadership programs and Partnership opportunity, we truly have our physician’s best interests at heart.

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- CME allowance
- Equitable scheduling
- Abundant opportunities for professional growth

For more information about joining Pennsylvania’s emergency medicine leader, contact Robert Maha, MD, at 888-647-9077, or send an e-mail to mahar@upmc.edu.
Need an incentive to leave urban life? How about a significant financial bonus plan to help defray those student loans? With the recent demand for ED physicians, rural areas have had challenges recruiting BC/BP physicians to staff their Emergency Departments. Lehigh Valley Health Network—now managing Hazleton General Hospital’s ED—is offering financial retention bonuses for those qualified physicians who want to work in the comfortable and affordable community of Hazleton, Pennsylvania. Join the Lehigh Valley Physician Group (LVPG) and share in our success. The greater Hazleton area is nestled in the foothills of the beautiful Pocono Mountains—a vacation spot where opportunities abound for skiing, boating, fishing, hunting, mountain biking, golf, and more. Hazleton is a friendly, family-oriented community located 2 and 1/2 hours from NYC, 2 hours from Philadelphia, and 1 hour from the Lehigh Valley. It offers a choice of solid public or private schools, many surrounding colleges and universities, and some of Pennsylvania’s most breathtaking scenery. The 17-bed ED receives 30,000 visits per year and has a robust MI alert process and a certified stroke and bariatric center. Benefits include:

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Please email CV to: ochsnerphysiciancv@gmail.com
Ref. # AEMEDP09 or call 800-488-2240 for more information. EOE.

Wisconsin, Eau Claire: Outstanding opportunity for ABEM (or AOBEM) certified / EM residency trained physicians to join a well-established, top quality group in an exciting practice setting. Infinity HealthCare is managing and staffing the ED at Sacred Heart Hospital in Eau Claire and St. Joseph’s Chippewa Falls, Wisconsin. A college town, Eau Claire is a major metropolitan center in northwestern Wisconsin, surrounded by lakes and recreational areas within a short distance to Minneapolis, MN. Excellent compensation and comprehensive benefit package including the exceptional benefit of distributed ownership/cookie. The practice at St. Joseph’s Hospital is 15K and Sacred Heart Hospital is 25K patients & growing. Level III Trauma Center & Paramedic Medical Control Center. Please direct inquiries to: Mary or Johanna; ihc-careerops@infinityhealthcare.com, 111 E. Wisconsin Ave, Suite 2100 Milwaukee, WI 53202 fax (414) 290-6781 or toll free number 1-888-442-3883.

Wisconsin, Green Bay: Outstanding opportunity for ABEM (or AOBEM) certified / EM residency trained physicians to join a well-established, top quality group Infinity HealthCare. The practice would include working out of both St. Mary’s Hospital and St. Vincent Hospital. Competitive compensation package includes base salary plus bonus, attractive benefits and retirement. Please direct inquiries to: Mary Schwei or Johanna Bartlett at Infinity HealthCare Inc; ihc-careerops@infinityhealthcare.com, 111 E. Wisconsin Ave, Suite 2100 Milwaukee, WI 53202 fax (414)290-6781 or at the toll free number 1-888-442-3883.

Wisconsin, Green Bay: Outstanding opportunity for ABEM (or AOBEM) certified / EM residency trained physicians to join a well-established, top quality group Infinity HealthCare. The practice would include working out of both St. Mary’s Hospital and St. Vincent Hospital. Competitive compensation package includes base salary plus bonus, attractive benefits and retirement. Please direct inquiries to: Mary Schwei or Johanna Bartlett at Infinity HealthCare Inc; ihc-careerops@infinityhealthcare.com, 111 E. Wisconsin Ave, Suite 2100 Milwaukee, WI 53202 fax (414)290-6781 or at the toll free number 1-888-442-3883.

Wyoming, Cheyenne: Join a dynamic emergency physician team in beautiful historic Cheyenne, Wyoming. Frontier Emergency Physicians (FEP) is seeking an energetic and enthusiastic team member, a physician who is board certified/board prepared in emergency medicine. He or she would fill a position at Cheyenne Regional Medical Center, which hosts a level II trauma center, operated by FEP, that sees about 35,500 patients a year. FEP offers a competitive salary, benefits, and partnership opportunities. Interested physicians should send a cover letter and a copy of their curriculum vitae by email to tlong@seriollc.com or by mail to SERIO Physician Management, Attention: Teresa Long, 1241 W. Mineral Ave., Suite 100, Littleton, CO 80120. Or, call Dr. Mike Means at (307) 633-7550.
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For more information, contact:
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Director, Physician Employment Services
P: (515) 643-8323   F: (515) 643-8943
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How to acquire contagious positivity

The holiday stretch and seasonally cool temperatures can be exciting for some but depressing for others. If early sunsets and shopping stress are cutting into your usual pep, here are some quick spirit-lifters to use when you need to change your mood for the better!

Then see this issue’s cover story on using contagious positivity to improve your rotations and shifts!

- Fake a smile or fake laugh for a few minutes (or until it turns into a real smile or a real laugh).
- Jog or walk outside. Fresh air and exercise can do wonders.
- Do something creative, then enjoy what you’ve made: a batch of cookies, a flower arrangement, a handmade card for a friend.
- Listen to a song that will either energize you (rock, hip hop, techno) or calm your nerves (classical, jazz).
- Do something nice for someone. Seeing their enjoyment will make you happier, too.


Medical definitions

Artery – Study of paintings
Barium – What doctors do when treatment fails
Cauterize – Made eye contact with her
Dilate – To live long
Fibula – A small lie
Morbid – Higher offer
Nitrate – Better than day rate
Node – Was aware of
Outpatient – Person who had fainted
Post operative – Letter carrier
Protein – Favoring young people
Secretion – Hiding something
Tablet – Small table
Urine – Opposite of you’re out
Varicose – Located nearby

and finally....

Emergency Physician – read Dr. Nathan Deal’s perspective on what makes an emergency physician (page 4).

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—Ronald Reagan
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