Advocacy corner

A fight for our patients

Nathaniel Schlicher, MD, JD, Washington ACEP, Legislative Chair, Seattle, WA

This month, I have invited EMRA’s immediate past Legislative Advisor, Nathan Schlicher, to write a guest column about the Washington State Medicaid three visits rule. As a practicing physician in Washington State, this issue is especially critical to me, but has potential consequences nationwide. – Alison Haddock, MD, EMRA Legislative Advisor

Two years out of residency and I am in my first lawsuit as a litigant instead of as an attorney. As any physician who has stepped in the court can tell you, it is a strenuous and trying experience. Between legal briefings, media interviews, and strategy sessions with my co-litigants, it is a near full-time commitment.

So how did I land in court? Thankfully it was by choice. On September 30, 2011 the Washington Chapter of ACEP filed suit in Thurston County Superior Court to protect emergency department patients in Washington State and the national safety net. Who is the defendant trying to put our patients in harm’s way? The Health Care Authority (HCA) of Washington State, the department that oversees the state Medicaid program.

Politics and non-collaboration
The Washington State Legislature enacted a budget proviso that required the HCA to limit Medicaid enrollees to three “non-emergent” emergency department visits per year. They also required the HCA to work with the hospital and specialty associations to create a retrospective review process to identify these non-emergent visits in a “collaborative” fashion. The state legislature passed the legislation without a hearing, without considering an alternative, and without consulting experts in EM. In one month, it became law as part of the budget, fundamentally changing policy with a budget maneuver.

The HCA started with a list of 500 diagnoses from a New York study by

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Thank you very much for your interest in advertising with EM Resident. As the largest organization to represent the needs of the emergency medicine resident, we are able to reach a unique and important niche of our specialty. EMRA’s mission statement is to promote excellence in patient care through the education and development of emergency medicine residency-trained physicians. It is our belief that this provides the best patient care in an emergency department setting.

To support our mission and provide the greatest advantage to our residency-trained members searching for jobs, we welcome you to advertise in EM Resident, but require that all positions advertised in our publication be addressed only to board-certified/board-prepared, residency-trained emergency physicians.

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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.
Dr. Frederick Blum of West Virginia was recently awarded one of the highest distinctions in our specialty, the John G. Wiegenstein Leadership Award. During his acceptance speech, he told a story which every resident and emergency physician should hear and take to heart.

During his term as ACEP President, Dr. Blum was called to Congress to testify about the ballooning cost of medicine. An internist testified right before Dr. Blum—he spoke of a patient who had cost our healthcare system millions of dollars. For the sake of this piece, we’ll call this patient “Rocky.”

Rocky was a homeless, medically non-compliant junkie with an impressive list of medical problems, which included renal failure requiring hemodialysis. Rocky had been admitted to the hospital in extremis multiple times over the past year and had come to the emergency department dozens of times more. To top it off, Rocky was an illegal immigrant and (for lack of a better descriptor) a nasty, repugnant character who all the doctors and nurses had come to covertly (or in this case, overtly) revile.

The internist continued by decrying the cost of the Rockys of the world, and asking whether they were worth society’s investment. He ended his testimony to Congress with a question: As cost continues to soar, who is going to care for people like this? Dr. Blum, the next speaker, opened his testimony: “That would be me…the emergency physician.”

It seems that many physicians in other specialties reach a point where they’ll refuse or resist seeing patients. The question of what limits a physician’s willingness to care for another human being is an important one. Some physicians have limits of time: Come during office hours with an appointment, or not at all. Some have limits of cost: If you’re uninsured or unable to pay out of pocket you won’t be seen, but feel free to return if your financial predicament improves. Still others have limits of tolerance and patience: If a patient is difficult, demanding, or has a psychiatric illness, then dismiss them and wish them good luck in finding another provider. Without isolating any groups, I think we can all agree that there are a good number of providers who aren’t answering the bell for our patients.

What sets us apart as emergency physicians is what Dr. Blum articulated in his speech. We are the only specialty that answers the bell 24/7/365. We fight hard to care for those who have been neglected and who have fallen through the cracks (or more aptly, chasms) of our healthcare system. The emergency department is available regardless of time, income level, insurance status, or psychiatric comorbidity. We care for the Rockys of society and are proud to do so.

The American healthcare system is entering into the fight of its life. As the fray intensifies, the defining role of our specialty as our country’s safety net will grow ever more important. The government plans to cut millions in Medicaid and Medicare reimbursement; as these cuts occur, an increasing number of specialists will opt to throw in the towel on those patients who won’t compensate as well. Moreover, the millions who find themselves newly insured with implementation of the ACA will also find disillusionment: Scheduling primary care visits will literally take months while acquiring acute care will be nearly impossible (e.g Massachusetts/i.e., insurance does not equal access). We all know where these patients will end up and I know that as emergency physicians, you will do your best to meet these patients’ needs.

Across the entire scope of healthcare, the fight bells are ringing. Currently, proposed “fixes” to the SGR threaten to cut specialist (including emergency physician) Medicare compensation by 17 percent over three years. Proposed cuts to the ACGME threaten to decrease the number of residency spots and may make it necessary for future residents to pay for residency training. Cuts to the NIH may cripple medical research endeavors for decades to come.

Perhaps the greatest atrocity, Washington State has passed a law limiting emergency department Medicaid visits to three a year for
“non-urgent” complaints such as chest pain, vaginal bleeding and hypoglycemic coma. Poorly executed regulation such as this threatens the health and lives of our patients. As state and federal government tries desperately to cut costs, the punches will continue to rain. But as emergency physicians it will fall on us to answer the bell, absorb the blows, and continue to fight for our specialty and our patients.

EMRA, as the only independent resident association in America, has laced its gloves. This is evident in our organization’s attempts to educate our membership, in the publication of our newest advocacy handbook, and in our $100,000 donation and board position on the Emergency Medicine Action Fund (EMAF). EMAF has recently agreed to help fund a lawsuit against the state of Washington, a decision in which EMRA representatives participated.

As healthcare reform and cost cutting continue, many questions will arise: Who will provide care for under-funded patients? Where will patients with insurance, but without access to primary care doctors, go for care? Who will fight unfair and unwise government legislation? And most importantly, who will continue to place the patient first, above all else? I hope that all of you will take a page from Dr. Blum in believing “that would be me…the emergency physician.”

As your new EMRA President, I am honored to answer the bell for our patients, our specialty, and for you, our EMRA membership. I challenge you to seek ways to answer the bell for our patients and our specialty, and I look forward to serving you and EMRA over my term as president.

**Mission Statement**

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

**Ground breaking Scientific Assembly!**

During Scientific Assembly in San Francisco, EMRA launched two exciting new initiatives in the Education Committee and EMRA Blood Drive. The Education Committee will strive to improve the educational products and services provided to you the member, and the EMRA Blood Drive will provide us with a yearly opportunity to literally give back by bleeding for our patients!

**Projects abound:** The EMRA board, committees, Representative Council and staff are hard at work on a number of exciting new projects including the creation of an International Emergency Medicine Handbook, Critical Care Handbook, Orthopedic Handbook, Video Documentary of the Beginning of Emergency Medicine, and development of an iPhone/Android Clinical App. Look for these exciting new projects to hit the market in the coming year!

**A is for advocacy:** With the passage of the Accountable Care Act and increased legislative focus on healthcare EMRA has been working hard to represent resident interests on all fronts! This October saw the launch of the first ever Advocacy Week, to complement the release of the second edition of EMRA Advocacy Handbook, participation in the Emergency Medicine Action Fund, and efforts during the ACEP Leadership & Advocacy Conference.

**Website overhaul:** In the next six months emra.org will be getting a much needed facelift. With the help of website designers, the EMRA staff and Board of Directors are working to create a website which is sleeker, better designed, and more responsive to your needs.

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  emresidenteditor@emra.org

- **David Chiu, MD**  
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  Beth Israel Deaconess  
  Boston, MA  
  techcoordinator@emra.org

- **Hamad Hussainy, DO**  
  Speaker of the Council  
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  Tacoma, WA  
  speaker@emra.org

- **Matt Rudy, MD**  
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  vicespeaker@emra.org

- **Alison Haddock, MD**  
  Legislative Advisor  
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  Tacoma, WA  
  legislativeadvisor@emra.org

- **Jonathan Heidt, MD**  
  Director-at-Large/RRC-EM Representative  
  Washington University  
  St. Louis, MO  
  rrcemrep@emra.org

- **Dan Stein, MSIV**  
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  University of California – Davis  
  Davis, CA  
  msgc@emra.org

**EMRA Staff**

- **Michele Byers, CAE, CMP**  
  Executive Director  
  mbyers@emra.org

- **Leah Stefanini**  
  Publications & Meetings Manager  
  lstefanini@emra.org

- **Alicia Hendricks**  
  Website Coordinator  
  ahendricks@emra.org

- **Chalyce Bland**  
  Administrative Assistant  
  cbland@emra.org

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**Editor’s forum**

**The elements of style**

My mailbox has one-third of a tree inside of it. Daily, I empty it, puzzle over why medical supply companies are sending me postcards, then swiftly toss them in the recycling with yesterday’s tree.

In my first year of medical school, I was thrilled whenever a company was daft enough to pop an “MD” after my name and mail me prescribing information about the newest anti-fungal agent. Seeing that MD gave me motivation to drag myself back to the library and study for another 5-10 hours. If it was a good day, maybe I’d even go see if that anti-fungal was legit or just another costly me-too drug.

Now — at last! — the MD has become a legal suffix. And the junk mail has quintupled. (Why would someone think an intern would be in the market for a laryngoscope?)

There are however a select few items I actually look forward to, principally, the Crate&Barrel catalog and *Esquire*. The most recent addition, joining my personalized pile since third year of medical school, is your very own *EM Resident*. True story.

Compared to much of the medical literature available to tuck away, I find emergency physicians write with more life, more style. I hypothesize that it has something to do with the obscene variety of life we see filing through the emergency department every day. It’s one of the countless reasons I chose emergency medicine, admittedly an odd and much less obvious reason for choosing a career path.

As careers go, we’re the lucky ones. We hear the most truly bizarre stories every day, and this happens all while curing people of scabies or learning some new reduction technique. It’s the ultimate in multi-tasking! Sometimes we may repeat these stories with the purpose of awe/shock/hilarity (always in a manner 100 percent HIPAA-compliant). Occasionally there is a situation too difficult to discuss, but will nevertheless be brightly stamped in our minds as a lesson to never forget. Or if we come across a really rare zebra, perhaps we’ll take the mature route and publish a case report.

As an example of excellent reading material, I give you the works of Bill Bryson, a non-fiction author with singular wit. My personal favorite is *A Short History of Nearly Everything*, where he goes about researching scary stuff like dark matter and quarks and the ice age. It’s not just that I’m a
science geek (I hold no passion for geology); it’s that Mr. Bryson does not write like your run-of-the-mill science geek. He writes about the things that he’s curious about, and then proudly makes his curiosities available for public scrutiny. The best part is that he presents this small tome in a way that makes one laugh aloud whilst reading on the subway. He’s just tops.

Not that we can make every article humorous. That’d be pathologic. “Interesting” is the key word. Through word-of-mouth and mentors and Google, we’ve all discovered an excellent resource that publishes high-yield information. On top of that, by sheer willpower and caffeine, *EM Resident* has kept thousands of ADHD residents around the U.S. interested in emergency medicine even after we’re done with our shifts.

Luckily, residents know what residents like. So if you notice that your patient’s emergency department visit makes for a riveting anecdote; or if a zebra happens to stumble through your doors; or if you just like telling stories – join in! *EM Resident* could always use new authors or an editorial eye. My mailbox is always open.

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**Call for Academy of Women in Academic Emergency Medicine (AWAEM) Resident Award Nominations**

Are you, or do you know, a female resident who has shown promise for significant career achievements in Emergency Medicine and/or who have worked to promote the role of women in academic emergency medicine?

**Nominations are being accepted until February 15, 2012** and nominee must be an emergency medicine resident in accredited ACGME program in good standing. Selections will be based on evidence of achievements, innovation, and dedication in academic emergency medicine, whether through education, research, advocacy, or administration.

Contact Kinjal Sethuraman at ksethuraman@umm.edu for more information and to submit required documents: CV, nomination letter, letter of support from residency director, letter of support from colleague.
Meet Your New Board Members

Swearing in of the 2012 EMRA Board of Directors during Scientific Assembly in San Francisco.

Cameron Decker, MD, EMRA President-Elect, Baylor College of Medicine, Houston, TX

Cameron Decker was born and raised in Houston – he started his medical career early as a paramedic in high school and carried on when he went to Rice University. He majored in Psychology as well as Policy Studies in Healthcare Policy and Management.

Cameron went to Baylor for medical school, maintaining his sanity by commanding the Child Predator Apprehension Team as Sergeant for the third largest Sheriff’s Office in the nation. There, he founded the department’s tactical medicine unit that works with many local, state, and federal agencies on high-risk tactical operations. He continues his work with them today and hopes to continue on his Paramedic/Police Officer path by completing an EMS fellowship after residency at Baylor. In the meantime, he flies planes in the little free time leftover.

As Cameron begins his work with the EMRA Board, he plans to strengthen member benefits to recruit new members while continuing to engage the current ones. EMRA will be at the forefront of protecting residents’ ability to practice, as they become the future leaders within emergency department. He is dedicated to keeping the interests of residents afloat during this time of turmoil in healthcare reform. EMRA will speak with a unified voice to protect the safety net of vital care provided to patients.

Cameron is thrilled to represent your views! If you have ideas to share, email him at presidentelect@emra.org.

Matt Rudy, MD, Vice Speaker of the Council, Washington University School of Medicine, St. Louis, MO

Matt grew up along the east coast – first in Fairfax County, Virginia – and ultimately in Georgia. He attended the University of Georgia in Athens, earning his degree in Biochemistry and Molecular Biology. At UGA Matt worked as Information Technology Director for a non-profit service called WatchDawgs, which has given over 58,000 free, safe rides to students and the Athens community.

Interested in blending a career that involved both science/technology and caring for others, Matt headed to medical school at the Medical College of Georgia. While at MCG, Matt was elected to serve as National Chair for AAMC’s Organization of Student Representatives. During that time, he also became active within the AMA and medical advocacy, visiting Washington, D.C. yearly to represent patients and fellow medical professionals.

Emergency medicine was an easy choice for Matt, promising a fast-paced profession with incredible experiences. As he learned from EMRA as a senior medical student, he knew he’d also retain enough flexibility to stay active within organized medicine and advocacy. Matt has continued his path in emergency medicine at Washington University in St. Louis. Staying close to EMRA, he has already served as Program Representative and as Regional Representative.

Now, as a member of the EMRA Board, Matt hopes to engage EMRA’s members to cultivate future leaders – both for our organization and our specialty. As membership grows, maintaining an engaging and open relationship with all members is crucial. He will help fulfill our mission to promote excellence in patient care through the education and development of emergency medicine-trained physicians.
David Chiu was born in Taiwan where the humid, tropical air introduced him to emergency medicine in the form of frequent visits to the emergency department for his asthma. He later moved to the Boston area, which was much kinder to his lungs and attended primary school in the Needham public school system. In high school Dave was attracted to both biology and computer science, which is probably why he concentrated in Computational Biology at Cornell University, where he did his undergraduate studies. He spent much of his time there doing basic science research in DNA microarrays and other microbiological diagnostic testing.

He returned to Massachusetts, where he attended University of Massachusetts Medical School. It was there he was introduced formally to emergency medicine. He ended up matching just down the road in Boston, at Beth Israel Deaconess Medical Center – one of the Harvard Affiliated Emergency Medicine Residencies – where he is a second-year resident. As an intern, Dave became Vice-Chair of the Technology Committee and learned of the exciting developments in all-things-technological going on in EMRA.

As the Technology Coordinator, Dave will help revamp the EMRA website to a less cluttered, more intuitive user experience as well as adding interactive Web 2.0 principles. He also intends to increase EMRA’s mobile presence by launching an e-book library of all the print material EMRA currently publishes, as well as more mobile apps (beyond the incredibly useful antibiotic guide). Another priority will be to work with all the committees and create useful technological solutions to promote education, global health, research, policy, and critical care.

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**Chadd Kraus, DO, MPH**, Academic Affairs Representative, Lehigh Valley Health Network, Bethlehem, PA

Chadd Kraus is currently a resident at Lehigh Valley Health Network in Allentown, PA and attended medical school at the Philadelphia College of Osteopathic Medicine (PCOM) in Philadelphia. Prior to residency and medical school, Chadd completed a Master of Public Health program in Health Policy and Management at Johns Hopkins and a BA in Political Science from Loyola College in Maryland. While at Johns Hopkins, Chadd worked as a clinical researcher in the Department of Emergency Medicine. There, he co-authored several research articles and abstracts in emergency medicine as well as general medicine journals.

Chadd previously served EMRA for two years during medical school as the Editor for the Medical Student Governing Council, editing the medical student section of EM Resident. He also developed content for the medical student section of the monthly e-newsletter communication to members, What’s Up in Emergency Medicine? Chadd also served as a member of the Reference Committee during EMRA Representative Council activities and as EMRA Program Representative for his residency program.

As Academic Affairs Rep, Chadd hopes to advance member interests and increase the educational opportunities available to EM residents. He’ll do this by building upon the relationships EMRA has developed with organizations like CORD and SAEM. He’s also excited to work with the newly-formed Education Committee to develop resident programming at national emergency medicine meetings as well as expanding the variety EMRA-sponsored educational materials.

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**Stephanie Krema, MD**, Secretary and EM Resident Editor-in-Chief, University of Louisville, Louisville, KY

Stephanie grew up in downtown Chicago, choosing Washington, D.C. as a fine urban alternative for college. At GWU, she studied Marketing and Fine Arts to integrate her artistic inclinations into a practical outlet.

Out of college, she was hired as a management consultant in D.C., where she discovered an odd skill for technical writing. There, she authored and edited reports for organizations like HHS, HUD, the EPA, and DOT. She augmented writing whenever possible with graphic design projects, most excitingly leading the design work for a nationwide ad campaign for HUD.

After a time, medicine stole her undivided attention - but the skills from her past have been endlessly useful. It aided her work on Chicago Medical School’s Executive Student Council; on the EM Resident Editorial Board; and now at her new home within University of Louisville’s emergency medicine program. As Secretary/Editor-in-Chief of EM Resident, she will carry on the tradition of providing a practical, interesting, easy-to-read publication for the new generations of residents and medical students alike.

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**David Chiu, MD**, Technical Coordinator, Beth Israel Deaconess, Boston, MA

David Chiu was born in Taiwan where the humid, tropical air introduced him to emergency medicine in the form of frequent visits to the emergency department for his asthma. He later moved to the Boston area, which was much kinder to his lungs and attended primary school in the Needham public school system. In high school Dave was attracted to both biology and computer science, which is probably why he concentrated in Computational Biology at Cornell University, where he did his undergraduate studies. He spent much of his time there doing basic science research in DNA microarrays and other microbiological diagnostic testing.

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Advocacy corner
continued from cover

A fight for our patients

Dr. Billings that evaluated ambulatory care alternatives. Unfortunately this list contains over 190 diagnoses that were deemed by the study authors to be emergent 100% of the time, including chest pain, asthma exacerbation, shortness of breath, and abdominal pain. Despite attempts by physicians to explain potential harms, the HCA refused to consider the physicians’ concerns. To add insult to injury, the state then unilaterally added 200 additional diagnoses to the list, including burns.

The list now contains over 700 of the most common diagnoses in the ED. Painful conditions such as kidney stones and gallstones are on the list. Sexually transmitted diseases are on the list. Injuries not resulting in a broken bone – such as an ankle sprain – are on the list. The message from the state is clear: If you come to the ED more than three times, you’d better break something or be near death to be considered emergent.

**Destruction of the safety net**
The potential cost to hospital and providers could be over $36 million per year from the loss of Medicaid funds; however the true costs could encompass 50% of all reimbursement if private insurers were to implement a similar program. Currently, there is a 20-year old “prudent layperson standard,” which has protected private citizens from private insurers performing similar retrospective reviews. This standard requires insurers to provide coverage if a prudent person with similar symptoms would believe that emergency care would be required to protect life, limb, or health; such a standard is in place in most states and included in the Accountable Care Act. The HCA in its decision essentially bypassed this important protection.

It is estimated that if private insurers picked up similar three-visit ED limitations, 10-15% of visits could be considered “non-emergent.” If this were to progress to none of these visits being covered, the effects could be devastating, upwards of 50% potentially – few hospitals could survive that type of damage, especially since EMTALA dictates that EDs cannot refuse to treat patients. In turn, fewer hospitals would be able to attract highly qualified EM-trained physicians.

This situation is not just a local issue. Washington State has been working with 19 other state Medicaid directors about implementing ED limitations. Other state such as California and Tennessee have developed other programs with more narrowly tailored lists, but could be inspired to expand if this policy survives.

**Time to fight**
If you had asked me what I would be doing when I joined the Washington ACEP Board of Directors... suing the state was not on the list of things to do.

Nathaniel Schlicher, MD, JD
Washington ACEP
Legislative Chair
Seattle, WA

“If you had asked me what I would be doing when I joined the Washington ACEP Board of Directors... suing the state was not on the list of things to do.”
and national attention. The courts are beginning to weigh in and will likely play an increasingly active role.

The legal work necessitated the formation of an action fund to provide financial support for our litigation. We are a small state chapter and have an operating budget that could never support this case. As such, in the course of a week we established an emergency fund, defined an ask of 5 cents per chart per physician, and launched a campaign for support. I am proud to say that in one month, we collected commitments from physicians, organizations, and national leaders for more than one quarter million dollars. We continue to grow our war chest, as a long-term lawsuit against the state could reach a million dollars quickly.

**And the (first) winner is...**

On November 10, the Thurston County Superior Court for the State of Washington heard the case of Washington ACEP, et al v. The Health Care Authority on the matter of a Stay and Temporary Restraining Order. The judge ruled that the state had violated the Administrative Procedures Act in failing to use proper rule making procedures and trying to inappropriately use an emergency rule making process. As such, the entire rule was thrown out. To create a new rule to change Medicare, the state is required to go through a standard process that will likely take 90-120 days.

The traditional rule making process will mean the state loses most of its savings for the 2011-2012 fiscal year. Since the state cannot again consider the rule until February 1, 2012, they will have only four months for discussion before the June 30 fiscal year close. This gives us now eight months to achieve a better rule, an alternative strategy, or again obtain success in the courts.

**A busy future**

Even with our initial success in court, the work ahead remains daunting. After displaying our willingness to defend our patients and our specialty, we have earned new respect in the congressional halls - and hopefully in the regulatory landscape. This means that we are opening a second front on the war through collaborative meetings, regulatory hearings, legal challenges, legislative policy, and media campaigns. It will be especially tough working in an accelerated window around the holidays and a shortened legislative session.

EM is constantly cited as contributing to “excessive health care costs,” despite only representing 2% of all health care expenditures. Your future as an emergency physician is in the balance. I encourage you to get involved and advocate for your patients and your specialty. These issues will only be won by active involvement of emergency physicians at every level. Whether through your hospital, your legislator, ACEP, EMRA, or other organizations – make the time to get involved. Your patients need your help.

For more information about our issues, or to contribute to the action fund, visit our website at www.washingtonacep.org.
More fellowships, less GME funding

At the ACEP Scientific Assembly in San Francisco there were several important announcements and updates by both the RRC-EM and the American Board of Emergency Medicine (ABEM). Even though changes within the ACGME usually take years to develop, events have begun to rapidly occur over the past few weeks. In this RRC-EM article, I will summarize the key advancements and announcements and their potential impact upon residency training.

ABMS/ABEM

- On September 21, 2011 the General Assembly of the American Board of Medical Specialties (ABMS) approved ABEM co-sponsorship of the American Board of Internal Medicine (ABIM) Critical Care Medicine (CCM) subspecialty. Negotiations between ABEM and ABIM had proceeded for several years before a proposal was finally approved by both specialties’ boards of directors. This co-sponsorship will allow Emergency Medicine (EM) trained physicians who complete an Internal Medicine (IM) CCM fellowship to apply for certification through IM. Additional details will soon be available on the ABEM website regarding certification through a “grandfather” pathway and pre-requisites for entry into an IM CCM fellowship.

- Certification in the subspecialty of Emergency Medical Services (EMS) is available to diplomats of any ABMS Member Board who meet the eligibility criteria. There are three application pathways: A practice pathway, a practice plus training pathway, and a training pathway. The full description is available on the ABEM website. It is anticipated that the first certification examination will be administered in the fall of 2013. ABEM will begin accepting applications in the fall of 2012. The RRC of EM is currently developing the subspecialty program requirements. These program requirements will soon be released for public review and comment.

- The ABEM Board of Directors (BOD) approved new content standards that will take effect with the fall 2014 qualifying exam. For the first time, standards will include specific requirements in areas such as pre-hospital care, emergency stabilization, communication, and disaster management.

  The BOD has also approved a pilot of an enhanced multiple-choice question exam and an enhanced oral examination format. The purpose of the enhanced exam format is to better simulate the practice of emergency medicine and add more value to the initial certification exam. Examples of the enhanced format would include computers to display multimedia images, real time vital sign displays, and simulated electronic medical records and PACS systems.

- In September 2011, ABMS approved Clinical Informatics as a subspecialty through the American Board of Preventive Medicine (ABPM). The initial sponsorship agreement by ABPM began in 2009. Since then, the American Board of Pathology has also...
agreed to co-sponsor the subspecialty. The ABPM plans to have the first exam available in 2012. During the EMRA Representative Council at Scientific Assembly, the Council voted on an emergency resolution voicing support for EM co-sponsorship. The EMRA Board of Directors has begun to explore this possibility with both ABEM and the ACGME. We will continue to provide updates as they become available.

ACGME

- The ACGME have released the results of a survey that examined the potential impact of various GME funding reduction scenarios. Between August 16, 2011 and September 16, 2011, the ACGME contacted all Designated Institutional Officials (DIOs). The DIOs were asked how they would respond to various proposed federal spending reductions for GME (45 percent response rate).

Extrapolating the results to the entire population, the ACGME estimates that under a 33 percent reduction in funding, 1,639 programs would close (18.4 percent of all programs) and 19,879 positions would be lost. Under the 50 percent reduction scenario, the ACGME estimates that 2,551 programs would close and 33,023 positions (29.2 percent of all GME positions) would be lost. The loss of these positions would have a profound impact upon the structure and design of graduate medical education. If these positions are lost, we may have significantly more medical students graduating each year than residency positions available.

- The Liaison Committee for Medical Education (LCME) has announced that accreditation for the San Juan Bautista Medical School in Puerto Rico has been revoked effective October 3, 2011. The AAMC has established a website to provide more information to SJB students. https://www.aamc.org/students/sjb/. EMRA will continue to follow these developments closely.

- The development of the emergency medicine milestones continues to proceed rapidly. The Milestone Project is designed to use outcomes rather than processes to demonstrate the progression towards competency in independent practice as resident physicians progress through training. EMRA is proud to be a part of this process. We will release more information regarding the specific “milestones” when they are released for public comment.

- The next RRC meeting will be held February 10-12. If you have any specific questions or comments regarding program requirements or training in emergency medicine, please do not hesitate to contact me.

- Are you interested in becoming the next EMRA board liaison to the RRC? Applications will be made available in January 2012. The application process takes approximately 8-10 months to complete. After appointment, a nine-month orientation process will follow. The next term on the RRC will begin July 1, 2013 and will last until June 30, 2015. Please contact rrcemrep@emra.org for more information.
At ACEP’s Scientific Assembly in San Francisco, Dr. Sandra Schneider passed the ACEP presidential gavel to Dr. David Seaberg, who was one of her former residents. Upon stepping in to his role as leader of the college, Dr. Seaberg had the opportunity to address the ACEP Council and lay out his vision for the future. Not surprisingly, his comments centered around healthcare reform and how it affects the direction that both the college and the practice of emergency medicine should take.

"Now is the time to act"

Now that healthcare reform has passed, Dr. Seaberg emphasized that it is time for emergency medicine to brace for its implementation. Over the next few years, the legislation will be moving through the regulatory process – and it is through this process that the implications for the day-to-day practice of medicine will become realized.

Dr. Seaberg emphasized that the next three years will affect the 30 years that follow; as a result, it is vital for emergency medicine to be involved in the regulatory process. ACEP has joined with other stakeholder organizations to establish the Emergency Medicine Action Fund, which allows emergency physicians to speak with a unified voice during this all-important time. EMRA is proud to be an inaugural member of the EM Action Fund (more information available at www.acep.org/EMActionFund), realizing that the outcome of the regulatory process will influence how we work, how we get paid, and how we provide care to our patients.

Three pillars of healthcare reform

Dr. Seaberg went on to outline the core tenets of healthcare reform – access, quality, and cost. With regard to access, as the pool of insured Americans is set to rapidly expand, it is important to emphasize that coverage does not equal access to care. Without options for primary care, where do patients end up? At the emergency department.

This is the time for emergency medicine to show its value, which is defined by the tenets of quality over cost. With integrated care delivery systems – such as accountable care organizations, bundled payments, and episodes of care – on the very near horizon, it will be extremely important to determine how emergency medicine will fit in to these models. Insurance companies want emergency physicians to function as gatekeepers;
and keeping patients out of the emergency department is their primary goal. The government also shares this sentiment – pointing to “unnecessary” emergency department visits – with some states going so far as to limit the number of emergency department visits Medicaid patients are allowed.

Of course, we know these claims to be dangerous fallacies. The truth is that emergency departments see 136 million visits a year; less than eight percent of those visits are deemed unnecessary; and all while comprising only two percent of the nation’s spending on healthcare. We need to ensure what is obvious to us is communicated clearly to everyone else.

The reinvention of emergency medicine
After reviewing the importance of being proactive in advocacy efforts as well as in demonstrating the value of emergency medicine, Dr. Seaberg went on to outline an alternate vision for the future of emergency medicine. In this future, emergency physicians will have to step out of their perceived comfort zone of acute care and explore new treatment areas by partnering with other providers, payers, and hospitals. Through this reinvention, and along with the acquisition of additional resources, emergency departments can expand their offerings to include such services as preventative care, wellness services, and end of life care.

To emphasize his point, Dr. Seaberg referenced a past ACEP President, Dr. Greg Henry, who sixteen years ago expressed the desire to make the emergency department the “central hub” in the healthcare system. In addition to enhancing the value found within the emergency department, Dr. Seaberg explained that emergency medicine can also serve as a bridge into integrated care delivery systems – further demonstrating the value of emergency medicine outside of our doors as well.

Looking forward
Without question, what happens during the next few years will dictate the future of emergency medicine – our future. Dr. Seaberg proposes that we find ways to show how emergency medicine encompasses the three pillars of access, quality, and cost. And to demonstrate our full value, we need to find new ways to acquire additional resources and to work with others – both within the emergency department and beyond – to provide the care that patients need. Up until now, the emergency department has too often been labeled as merely a “safety net” – which is an important, although limited, role. We must create a future where the emergency department serves “the hub” for patient care, and as “the bridge” into new delivery systems, all while continuing to serve as the high value acute care center and safety net that our patients rely on.

“Without options for primary care, where do patients end up? At the emergency department.”

Need Money for Research?
The Emergency Medicine Foundation is offering up to four grants:

- EMF/EMRA Resident Research Grant, $5,000 up to 3 available
- EMF/Medical Toxicology Foundation Research Grant 1 available

Applications are due January 9, 2012.
To learn more, go to www.emfoundation.org

“Without options for primary care, where do patients end up? At the emergency department.”
Can’t miss ECGs

Left ventricular aneurysm morphology distorted by right bundle branch block… mimicking acute STEMI with RBBB

General background
Prior myocardial infarction (MI)/left ventricular aneurysm (LVA)

Approximately 60 percent of patients with a previous anterior transmural MI, and even fewer inferior MI patients, may have persistent ST-elevation (persistent STE),¹ which notably mimics acute STEMI. Of patients with this anterior persistent STE, approximately 80 percent have an anatomic left ventricular aneurysm; this can be seen on echocardiogram as “diastolic distortion” or myocardial wall thinning.²,³

In the reperfusion era, transmural MI is uncommon - so the incidence of persistent STE is also less than it once was. In a 1987 series of patients with prior MI presenting with chest pain and STE – only 50 percent proved to have an acute MI.⁴ Persistent STE may also be associated with systolic dyskinesis, akinesis, or a large area of myocardial necrosis - even in the absence of anatomic ventricular aneurysm.³

Anterior LVA, results in Qr-waves (deep Q followed by a small r-wave) or QS-waves (single, deep negative wave) in V1-V4, which is then followed by a moderate degree of STE. The QS-waves indicate complete loss of anterior electrical forces during depolarization. The T-wave may be upright (but not as large or as hyperacute as in acute STEMI) or inverted (but not deeply inverted, as in acute non-STEMI).

Inferior LVA – has STE and QR-waves, not QS-waves, and is thus much more difficult to differentiate from acute inferior STEMI.

How do you know if it’s LVA or acute MI? The best discriminator is the “T-wave amplitude/QRS amplitude ratio” – which has good sensitivity and specificity.⁶

<table>
<thead>
<tr>
<th>(sum of the T-wave amplitude)</th>
<th>(sum of QRS amplitude)</th>
</tr>
</thead>
<tbody>
<tr>
<td>if in V1-V4 ratio &gt; 0.22</td>
<td>if any one lead has a ratio &gt; 0.36</td>
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think acute MI        think acute STEMI

False negatives had a long time between symptom onset and ECG, so that the T-wave was no longer tall. Just as useful is evaluation of the patient’s prior ECG – but of course these are not always available. Echocardiography may also be useful if it shows dyskinesis (diastolic dysfunction); unfortunately, persistent STE after an old MI also occurs without anatomic aneurysm. STE with regional wall akinesis or hypokinesis is present in both acute STEMI and old transmural MI. In some cases, coronary angiography will be required to make the diagnosis. New STEMI in the same location as previous Q-wave MI may also have deep QS-waves, but has tall T-waves.

See figure 1 for an example of classic LV aneurysm morphology.

“In a 1987 series of patients with prior MI presenting with chest pain and STE – only 50% proved to have an acute MI.”
“In contrast to LVA, patients with acute STEMI who have Q-waves also have a larger T-wave.”

Figure 1
There is a QS pattern in V1-V3 with anterior STE. The T-wave amplitude is not sufficient for acute MI. If you apply either ratio rule, it turns out to be LV aneurysm. This is a classic LV aneurysm morphology.

Figure 2
This is normal RBBB, with rSR’; slight ST-depression in V2 and V3; and no ST-elevation anywhere.

Normal right bundle branch block (see figure 2)
A non-pathologic RBBB has an rSR’ in V1-V3 and no STE anywhere on the ECG. Absence of the r-wave in V1 only may be normal, but if it extends to V2 and beyond it is always abnormal! The differential includes not only MI but left ventricular hypertrophy and cardiomyopathy. There is usually up to 1 mm of ST-depression in V2 and V3, which is discordant (opposite direction of) the positive R’ wave (see figure 2). If there is a very large-voltage R’ wave, as in right ventricular hypertrophy, this ST-depression may be > 1mm in the absence of acute ischemia. To determine the presence or absence of STE in RBBB, one must first determine the end of the QRS, which is the beginning of the ST-segment (the J-point).

Case presentation
Right bundle branch block (RBBB) transforms a QS- into a QR-pattern, obscuring diagnosis of left ventricular aneurysm and suggesting acute STEMI and RBBB.

A 79-year-old man presents with dyspnea. He states that he had sustained a recent myocardial infarction and that it had been painless. His presenting ECG is shown in Figure 3.

Thus there are anterior Q-waves and anterior STE. So it’s an acute STEMI, right? I saw this patient in the late 1990s (and have seen others since) and administered tPA for acute MI. Before the

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Figure 3
There is sinus rhythm at almost 100 beats per minute. There is a large R-wave at the end of the QRS-complex in V1; wide S-waves in lateral leads I, aVL, V5, and V6; QRS duration > 120 ms, which is diagnostic of RBBB. There is absence of r-wave in V1-V4, resulting in a QR-wave, rather than an rSR’-wave. If the r-wave is absent, then it is a Q-wave, which strongly suggests a Q-wave MI (whether due to acute or old MI). Figure 4 magnifies V1-V3 and shows how to find the end of the QRS, which is the J-point and beginning of the ST-segment.
Can’t miss ECGs

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tPA had time to work, the rate slowed, the RBBB disappeared – and then showed the ECG in figure 1.

Old records were retrieved and indeed the patient’s previous ECG was the same. In fact, he had presented one week earlier with the exact symptoms and exact same RBBB ECG and had also received tPA from one of my partners!

How is this possible? Normally, anterior LVA has little or no R-wave amplitude. However, this patient has rate-related RBBB. His right bundle has a long refractory period so that when his rate increases, his right bundle is refractory and does not conduct. In RBBB, there is automatically a large R’-wave, even if the anterior wall is dead there, simply because of the sequence of depolarization. So the LVA morphology gets replaced and distorted.

How can you suspect this? On the ECG, it is nearly impossible as far as I can tell. So you must use other clinical data. First, you have to know that this is possible. Second, you can use echo to look for aneurysm (by diastolic dysfunction or bulging). But if you see only systolic dyskinesis, it could still be either LVA or acute STEMI.

In contrast to LVA, patients with acute STEMI who have Q-waves also have a larger T-wave. See figure 4 for an example of a patient with QS-waves, and also with hyperacute T-waves, such that the T/QRS ratio is high. It was an acute LAD occlusion.

References


About Dr. Smith

Dr. Stephen W. Smith is a faculty physician at Hennepin County Medical Center and the author of a textbook and several chapters on the ECG in Acute Coronary syndromes and Acute MI. His blog is the most visited ECG blog in the world: http://hqmeded-ecg.blogspot.com.
Stewards of the checkbox

For those of you that follow my column, in the last issue I wrote about the reasons we practice medicine and the extracurricular activities that confirm our decision. In keeping with the theme of “the small things” that make each of us a better physician (and thus a better human being) I’m writing about an imperative quality to aid the current healthcare situation in our great country.

Stewardship

I have since graduated and completed my written board exam, but I’d like to rewind for a moment to my years as an emergency medicine resident. It’s my own scenario, but each of you will undoubtedly relate.

Within every program, residents come on shift and - among other things - check which staff physician is working. The result is invariably met with a cheer…or a cry. At my program, there was one staff physician that junior residents really tried to steer away from. In fact, some residents successfully avoid him for their entire career. But since graduating, I’d like to thank him for teaching me the meaning of “stewardship” in our profession.

As residents, we’re quite aware of the current healthcare situation and the national debt crisis. This might be because we are more connected or because our futures are more unknown. Our years as a resident are filled with many tough decisions, late nights, and mentally challenging situations. Some of the not-so-tough situations often include taking care of the “obvious” medicine admission or the “not-so-sick” trauma patient. I would submit to you though, that there are some important decisions regarding the care of such easy patients.

After visiting the American Medical Association website and perusing some data, I found that the U.S. spends more than any other country on healthcare – and conversely has only mediocre outcomes to show for it. The United States’ financial resources are finite, however; we should preserve them for our patients when they are in their greatest need. I could write a thesis about this but would prefer to present some facts regarding the use of liberal versus conservative lab testing.

After a bit of research within my own institution, I was able to find cost associations with commonly ordered labs. (By the way, my discussion here is not to battle the workup and care of certain patients, but rather address excessive spending when “checking the boxes” on the order sheet.)

- Amylase: $38.55. I have never used this and have yet to see a study that shows that it affects patient care in the emergency department. I assumed it was a “dead” test, yet I see it ordered regularly.
- When a patient is on Coumadin and you would like to know INR, order a PT/INR for $37.88. But why do you need a PTT at another $38.27? Also, nurse-initiated orders and protocols have become a part of our practice – but every patient with chest pain or dizziness does not require PT/INR. They can be added if needed.
- Cardiac enzymes: This can be somewhat controversial. In short, the overwhelming majority of lab-based medical decision-making arises from the troponin result ($53.56). Adding CK/CK-MB tacks on another $87.36.
- Lastly, when patients present with first-trimester bleeding and are hemodynamically stable, an ABO and Rh (which is needed) runs $54.60 while a type and screen is $85.82.

I bring up these points to show out how easy it is to save in our own emergency departments, regardless of whose money we are spending. We spent hundreds of thousands of dollars in medical school. We’ve trained for three-to-four years to become experts in our field. We believe that our profession can make a difference. While we account for only two percent of healthcare expenditure, it is clear that we can still make changes that will save resources without altering our decision-making. This is how stewardship is a necessity within our practice.

And for this, thank you Dr. Cox, for teaching me something that is so often ignored in medical education.
Three things to think about with every patient

I remember James like it was yesterday. He was a 40-year-old, previously healthy guy who came to the emergency department with mental status changes. It was my last week (finally!) of my third-year medicine rotation and our team was accepting admissions that night. His initial workup revealed moderate uremia. He was admitted to our service and I was to follow him.

The eight weeks on medicine wards had been tough. It was my first third-year clerkship and – beyond not really knowing anything about how to manage patients – I really had no clue how to even present patients during rounds; find my way around the hospital; or find information on the EMR (among other things). To make matters worse, the patient I had seen right before James had told me “I don’t want a medical student practicing on me. I want a real doctor.” I backed away. My attending spoke with them and explained the “benefits” of having a team of learners follow her. Needless to say, it was a bit awkward to greet her at 5:30 a.m. every morning during her hospitalization.

The “no med student” preference hurts. The ego definitely takes a hit. James’ partner took another stab at my ego. “I don’t think we want a student taking care of him.” This time, I decided I wouldn’t back down so easily. I tried to emulate what the attending had said earlier about the benefits of care from an entire team. Surprisingly, James and his partner were agreeable.

And so, James had to answer – as best he could – the same questions over and over and over. He had to lean forward, breath deeply, roll over, walk across the room, follow the finger “H,” and get his belly mashed on over and over and over again. Each time I went in the room, I felt awkward thinking that the partner didn’t want me there. But I did my best, listened to their concerns, answered their questions, and followed his mental status changes.

Long story short, James had a complicated hospitalization. His mental status deteriorated, at which point he was electively intubated and sent to the MICU, where he died shortly thereafter. Autopsy revealed that James had a rare urea cycle disorder that had been unmasked by the doxycycline he had taken two weeks earlier for sinusitis.

Now fast-forward to two months ago: I’m on the MICU service as a fourth-year acting intern, more than two years since the medicine clerkship (I’d taken a year off between third- and fourth-year). During one of our didactic sessions, the fellow began presenting a case of a 40-year-old previously healthy man who presented with mental status changes and moderate uremia. He begins by explaining how the patient’s partner didn’t want the fellow seeing the patient; the partner wanted the attending. Again…enter attending…magic words…fellow allowed to treat patient. Yes, it was James. And, yes, everyone in that room learned from James’ tragic condition.

The fellow went on to describe how important it is to see as many patients as possible; to not fold at their initial refusal of our presence. Those who cared for James during his hospitalization were not the only ones who learned from him. Every one of us who worked on his case can now share our experiences and pass on what we learned. Thanks to him, dozens of fellows, residents, students, and nurses know more. And it is because our attending stood up for us and pressed the issue of us being able to care for him.

This story helps me remember the three things I think about with every new patient:
1) I need to learn something from every patient I see; 2) I need to share what I’ve learned with my colleagues; and 3) I can’t immediately back down from the challenges patients present – be they social challenges, language barriers, or special requests. As students, we are at the bedside to learn – we learn best by seeing patients, managing their care, and teaching others. That is what will make us outstanding physicians.
Medical students develop EM Futures program in Texas

In Texas, medical students have been key leaders in the creation of an innovative program called EM Futures: Engaging Members, Developing Leaders. EM Futures is composed of four initiatives designed to recruit and retain members across the emergency medicine career spectrum. Its institution correlates with the Texas College of Emergency Physicians (TCEP) consistently exceeding the three percent annual membership growth benchmark set in the ACEP Strategic Plan for 2011-2014. Starter kits for the initiatives of emergency medicine Futures are now available on the ACEP website so other medical students and residents can launch EM Futures in their own states.

TCEP is the fourth largest state chapter in the United States. We lead the nation in membership gains. The medical student contribution to creation and implementation of EM Futures has been critical to these membership gains and increased participation. Our gains consistently surpass the ACEP Board of Directors’ goal by nearly threefold annually.

The four EM Futures initiatives and their target audiences are as follows:

1. Medical Student Leadership Initiative (MSLI) – medical students
2. TCEP Residency Visit Program – residents
3. TCEP Leadership and Advocacy Fellowship (TLAF) – young physicians
4. TCEP Mentors Program – active physician leaders

Medical students have been pivotal in envisioning and implementing these successful programs. Since 2006, TCEP has achieved annual growth of more than five percent with an all-time high of 1,587 total members. This year we anticipate membership growth of more than 11 percent. Each element of EM Futures achieves the following goals:

- Increase visibility and publicity for the specialty of emergency medicine.
- Provide opportunities for networking, leadership development, and mentorship for all participants.
- Increase membership, participation and retention in ACEP, TCEP, and EMRA through increased awareness of value and benefit.

The Medical Student Leadership Initiative was instituted in 2010. Since MSLI’s inception, medical student membership has increased by 48.7 percent, from 78 to 116 active members. MSLI contacts Emergency Medicine Interest Groups (EMIGs) across the state to host a meeting informing medical students of opportunities available to them in organized emergency medicine. Similar to the Residency Visits, the meetings conclude with an open panel Q&A with state leaders in emergency medicine.

The TCEP Residency Visit Program was instituted in 2006. Since the TCEP Residency Visit Program’s inception, resident membership in TCEP has increased by 69.4 percent, from 114 to 244 active members. TCEP coordinates lecture presentations on topics which include career development and advocacy, an open panel Q&A with state leaders and a networking breakfast and lunch. The program began with one visit in 2006, and currently boasts successful events at all nine residency programs in Texas.

The TCEP Leadership and Advocacy Fellowship was instituted in 2008. The fellowship is a yearlong program that mentors young physicians for future leadership positions in organized medicine. As ex-officio members of the TCEP Board of Directors, our fellows are actively involved on a local, state, and national level at meetings, retreats, and conferences. Over the past four years, we have trained a total of forty-one fellows, starting with seven in 2008 and growing to thirteen in 2011. Our fellows continue to be active TCEP members, participating as leaders within their groups and hospitals as well as in ACEP, TCEP, EMRA, Texas Medical Association, and county medical societies.

The TCEP Mentors Program was formalized in 2011 and serves as the backbone for the above programs. The database of TCEP Mentors, organized by region and containing 130 members, is a source of speakers for Residency Visits and MSLI meetings. TCEP Mentors also serve as formal advisors for young physicians, residents, and medical students interested in leadership opportunities and career development. We aim to achieve three percent annual growth in the database, providing greater opportunities for TCEP members each year.

These programs, developed and supported by TCEP, are reproducible and can be easily implemented by medical students and residents in all state chapters. Following national implementation of EM Futures by other dedicated medical students and residents, we anticipate accelerated membership and engagement of all members that will lead to a stronger voice for our emergency patients. Residents and medical students have this key opportunity to make a difference on a state and national scale.
Residency fairs – A Parisian cheese aisle of choices: Advice for DO applicants

Nothing quite describes the essence of a residency fair like the look on a medical student’s face as they enter one for the first time. I discovered this recently while playing the role of Official Greeter and EMRA Raffle Card Distributor during EMRA’s Residency Fair at ACEP’s Scientific Assembly.

Anyone who has attended a residency fair can agree that they are busy. They are loud, crowded, hot, and hectic. But then again, so is the typical emergency department. So what specifically is it about a residency fair that immediately drains the color from every medical student’s face?

My conclusion: Choices.

Yes, residency fairs are like the cheese aisle in a Parisian grocery store – foreign, intimidating, and incredibly overwhelming. As medical students, we are burdened with a wide, delicious array of fabulous programs. How can we possibly narrow down the choices? For osteopathic medical students in particular, the list is even longer. Plus, with an earlier match than the allopathic programs, osteopathic students must decide very early on where to focus their attention. So which route should I take?

I decided to approach this issue the same way I approached most predicaments while living in France. When the gargantuan display of foreign-labeled cheeses got too scary, I’d scrounge up some courage, gather my thoughts – and in broken French – politely ask for some expert assistance.

Megan McGrew might not be an expert on French cheeses, but she sure knows a lot about being accepted to your residency of choice. I asked her to share some advice about how to navigate through third and fourth year. In true French fashion, she politely accepted.

Here, she comments on differences between DO and MD residencies, how to highlight yourself as an applicant, and most importantly, how to focus on what truly matters to you in a program.

Name: Megan McGrew, DO, MBA, MS

Year of Training and Program: PGY2 at Midwestern University/CCOM Emergency Medicine Residency Program

Medical School and Graduation Date: Kansas City University of Medicine and Biosciences, May 2010

Was there ever a point in which you liked both osteopathic and allopathic residency programs?

Actually, no – I was involved with the ACOEP throughout medical school and knew a good deal about the osteopathic programs. I was very impressed by several of them and knew that they would provide me with the education I needed.

What did you take into consideration when choosing between DO versus MD residencies?

One of the major differences I took into consideration was length of training – three years versus four. After speaking with recent emergency medicine grads from both osteopathic and allopathic programs and hiring companies at national conventions, I realized that some allopathic residents were struggling to get jobs straight out of three years of training. I even heard several examples of programs not hiring their own graduates until they went out and got “more experience.”

The consensus seemed to be that three years was maybe just a little too short and four years was just a little too long; and obviously, if there was a right answer, everyone would be doing it that way. So I wanted to err on the side of being over-prepared.

What was it about the osteopathic programs that made it feel like a better match for you?
The decision mainly came from my experience with the ACOEP nationally – this gave me the opportunity to work and interact with many graduates from osteopathic programs. As a result, I became confident that I would receive the education I needed from any program. Soon, my focus turned to finding a program that supported my future goals – leadership and the ability to practice in any environment.

Some of the bigger allopathic programs are located at Level I trauma centers – that usually excites most medical students. While you get to see some pretty gruesome cases, GSWs and stabings get pretty monotonous after a few months.

Additionally, only around four percent of the emergency departments in this country are Level I, so the odds that I will actually work in that environment are slim to none. More likely, I will be working in a suburban emergency department, where I will not have unlimited resources. I wanted to be trained like MacGyver so that no matter what environment I am thrown in, I could practice emergency medicine.

At some Level I centers, you get very good at knowing whom to consult and what number to call. To really learn, I have found that I need those moments where I get a little nervous; don’t have an attending behind me to answer questions; can’t “phone a friend” or look up the answer on an iPhone. That is where you really begin to think about the art of medicine!

I also wanted to be taught by specialists at academic institutions. So, I was looking for a program that allowed me to rotate at a variety of emergency departments to get a taste for both the Level I trauma center experience as well as the suburban feel.

When did you begin to research and set up fourth-year rotations?

I started researching programs first year of medical school at national ACOEP conferences through residency fairs. I started setting up fourth-year rotations one year in advance of each rotation, so really I began June/July of my second-into-third year.

Did you rotate through any allopathic programs?

No, I did not.

How important are standardized letters of recommendation (SLORs) to osteopathic programs?

Letters of recommendation can be very beneficial if written by someone well-known to the program and/or if the letter is personalized to show that the writer knows the student well – as opposed to using a generic template for every student.

How important is it to rotate through academic institutions?

EM is becoming so competitive that you need to rotate at as many places as possible to give yourself the best chance. If you see a weakness in your application, like low board scores, low GPA, I’d consider rotating nearly a requirement.

For students from medical schools without a residency program or for students from the newer medical schools – what is the best way to get more connected to osteopathic program directors?

The best way to get to know program directors, faculty, and residents from programs is to rotate there; attend their weekly academic conferences; or travel to national conferences in that specialty. Do your research – every program should have a website with contact information to get connected at least through email and express your interest in their program.

In general, do you think osteopathic programs and allopathic programs emphasize different qualities in their applicants? For instance, do they place different levels of importance on research, board scores, audition rotations, or SLORs?

Every program, regardless of osteopathic or allopathic accreditation, judges things slightly differently. Some programs weigh board scores heavily; whereas others will still review your application even if your grades aren’t stellar, as long as you have something to bring to the table. Of course, in certain situations, networking can play a big role in securing an interview, which can level the playing field come Match time. And then some programs place heavy emphasis on research and other leadership.

Your struggle as a student is to figure out which programs emphasize the things that matter to you. Personally, I knew I wouldn’t fit into a program where all my colleagues focused heavily on research; that is just not my main interest. I did want to be at a program where everyone had a great work ethic and a desire to be a great clinician.

Now that you are on the other side of The Match, what advice do you have for medical students interested in emergency medicine?

Go where you feel you fit in best. Don’t try to squeeze in somewhere just because of prestige, or what you think others might think. The Match really does work in favor of the students, so rank them according to your criteria. DO NOT try to game the system by trying to predict what programs might be thinking…And letting that guess affect your numbering.

If you could have done it all over again, what would you have done differently?

I wouldn’t have changed a thing! I am so happy with how things worked out. Along the way, I’m sure there were times where I wondered if I was making the right decision. But looking back, I believe everything happens for a reason and I’m confident I am where I was meant to be.
A patient presents to emergency department vomiting, hallucinating, anxious, tachycardic, and hypertensive – they may even be seizing. The urine drug screen is negative and the head CT and LP are normal. Poison Control provides general suggestions but no definite answer. What is going on?

It’s legal, relatively cheap, undetectable on most urine drug screens, and is another fad in designer drugs. K2, Spice, Demon, Genie, Mr. Nice Guy, and Hi-5 are only some of the brand names of the “incense” or “potpourri” mixtures you can buy in head shops, online, or even in your local gas station. It only costs about $40 for three grams and allows the user to avoid the illicit drug market. They’re all marked “not for human consumption.”

Commonly called “synthetic marijuana” or “fake weed,” the active compound is a synthetic cannabinoid, similar to tetrahydrocannabinol (THC). However, THC is only a partial agonist at cannabinoid receptors, while many of the synthetic cannabinoids are full agonists that bind to receptors with many times the affinity of THC.

The most commonly used compound ingredient has traditionally been JWH-018 (JWH are the initials of the compound’s creator, Dr. John W. Huffman), which was originally created for research purposes, and not designed for human consumption. Huffman states “Using these things is like playing Russian roulette because we don’t have toxicity data, we don’t know the metabolites, and we don’t know the pharmacokinetics.” Huffman mentions a girl who killed herself by jumping out of a window after smoking the chemical, and Iowa is investigating another suicide in a young teen that shot himself after smoking K2.

There are multiple synthetic cannabinoids that have been developed over the last 60 years either as pharmaceutical candidates or as research tools. Herbal incense laced with synthetic cannabinoids hit the market in Europe around 2004 and has since been banned nearly all European countries. Domestic use of synthetic cannabinoids has been gaining popularity, rapidly resulting in recent federal and state regulatory measures.

As of August 2011, poison centers nationwide have received over 4,000 calls involving synthetic cannabinoids, an increase of over 50 percent from the previous year. In one study, K2 usage was reported in eight percent of polled college students. Use of K2 in this study was higher than other drugs of abuse monitored in adolescents and young adults.

So what’s the big deal? While marijuana is the most widely used illicit substance in the country, it accounts for relatively few emergency department visits. The danger of K2 and other synthetic cannabinoids resides in the trend of users to equate the relative safety of cannabis to all cannabinoids. In addition, concentration and chemical contents vary from packet to packet, making the trademark statement “not for human consumption” the most accurate part of the label.

Unlike marijuana that often “mellows” patients, synthetic marijuana has more of a sympathomimetic toxidrome, common symptoms being tachycardia, hypertension, hallucinations, paranoia, severe anxiety, and even seizures. The pharmacology and toxicology of the cannabinoids is not fully understood.
Unlike marijuana that often ‘mellows’ patients, synthetic marijuana has more of a sympathomimetic toxidrome, common symptoms being tachycardia, hypertension, hallucinations, paranoia, severe anxiety, and even seizures.

understood but cannabinoid receptors are known to modulate effects of other neurotransmitters such as GABA and glutamate. Inhibition of GABA release with potent cannabinoid agonists has been postulated as a possible reason for patients presenting with sympathomimetic symptoms.

Tuesday, March 1, 2011 the DEA used its emergency authority to make illegal for one year the sales and possession of five synthetic marijuana products that include: JWH-018, JWH-073, JWH-200, CP47,497 and cannabicyclohexane. Bans also currently exist in Missouri, Arkansas, New York, New Jersey, Illinois, Louisiana, Michigan, Ohio, and most recently in Florida on July 1, 2011. Many other states are cued to follow this year. The need for regulatory legislation stems from the existing synthetic cannabinoids that skirt substance control law by being structurally different from THC – and by being labeled as “not for human consumption.”

So, once the ban is complete, all is well, right? Not quite. Manufacturers are quick to change the substance just enough to elude ban restrictions. The official K2 website, www.realk2incense.com, claims their new products include none of the DEA-banned substances, boasting its products to be the most potent in the US. Some new analogs are claimed by the company to be even more potent than previous substances. One group of researchers in Europe studied the herbal mixtures and showed that the composition of many of the examined products changed rapidly over time in response to bans.

Treatment in the emergency department can be summarized by the phrase “treat the patient, not the poison.” Supportive care and sedation with benzodiazepines is the mainstay. However, as tachydysrhythmias and hypokalemia have also been reported, patients should be observed until asymptomatic. Severe cases or large ingestions may require admission. Chronic usage has been studied in isolated cases and dependence has been reported. In one case report withdrawal symptoms were similar to those from cocaine; the patient took over a week in hospital detoxification to recover.

It is essential that the emergency physician keep up-to-date on the ever-changing drug and toxin market, assuring the best care is employed with every patient who comes into the emergency department. Avoiding over-reliance on confirmatory drug screens, offering prompt supportive care, consulting a medical toxicologist, and understanding the dynamic and dangerous synthetic drug market are strategies that ensure emergency physicians will be ready for just about any new recreational drug of abuse.

References
Head trauma in young athletes is concerning to parents, coaches, teachers, and physicians alike. Football is the most common sport associated with head injury. Downhill skiing, hockey, soccer, and wrestling are other sports with significant rates of head injuries. The majority of children experiencing blunt head trauma incur minor traumatic brain injury, better known as a concussion.

### Concussion Table 1. Concussion Symptoms

<table>
<thead>
<tr>
<th>Symptom</th>
</tr>
</thead>
<tbody>
<tr>
<td>Headache</td>
</tr>
<tr>
<td>Inability to complete goal-oriented tasks</td>
</tr>
<tr>
<td>Dizziness</td>
</tr>
<tr>
<td>Depression/anxiety</td>
</tr>
<tr>
<td>Confusion</td>
</tr>
<tr>
<td>Nausea or vomiting</td>
</tr>
<tr>
<td>Photophobia/phonophobia</td>
</tr>
<tr>
<td>Lethargy</td>
</tr>
<tr>
<td>Slow response to commands</td>
</tr>
<tr>
<td>Irritability</td>
</tr>
<tr>
<td>Diplopia</td>
</tr>
<tr>
<td>Insomnia</td>
</tr>
<tr>
<td>Poor balance</td>
</tr>
<tr>
<td>Decreased energy</td>
</tr>
<tr>
<td>Poor memory, balance, concentration</td>
</tr>
</tbody>
</table>

Concussion is defined as head trauma-induced alteration in mental status, with or without loss of consciousness (LOC). It is a functional rather than structural injury; as such, neuroimaging is normal whether LOC is present or not. Concussion is diagnosed by mechanism of injury and subsequent symptomatology (Table 1). The Standardized Assessment of Concussion (SAC) scale or neuropsychological testing can be used during evaluation as well. Athletes are tested at baseline, upon suspected concussion, then reassessed later and compared to baseline.

### Emergency department management

As always, start with the ABCs. Since concussion involves head trauma, consider C-spine injury. Test orientation and assess short-term memory. Ask: “What team did you play?” or “What’s the score?” This is the most sensitive way to diagnose sports-related concussion. Report of LOC and amnesia are of minimal utility for predicting the severity of TBI. Postural stability and gait should also be assessed.

Concussion history should be elicited from the patient or parent. Once a player suffers a concussion, they are at increased risk for subsequent concussions. Neuroimaging – to rule out an anatomic abnormality – should be considered. Medications such as acetaminophen can be given, but avoid NSAIDs. Anti-emetics can be used for symptomatic relief.

### Neuroimaging

The main concern in TBI is determining if an intracranial bleed is present. More than 90 percent of head CT scans obtained in alert children after minor head injuries are negative, suggesting that this modality may be overutilized. No specific signs and symptoms have borne out in the literature as being reliably predictive of intracranial abnormalities. That being said, most agree that a CT scan should be obtained for patients with a GCS<14, focal neurologic abnormalities, or if a basilar skull fracture is suspected.

“More than 90 percent of head CT scans obtained in alert children after minor head injuries are negative.”
A child without focal neurologic findings and a negative head CT can be safely discharged from the emergency department with close follow-up, as they are at very low risk for developing intracranial abnormalities.

**Anticipatory guidance includes mind and body**

<table>
<thead>
<tr>
<th>Table 2. Return to Play Steps</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. No activity. Complete physical and cognitive rest.</td>
</tr>
<tr>
<td>2. Light aerobic activity including walking, swimming, stationary cycling at 70 percent of maximum heart rate, no resistance exercise.</td>
</tr>
<tr>
<td>3. Sport-specific exercise and drills, but no head impact.</td>
</tr>
<tr>
<td>4. Non-contact training drills, more complex drills, and may start light resistance training.</td>
</tr>
<tr>
<td>5. Full-contact practice after athlete is asymptomatic at previous levels. Participate in normal training.</td>
</tr>
<tr>
<td>6. Return to normal game play</td>
</tr>
</tbody>
</table>

**Neurocognitive**
Activities that require concentration such as reading, driving, playing video games, watching television, and using a computer may exacerbate symptoms and should be avoided. Post-concussion students have reduced ability to rapidly process information as they recover. They may require a shortened school day as well as more time to complete tasks.

Students should not take tests after a concussion. Return to examinations should be considered as return to play, which would suggest no test taking until the child is asymptomatic throughout an entire day of school. Many schools offer programs to help students after a concussion, such as individualized educational plans (IEPs).

**Return to play**
Parents, coaches, and teachers always want to know when the child can return to play. The axiom, “When in doubt, sit them out,” is a safe initial guideline. No player should return to play on the same day as the injury. Children must be off analgesics, anti-depressants, anti-emetics, and other agents used to control post-concussive symptoms.

The most widely-accepted guidelines, supported by Concussion in Sport and the American Academy of Pediatrics (AAP), are listed in Table 2. Each stage should take at least 24 hours, resulting in a minimum of five days for return to full competition. Younger children and athletes with multiple concussions may take up to a month to become asymptomatic. If the athlete develops symptoms at any point during recovery, they should stop play immediately. Go back to the previous stage in return to play. There is limited data on concussion and return to play in children under 12 years old.

**Second impact syndrome**
Returning to play too soon can put the athlete at risk for second-impact syndrome. This is defined by the DSM-IV as repeat minor traumatic brain injury during the symptomatic phase of the first concussion. An additional head injury has the potential to cause cerebral vascular congestion from diffuse axonal injury, which can progress to cerebral edema, herniation, and death. As a result, nearly all authorities recommend an athlete be asymptomatic prior to return to play.

**Discharge instructions**
The AAP recommends observation in the emergency department for four to six hours. In the past some practitioners counseled parents to arouse the child periodically throughout the night; however, recent studies suggest this practice is not necessary. Passive observation at home is sufficient. Upon awakening, the child should be able to recognize their surroundings, speak normally, and walk with a stable gait.

**Take home**
After clinically or radiologically ruling out an intracranial hemorrhage, the key to concussion management is to protect patients from second impact syndrome and poor school performance. This can be done by education of parents, teachers, and coaches. It is important that those involved realize concussion is a functional rather than anatomic disturbance. As a clinician, think hard before obtaining a head CT unless high clinical suspicion exists. Education starts in the emergency department prior to discharge. It is important to address the concept of a structured period of cognitive and physical rest. Remember: “When in doubt, sit them out.”

**References**
A majority of medical school graduates accumulate a significant student debt burden, with the national average of student loan debt for medical school graduates surpassing $174,000 last year. Student loan regulatory updates and fluctuating financial markets have captured major headlines in recent months due to the significant impact they may have on student loan borrowers. This article reviews recent regulatory changes and provides an overview of the considerations that all EMRA members should evaluate in order to ensure they make the best decisions regarding their debt.

Legislative and regulatory updates impacting student borrowers

Throughout this year, the Obama administration has proposed multiple changes to existing federal student loan repayment programs. These updates may impact some borrowers’ debt retirement strategies and potential savings opportunities, so below we have highlighted the critical updates that all EMRA members need to consider when repaying their debt.

Enhancements to income-based repayment (IBR) – the ‘pay as you earn’ initiative

As you may be aware, IBR is a federal repayment program which limits borrowers’ monthly payment to 15 percent of their discretionary income and provides loan forgiveness for any remaining balance after 25 years of making qualifying payments. IBR helps eligible borrowers obtain payment relief and interest savings, as the government will pay any interest that accrues on their subsidized loans not covered by reduced monthly payment for up to three years after IBR begins. IBR has recently become a more common repayment option for medical residents.

Recently, President Obama introduced the Pay As You Earn initiative, which will accelerate enhancements to the IBR program originally scheduled for July 2014. Anticipated to begin as soon as 2012, Pay As You Earn will reduce monthly payments to 10 percent of discretionary income and forgive outstanding loan balances at the end of 20 years for eligible borrowers. Proposed eligibility requirements for Pay As You Earn require that a borrower must 1) have taken out their first federal loan no earlier than 2008 and 2) take out at least one more federal loan in 2012 or later. Although the proposed eligibility requirements limit the number of student borrowers affected by this update, this may change as the Department of Education negotiates the details of this program over the next six months.

In order to obtain the greatest savings through federal student loan relief programs, such as IBR, all students and residents should file a tax return this year regardless of income level, because how and when taxes are filed can have a direct impact on savings obtained. Monthly payments under IBR are based on a borrower’s Adjusted Gross Income (AGI) less 150 percent of the appropriate poverty line associated with the size of your household and a tax return can be used as income documentation for this purpose. Additionally, married borrowers must also consider the tradeoffs of “married filing jointly” versus “married filing separately” because of the impact reported AGI has on the benefits of IBR. This decision is dependent upon several factors including each partner’s income, potential deductions, and federal educational debt levels.

Unique consolidation opportunity – special direct consolidation loan program

The recently introduced Special Direct Consolidation Loan program will be available from January 1st through June 30, 2012. This program provides borrowers with at least one
Perform multiple consolidations grouped
a diverse loan portfolio may need to
as soon as possible. Borrowers with
should begin the consolidation process
for maximum benefits, EMRA members
complete, so in order to position loans
Consolidation can take months to
monthly payments.
for PSLF, and have their outstanding
majority of EMRA members will qualify
as a non-profit entity, it is likely that a
treated. With most hospitals qualifying
medicine practiced, or types of patients
limitations regarding geography, type of
other forgiveness programs, there are no
profit health system or hospital. Unlike
defined by the program, such as a non-
specified. The elimination of subsidized Stafford
loans means that graduate students will no longer have access to the interest
subsidies once paid by the government
during certain periods such as borrowers’
in-school, deferment or grace periods. However, students will still be able to
borrow unsubsidized Stafford loans.

It is important to note that this legislation is not retroactive. This means the current
benefits associated with subsidized loans will remain intact for borrowers who have obtained these loans prior to July 1, 2012.

Elimination of interest rebate for on-time payments
The Budget Control Act of 2011 also included the elimination of the on-time
payment rebate incentive for loans disbursed on or after July 1, 2012. At
that point, all student borrowers will be responsible for the full origination fee on
all federal Direct Loans they borrow (4 percent for Grad PLUS loans). Similar to
the aforementioned subsidized Stafford Loan change, this legislation is not
retroactive, so loans secured for this year or previous years will not be impacted.

Taking a comprehensive approach to managing your debt
It is critical to understand that as a medical student or resident, your debt retirement
strategies may be impacted by a majority of factors like the aforementioned regulatory
updates. In addition, due to time constraints and an emphasis on career building
activities, many EMRA members lack the time and resources to explore their options
to properly manage their outstanding debt. Since debt can have a significant effect
on financial net worth, it is important that debt be given equal consideration in any
financial plan.

We hope this article has provided you with some insight into your student debt
and repayment as well as clarified any previously misunderstood information
relating to the recent legislative and regulatory updates. Understanding how
to effectively manage your student debt burden as part of a comprehensive
financial plan is necessary as you prepare to navigate financial decisions often faced
by young professionals. To ensure you make the best financial decisions, we
recommend researching your options and consulting with a financial professional
who has expertise in the management of student loan debt.

*Based on data collected by AAMC, AMA and GL internal student database.
**Please note that there are two exceptions to this change: graduate students whose degree
requires preparatory coursework or whose teacher
certification requires a specific course will still be
allowed to borrow a subsidized Stafford loan.

GL Advisor is a division of Graduate Leverage, LLC (GL). GL Advisor does not offer all services to residents of North Dakota at this time. Investment services are provided by GL Investment Advisory Services, LLC and insurance services are provided by Graduate Leverage Insurance Services, LLC.
It’s Friday night, and the department is hopping with activity. Just when you feel like you’re getting a handle on the chart rack, a wild-eyed young man rushes through the ambulance entrance carrying a limp woman on his back. As the emergency department staff lowers the woman onto a stretcher, you quickly assess the ABCs. She is moaning incomprehensibly, breathing shallow, and is warm with bounding peripheral pulses. He admits that he and the woman had been speedballing – injecting heroin and cocaine intravenously – when she suddenly collapsed after a hit.

The nurse obtains a set of vitals: T 98.9 HR 99 BP 145/90 RR 10 Sat 90 percent with fingerstick glucose of 100. As you place the patient on supplemental oxygen, she begins to posture and deviate her eyes to the right. An intravenous line is placed and etomidate and rocuronium are administered for RSI. After intubation she is rushed for a head CT, which reveals diffuse subarachnoid hemorrhage.

Subarachnoid hemorrhage (SAH) is a true neurosurgical emergency, leading to significant morbidity and mortality even with prompt recognition and treatment. While most cases of SAH are the result of trauma and thus picked up on noncontrast head CT scans, the diagnosis of atraumatic SAH remains a hot topic in emergency medicine.

Atraumatic SAH has an international incidence of seven-to-nine cases out of 100,000 per year. While two percent of all emergency department visits are due to headache, only one percent of these patients will have SAH. Estimates of the rate of misdiagnosis for SAH vary considerably, though those with delayed diagnoses tend to have worse outcomes. The mortality rate of SAH is 40 percent; plus, a recent study indicated that SAH was the causative factor in 16 percent of hospital cardiac arrests.

Ruptured intracerebral aneurysms are the most common cause of atraumatic SAH. While 2.5 percent of the American population has aneurysms – acquired over time through aging and hypertension – most of these will not rupture. The risk of aneurysm rupture is based mainly on size, though it is unclear why aneurysms rupture when they do, and only a minority of SAH can be linked to valsalva, physical exertion, or sexual intercourse. Cocaine use has been implicated as both a causative factor and an indicator of poor prognosis.

The classically described “thunderclap headache” – a severe, rapid-onset headache reaching maximal intensity in seconds – and the “worst headache of my life” will only be ascribed to SAH or other serious pathology in roughly 15 percent of cases. There are no historical findings that will definitely rule in or rule out SAH. However, a new severe headache or a headache associated with syncope, seizure, or neurological findings should raise one’s suspicion.

The gold standard for diagnosis of SAH is lumbar puncture (LP). While it is common practice to order a head CT prior...
to LP to assess for subarachnoid blood or alternate diagnoses, in the neurologically intact patient, this can be low-yield, leading some experts to suggest an “LP first approach” for these patients.

It is important to note that the sensitivity of the CT scan for detecting SAH decreases as the time from headache onset increases. A recent multicenter study suggested a sensitivity of 100 percent for scans performed by third generation scanners (common in many emergency departments) at six hours after headache onset, but drops sharply to 85 percent after six hours. CT angiography and MRI have been suggested as new diagnostic modalities for SAH, though larger studies are needed to confirm their utility.

Cerebrospinal fluid findings suggestive of SAH include an increase or persistence in red blood cells from the first to the fourth tube. There is no consensus on how much the red blood cells should clear to indicate a traumatic tap versus true SAH. Xanthochromia, a yellowing of the CSF caused by the in vivo degradation of hemoglobin to bilirubin products, is highly suggestive of SAH, if present. If there is any ambiguity in the CSF findings, further diagnostic testing or repeat LP at another interspace is indicated.

Management of SAH
All patients diagnosed with SAH should be evaluated by a neurosurgeon or transferred to a facility that will be able to provide definite care through clipping or coiling. The emergency physician should be wary of myocardial stunning – acutely reduced ejection fraction and hypotension – that often occurs in cases of aneurysmal SAH. If the patient is hypertensive, there is conflicting data on whether acutely lowering the blood pressure improves outcomes. Anticoagulants such as warfarin should be reversed. To prevent vasospasm-related cerebral ischemia further in the patient’s clinical course, systematic reviews recommend early administration of nimodipine, a calcium channel blocker.

Conclusion
Emergency physicians should maintain a low threshold for initiating a workup for subarachnoid hemorrhage in patients with a new severe headache. Currently, there is no substitute for lumbar puncture in the diagnostic algorithm – especially in the setting of a negative head CT. Once diagnosed, early consultation with a neurosurgeon and an intensivist is key for good outcome.

References
1. Edlow JA. What are the unintended consequences of changing the diagnostic paradigm for subarachnoid hemorrhage after brain computed tomography to computed tomographic angiography in place of lumbar puncture? Acad Emerg Med. 2010 Sep;17(9):991-5; discussion 996-7.
Career Panel
This year EMRA hosted a Career Panel during the Medical Student Forum to give students an opportunity to ask riveting questions of our distinguished panel. Pictured left to right: Sara Lary, DO, Loma Linda University, Peter E. Sokolove, MD, FACEP, University of California-Davis, Derek Robinson, MD, MBA, FACEP, Centers for Medicare/Medicaid and Haney Mallemat, MD, University of Maryland.

Medical Student Luncheon
Medical students from around the country had a chance to engage sponsoring program directors and chief residents in one-on-one conversations during the Medical Student Luncheon.

Intern Panel
Another new feature to the EMRA programming this year was the Intern Panel, where students had questions answered on the best practices for the application process. Pictured left to right: Aaron Danielson, MD, University of California-Davis, Nathan Wilson, MD, University of California San Francisco, Shae Sauncy, MD, LSU New Orleans and Cameron Decker, MD, Baylor College of Medicine.

Residency Fair
Close to 300 medical students preparing for the interview season networked with 115 participating programs during the EMRA Residency Fair.
Career Panel

Representative Council at Work
EMRA President Don Stader addressing the Representative Council.

Resident Forum
Once again, EMRA’s spectacular list of speakers focused on the issues important to residents at all levels of training in the Resident Forum.

Job Fair
Thousands of eager job seekers networked with the 200 participating companies that exhibited at the EMRA Job Fair.

SimWars Winners
Congratulations to Alameda County Medical Center, Oakland California for this year’s SimWars victory! Pictured from left to right: Eric Snoey, MD, Director Simulation Education, Annie Chipman, MD, Nick Gavin, MD, Kris Chiles, MD and Gerin River, MD. Not pictured: Benjamin Wiederhold, MD.

Congratulations to this year’s 2011 National Emergency Medicine CPC Competition Winners!

Winners
Resident Presenter:
Nadine Himelfarb, MD
Warren Alpert Medical School of Brown University
Faculty Discussant:
Daniel Egan, MD
St. Luke’s – Roosevelt Hospital

Runners-Up
Resident Presenter:
Kevin Koehler, MD
Naval Medical Center Portsmouth
Faculty Discussant:
Tala Elia, MD
Baystate Medical Center

From Left: CPC Chair, Saadia Akhtar, MD and Tala Elia, MD. Not pictured: Kevin Koehler, MD.
The febrile solid organ transplant patient

Modern advances in transplantation surgery and immunosuppression have given patients with formerly incurable diseases a new chance at life. In the U.S. alone, more than 180,000 people were listed in the Organ Procurement and Transplantation Network (OPTN) as living with a functioning transplanted organ in 2007. In 2008, more than 27,000 organs were transplanted in the US alone. The long-term success of a solid organ transplant relies heavily upon immunosuppressive regimens – which walk a fine line between staving off rejection and predisposing to deadly infections. While most transplant programs are based in tertiary academic medical centers, every emergency medicine physician should possess a working knowledge of the wide spectrum of infections seen in the febrile transplant patient.

The timeline of infections typically occurs in three stages, reflecting surgical complications and the ensuing “net state of immunosuppression.” Type, dose, and duration of therapy, pre-existing immunodeficiency, iatrogenic neutropenia, and a host of other medical conditions, all factor into the latter. Postoperative infections related to surgical anastomoses (particularly in liver and lung grafts), fluid collections, and dehiscent wounds are most likely to present within the first month of transplant.

The common sequelae of prolonged hospitalization include central line, associated infections, pneumonias, and UTIs, frequently with multidrug-resistant organisms (e.g., methicillin-resistant Staphylococcus aureus, vancomycin-resistant enterococci, Gram-negative bacteria,azole-resistant Candida). Clostridium difficile colitis is common as well.

The donor organ itself may be a source of infection in rare cases, transmitting latent fungi (e.g., Aspergillus, Cryptococcus neoformans, Histoplasma capsulatum, Coccidioides immitis), viruses (e.g., cytomegalovirus [CMV], Epstein Barr [EBV], varicella zoster [VZV], and herpes simplex virus [HSV]), and parasites (e.g., Toxoplasma gondii, Trypanosoma cruzi, Strongyloides stercoralis). Recipient-derived infections resulting from reactivation after transplant with the onset of immunosuppression are also possible.

Immunosuppression to prevent rejection is usually the greatest after the first month, extending to the sixth month after transplant. The use of corticosteroids, calcineurin inhibitors (e.g., cyclosporine, tacrolimus, sirolimus), mycophenolic acid, azathioprine, and other immunosuppressive therapies (e.g., anti-lymphocyte antibodies) create a tremendous window for opportunistic infections, particularly in patients not on prophylactic antimicrobials.

For example, especially dangerous players arise in patients not taking trimethoprim-sulfamethoxazole – Pneumocystis jiroveci pneumonia, toxoplasmosis, Nocardia (causing lung and brain abscesses, particularly in heart transplant patients), and bacteremia or meningitis secondary to Listeria monocytogenes. Among the herpes viruses, CMV can
present as a febrile syndrome with viremia - or in more invasive cases, pneumonitis, hepatitis, or colitis, particularly in patients not on prophylactic antivirals (ganciclovir, valganciclovir, acyclovir, valacyclovir). Influenza and other respiratory viruses are also important to keep in mind.

Invasive fungal infections most commonly involve Candida or Aspergillus but may include C. neoformans and the endemic mycoses (H. capsulatum, C. immitis). Tuberculosis should also be considered in the appropriate clinical setting. Lastly, it is important to remember that graft rejection itself may manifest as a non-infectious cause of fever.

In transplant recipients with adequate graft function and no evidence of rejection, immunosuppression may be tapered as early as six months after transplant. From this point onward, these patients are more likely to present with the usual community-acquired infections (e.g., bacterial pneumonia, UTI). Yet they still retain some vulnerability to opportunistic infections, albeit to a lesser degree. For patients with acute or chronic rejection, prolonged and often heightened immunosuppressive therapy perpetuates opportunistic infection risk; at the same time, they are also susceptible to malignancies. In particular, post-transplant lymphoproliferative disorder (PTLD) secondary to EBV may manifest as fever, lymphadenopathy, and extranodal masses.

Apart from fever, the signs and symptoms of a potentially devastating infection may be absent as inflammatory processes are frequently muted in the face of immunosuppression. Patients presenting within the first six months of transplant, or on heavy immunosuppressive regimens for rejection, must be aggressively evaluated for occult infections. Obtain blood, urine, wound, and sputum cultures prior to antibiotics. Likewise, cultures should also be obtained from pre-existing central lines, urinary catheters, and surgical drains. Judicious use of CT, MRI, and ultrasound should be employed to look for abscesses and other hidden infectious processes.

Once mass lesions have been excluded, patients presenting with headache or altered mental status should undergo lumbar puncture to rule out meningitis or encephalitis – platelet count permitting. Consultation with a transplant surgeon, infectious diseases specialist, and the particular specialty involved based on the graft type (e.g., cardiology, pulmonary, nephrology) should be pursued to guide further testing and intervention.

Empiric antimicrobial therapy should cover both Gram-positive and Gram-negative organisms, usually including vancomycin plus an anti-pseudomonal β-lactam (cefepime) or carbapenem (e.g., meropenem, imipenem-cilastatin). The possibility of infection with a multidrug-resistant organism is high and should be accounted for. In critically ill patients where an invasive fungal infection is suspected (e.g., Candida, Aspergillus), consider empiric antifungal therapy with liposomal amphotericin B. Otherwise, guide therapy by culture data.

Empiric antiviral therapy should be undertaken in concert with an infectious diseases specialist unless there is clear evidence of HSV or VZV infection, usually in the form of characteristic skin lesions or viral encephalitis. Knowledge of the patient’s antimicrobial prophylaxis regimen can help narrow the differential diagnosis of possible infections and should guide rational antimicrobial choices. For instance, a patient on antiviral prophylaxis is unlikely to present with CMV, HSV, or VZV infection (although it is not impossible).

The approach to fever in the solid organ transplant patient hinges upon an appreciation of the timeline of possible infections after surgery and along the continuum of immunosuppression. The measured use of outpatient prophylactic antimicrobials has greatly reduced the incidence of life-threatening infection in high-risk transplant populations. Nevertheless, emergency physicians must remain vigilant for serious, and potentially fatal, infections in these extremely complicated and challenging patients.

References


One of the centerpieces of the health care bill passed in 2010 (officially, the Patient Protection & Affordable Care Act, or ACA) is the concept of Accountable Care Organizations (ACOs). This is a team-oriented approach to 1) coordinate the currently fragmented patient care and 2) realign financial incentives to help minimize inpatient hospitalizations and redundant tests. The federal government has touted ACOs as a way to simultaneously improve patient care; improve health outcomes; and reduce per capita costs.

What is an ACO? An ACO is a team that can consist of physicians, physician-assistants, nurse practitioners, networks of individual practices, joint venture arrangements between hospitals and providers, or hospitals that employ health providers. This team is specifically designed for flexibility.

How will ACOs improve coordination of care and quality? Ideally, each patient will have an individualized health care plan with both short- and long-term goals, which are all centered on preventative medicine and primary care. Since those within an ACO will have access to (much-improved) patient data storage and sharing methods, physicians can more easily coordinate care by requesting claims information data (with patient approval) from CMS. In addition to improved reporting and increased attention to specific quality factors, this is expected to improve both quality of care and health outcomes - while reducing the number of redundant tests ordered.

How is the ACO paid? In the initial phase, Medicare will pay physicians by fee-for-service. Later, Medicare and private payers will pay the ACO directly, and the ACO distributes that money to all providers based on a negotiated reimbursement scheme. Importantly, at the end of the year, an ACO may share in savings it creates from providing more efficient care, assuming the required quality metrics are reported.

How are physicians in ACOs paid? This depends on the agreement physicians have with the ACO, and may vary depending on specialty. Reimbursement for emergency physicians will ultimately depend on the perceived value of the services we offer.

CMS utilized fee-for-service payment, but ACOs – and healthcare in general – are slowly shifting towards a lump sum payment model for each clinical encounter. The goal of switching to a lump sum is to create financial incentives to encourage less resource use. Many experts expect a marked decrease in diagnostic tests and hospitalizations in order to rein in costs.

How are the ACO final rules different from the original proposed rules? The initial rules for ACOs included mandatory risk-sharing and electronic health record (EHR) usage, and required providers to follow 65 quality measures. With the final rule, the number of quality measures has been reduced to 33. EHR use is one of the most important quality measures, but not a prerequisite for an ACO. These changes are a significant response to the concerns

“With the failures of managed care in mind, it behooves us to vigilantly monitor the impact of ACOs on our autonomy, reimbursements, and medicolegal affairs.”
of many medical groups, and have been generally well received by organized medicine.

**How do ACOs affect emergency physicians?** Because of the massive startup costs in creating ACOs (estimated at $1.5 to $30 million), most physician groups are unable to acquire enough capital to organize themselves. Providers also typically lack 1) the infrastructure to successfully assess and manage risk, and 2) the experience managing finances and patient care effectively. As a result, hospitals and insurance companies are beginning to buy up physician practices in anticipation of an ACO-driven future.

Physicians have two main concerns regarding ACOs: 1) Since hospital systems are the main players with enough capital to make these changes, many emergency physicians working in independent groups are worried about being forced to become hospital employees. 2) Since hospitals may organize ACOs, they would also likely control how different parties within the ACO are reimbursed. Our reimbursement as emergency physicians will be subject to how valuable our specialty is deemed in the greater healthcare landscape. Physicians could potentially be left fighting for a smaller slice of the reimbursement pie.

**What are some other potential concerns about ACOs?** The “individualized care plans” required by ACOs may become fodder for lawyers in medical malpractice cases. Barring future legal protections, plaintiffs will be able to leverage specifics from an individualized care plan to argue that goals and duties within it were not met. This could unfairly increase the liability exposure of providers participating in ACOs. The emphasis on incorporating “evidence-based medicine” could similarly alter the standard of care, potentially increasing liability exposure while reducing physician autonomy.

What will the role of emergency physicians be in the overall healthcare landscape? The restructuring of healthcare systems, from independent providers to physician groups to comprehensive ACOs joined with hospitals, has yet to take shape on a national level. The ten participants in the ACO pilot program were integrated health systems that did not require the fundamental restructuring that ACOs will demand in the coming years.

Who will pay penalties, receive bonuses, and cover start up costs in ACOs in the future? How will emergency physicians prove their value as part of an ACO? How will hospitals manage the transition from hospitalization-based reimbursement to a model where shared savings are only achieved when hospitalization is avoided? And how can emergency physicians provide the most cost-effective care without medical liability reform?

We are approaching a paradigm-changing ACO-led future in health care, one that promises increased coordination of care, improved quality, and realignment of financial incentives. The concept of the ACO is an opportunity to improve care and coordination, while at the same time to control costs without slashing reimbursement to providers. With the failures of managed care in mind, it behooves us to vigilantly monitor the impact of ACOs on our autonomy, reimbursements, and medicolegal affairs.

We need to support studies by the American College of Emergency Physicians that seek to quantify the value of emergency medicine in order to improve our position when the ACO health care reimbursement pie is served. In addition, we should strongly advocate for solutions like EMTALA-provider liability reform (HR157) that are mutually beneficial for both emergency physicians and an ACO-based healthcare system.

Special thanks for the time, patience and wisdom gleaned from Barbara Tomar, ACEP Director of Federal Affairs, and Francis J. Crosson, MD, CEO & President of the Permanente Company, and senior fellow at the Kaiser Permanente Institute for Health Policy.

**References**

1. Commonwealth Fund, Promising Payment Reform: Risk-Sharing with Accountable Care Organizations


See “Proposed rule versus final rule for ACOs in the Medicare Shared Savings Program” on page 38
Proposed Rule versus Final Rule for Accountable Care Organizations (ACOs) in the Medicare Shared Savings Program

<table>
<thead>
<tr>
<th>Topic</th>
<th>Proposed Rule</th>
<th>Modifications in Final Rule</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transition to risk in Track 1</td>
<td>ACOs could choose from two tracks, each entailing a 3-year agreement. Track 1 would comprise 2 years of one-sided shared savings with a mandatory transition in year 3 to performance-based risk under a two-sided model of shared savings and losses. Track 2 would comprise 3 years all under the two-sided model.</td>
<td>Remove two-sided risk from Track 1. Two tracks would still be offered for ACOs at different levels of readiness, with one providing higher sharing rates for ACOs willing to also share in losses.</td>
</tr>
<tr>
<td>Prospective vs. retrospective</td>
<td>Retrospective assignment based on utilization of primary care services, with prospective identification of a benchmark population.</td>
<td>A preliminary prospective-assignment method with beneficiaries identified quarterly; final reconciliation after each performance year based on patients served by the ACO.</td>
</tr>
<tr>
<td>Proposed measures to assess quality</td>
<td>65 measures in 5 domains, including patient experience of care, utilization claims-based measures, and measures assessing process and outcomes. Pay for full and accurate reporting first year, pay for performance in subsequent years. Alignment of proposed measures with existing quality programs and private-sector initiatives.</td>
<td>33 measures in 4 domains. (Note: Claims-based measures not finalized to be used for ACO-monitoring purposes) Longer phase-in measures over course of agreement: first year, pay for reporting; second year and third year, pay for reporting and performance. Finalize as proposed.</td>
</tr>
<tr>
<td>Sharing savings</td>
<td>One-sided risk model: sharing beginning at savings of 2%, with some exceptions for small, physician-only, and rural ACOs. Two-Sided Risk Model: sharing from first dollar.</td>
<td>Share on first dollar for all ACOs in both models once minimum savings rate has been achieved.</td>
</tr>
<tr>
<td>Sharing beneficiary ID Claims Data</td>
<td>Claims data shared only for patients seen by ACO primary care physician during performance year; beneficiaries given opportunity to decline at the point of care.</td>
<td>The ACO may contact beneficiaries from provided quarterly lists to notify them of data sharing and opportunity to decline.</td>
</tr>
<tr>
<td>Eligible entities</td>
<td>The four groups specified by the Affordable Care Act, as well as critical access hospitals paid through Method II, are eligible to form an ACO. ACOs can be established with broad collaboration beyond these providers.</td>
<td>In addition to groups included in the proposed rule, Federally Qualified Health Centers and Rural Health Clinics are also eligible to both form and participate in an ACO. In order for beneficiaries to be assigned on the basis of utilization of primary care services, these organizations must provide a list of practitioners who directly render primary care services in their facilities.</td>
</tr>
<tr>
<td>Start date</td>
<td>Agreement for 3 years with uniform annual start date; performance years based on calendar years.</td>
<td>Program established by January 1, 2012; first round of applications are due in early 2012. First ACO agreements start 4/1/2012 and 7/1/2012. ACOs will have agreements with a first performance “year” of 18 or 21 months. ACOs starting 4/1/2012 and 7/1/2012 have option for an interim payment if they report CY 2012 quality measures. ACO must report quality measures for CY 2013 to qualify for first-performance year shared savings.</td>
</tr>
<tr>
<td>Aggregate reports/preliminary prospective list</td>
<td>Reports will be provided at the beginning of each performance year and include: name, date of birth, sex, and health insurance claim number.</td>
<td>Additional reports will be provided quarterly.</td>
</tr>
<tr>
<td>Electronic health record (EHR) use</td>
<td>Aligning ACO requirements with EHR requirements, 50% of primary care physicians must be defined as meaningful users by start of second performance year.</td>
<td>No longer a condition of participation. Retained EHR as quality measure but weighted higher than any other measure for quality-scoring purposes.</td>
</tr>
<tr>
<td>Alignment process</td>
<td>One-step assignment process: beneficiaries assigned on the basis of a plurality of allowed charges for primary care services rendered by primary care physicians (internal medicine, general practice, family practice, and geriatric medicine).</td>
<td>Two-step assignment process: Step 1: for beneficiaries who have received at least one primary care service from a physician, use plurality of allowed charges for primary care services rendered by primary care physicians. Step 2: for beneficiaries who have not received any primary care services from a primary care physician, use plurality of allowed charges for primary care services rendered by any other ACO professional.</td>
</tr>
<tr>
<td>Marketing guidelines</td>
<td>All marketing materials must be approved by the Center for Medicare and Medicaid Services (CMS).</td>
<td>“File and use” 5 days after submission and after certifying compliance with marketing guidelines; CMS to provide approved language.</td>
</tr>
</tbody>
</table>
1. A 74-year-old woman presents with weakness in her legs. She cannot walk and says that she has not seen a doctor in the past 10 years. She has had a rash on both shins for 4 months that has not responded to over-the-counter corticosteroids. Which of the following additional findings supports a diagnosis of myopathy?
   A. Distal muscle weakness with abnormal sensation and loss of control of bladder or bowel
   B. Intermittent weakness that is relieved by rest with normal reflexes and normal sensation
   C. Proximal muscle and limb girdle weakness with muscle tenderness and normal reflexes
   D. Symmetrical ascending weakness with decreased or absent reflexes and minimal sensory involvement

2. What is the most common cause of small bowel obstruction in children?
   A. Adhesions
   B. Hernia
   C. Intussusception
   D. Midgut volvulus

3. Which of the following statements regarding the use of multidetector CT pulmonary angiography to diagnose pulmonary embolism is correct?
   A. Inadequate contrast administration can lead to a false-positive result
   B. Motion artifact leads to a false-negative result
   C. Sensitivity for detecting any pulmonary embolism is higher than 97%
   D. Sensitivity is improved with venous phase CT venography of the lower extremities

4. Intermittent agitation and rapid, full return of consciousness from a state of coma are characteristic of poisoning from which of the following agents?
   A. Carisoprodol
   B. Flunitrazepam
   C. Gamma-hydroxybutyric acid
   D. Methylene dioxymethamphetamine

5. A 24-year-old woman presents with abdominal and chest pain after falling off of a horse. Chest radiograph reveals some irregularity of the left hemidiaphragm. Which of the following provides the most useful diagnostic information?
   A. Location of the abnormal finding
   B. Placement of a nasogastric tube
   C. Results of diagnostic peritoneal lavage
   D. Results of MRI
Risk management pitfalls in the treatment of mild traumatic brain injury

1. “I am concerned about child abuse, but this patient does not have current signs of MTBI.” If there is any suspicion of nonaccidental trauma, the pediatric patient warrants a head CT for evaluation of acute as well as old intracranial injury. Physicians are required to report a suspicion of child abuse, not to prove the etiology.

2. “Though the patient appears well and there wasn’t a suspicious history of severe injury, I am not comfortable with discharge unless I obtain a head CT to rule out injury.” Ordering imaging studies without true indications to completely rule out a diagnosis is a practice of defensive medicine that is not in the patient’s best interest nor is it cost efficient.

3. “It’s the PMD’s job to discuss concussion management.” The emergency clinician is responsible for providing discharge instructions and return to activities information as well as recommended appropriate follow up.

4. “I will order the head CT because I don’t want to miss something and be sued.” Doctors with a higher fear of malpractice order more head CTs in pediatric patients with minor head injury. Such practices have been termed “defensive medicine” and are not in the patient’s best interest.

5. “The patient has a mild head injury and seems well. Although there was a similar injury last week, this patient likely does not have TBI.” Second impact syndrome is an important concern for the re-injured concussive patient. The threshold to obtain imaging in a symptomatic patient with repeat injury should be lower.

6. “There’s a large cephalohematoma, but it’s frontal, so I am less concerned for skull fracture.” Large cephalohematomas may hinder identification of palpable skull fracture regardless of their location.

7. “The 7-year-old boy who hit his head while skateboarding appears well, despite vomiting. We can send him home with an antiemetic and pain medication.” Take caution in discharging an older child with an antiemetic after CHI that has not been evaluated with head CT, since vomiting may be an indicator of intracranial process.

8. “A 5-year-old boy who came to the ED after falling off his tricycle was diagnosed with an upper respiratory infection. He appeared well without cephalohematoma or vomiting and was sent home, but he returned the next day with vomiting and was found to have a basilar skull fracture.” Cerebrospinal fluid rhinorrhea or otorrhea is a sign of basilar skull fracture. Children who have these signs should have the fluid tested for the presence of CSF.

9. “A 5-month-old baby who rolled off the bed is now lethargic, has a large parietal cephalohematoma, and has been intubated. We do not have neurosurgery or PICU in our community hospital. I will obtain a head CT to confirm ICH prior to transfer.” If there is a suspicion for a medical condition that is not best managed in your institution, transfer to the appropriate facility should be discussed as soon as possible and should not be delayed for imaging.

10. “This family appears reliable to monitor the patient with a CHI and concussive symptoms at home.” It is the emergency clinician’s responsibility: (1) to ensure that the patient has a primary medical provider to follow up with, (2) to discuss a course of action with the patient’s family in the event of return to the ED, (3) to ensure that the family has a way to get to the hospital, and (4) to discuss returning to the nearest facility in case of an emergency.
Risk management pitfalls for traumatic hemorrhagic shock

From the November 2011 issue of Emergency Medicine Practice. Reprinted with permission.

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1. “The patient said she couldn’t be pregnant.”
   All women of childbearing age who are hypotensive should have a pregnancy test done to exclude ruptured ectopic pregnancy.

2. “The patient might be bleeding, but he is rock-stable as long as he is getting fluids.”
   Resuscitation is not a substitute for definitive bleeding control.

3. “This trauma victim is paralyzed, so he must be in neurogenic shock.”
   Hypotensive victims of trauma must have hemorrhagic shock ruled out definitively.

4. “She was bleeding out. I had to address that first.”
   Trauma care goes ABC for a reason. There is nothing wrong with addressing circulation early, but airway and breathing come first.

5. “I read this awesome thing about permissive hypotension. I thought it was the way to go for everyone.”
   Permissive hypotension is contraindicated in patients with TBI.

6. “I know I can get this patient’s blood pressure back to normal if I attach him to the rapid infuser.”
   Normalizing blood pressure is contraindicated in patients who have ongoing bleeding.

7. “Trauma management is a cookbook. You just do the same thing for everyone and wait for the cavalry.”
   This is an abdication of responsibility and means we are not maximizing the patient’s chance for survival.

8. “Blood products are dangerous and this guy is only mildly hypotensive. I’m just going to give him 2 L of crystalloid and see what happens. I know all bleeding stops eventually.”
   Failing to recognize hemorrhagic shock and initiate treatment will leave your patient far behind the 8-ball.

9. “I read about early goal-directed therapy for sepsis and I saw the Surviving Sepsis guidelines. Clearly the right treatment for shock is 6 L of crystalloid empirically.”
   Treatment of shock must be tailored to the etiology of shock and to the specific patient. Large-volume crystalloid resuscitation is discouraged in hemorrhagic shock.

10. “This old guy syncopized and it’s not clear why. I suspect his low blood pressure is just his baseline.”
    Consider gastrointestinal bleeding and aneurysmal rupture as etiologies of hypotension and syncope. Early appropriate treatment and endoscopic or surgical bleeding control will help this patient.

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To find out more about our fellowship and to apply, go to [www.eusfellowships.com](http://www.eusfellowships.com) or contact Uché Blackstock, MD RDMS at ublackstock@gmail.com and Joseph Novik, MD, RDMS at novik9111@gmail.com.

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**St. Luke’s Roosevelt**

Continuum Health Partners, Inc.

The Global Health Division of the Department of Emergency Medicine at St. Luke’s Roosevelt Hospital is offering a two-year fellowship focusing on HIV/TB, Tropical and Travel Medicine. Within this program fellows will acquire public health and clinical training in the most pressing global health issues of our time, while working in a highly-regarded adult and pediatric emergency department in New York City.

**Features include:**

- Adult and pediatric HIV, TB and Travel Medicine rotations  
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- Diploma in Humanitarian Relief  
- Structured overseas rotations  
- Opportunity to work with NGOs  
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- ED volume of 150,000+ per year  
- Academic center with 3-year residency program, ultrasound and simulation fellowships

Accepting qualified adult and pediatric EM trained applicants.

Contact: [applications@slredglobalhealth.org](mailto:applications@slredglobalhealth.org)  
Visit our website at: [www.slredglobalhealth.org](http://www.slredglobalhealth.org)
With Essentia Health, you’ll find a supportive group of 750 physicians across 55 medical specialties. Located in large and small communities across Minnesota, Wisconsin, North Dakota and Idaho, Essentia Health is emerging as a leader in high-quality, cost-effective, patient-centered care.

EMERGENCY MEDICINE OPPORTUNITIES IN MINNESOTA AND WISCONSIN

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• Option to acquire additional shifts from nearby hospitals within system
• Established and growing health system with strong resources
• EPIC electronic medical records
• Communities with abundant outdoor recreation and great quality of life
• Competitive salary and benefits package, including malpractice, disability and retirement
• Some positions at NHSC loan repayment sites

Requirements
BC/BE in Emergency Medicine or Family Medicine

Contact Us
EssentiaHealth.org/careers
800.342.1388 ext 63165
Southern California, Moreno Valley: Excellent Compensation with full-time/partnership and part-time opportunities in a growing area and dynamic medical community. Moreno Valley Community Hospital is a modern, 101-bed hospital situated in the developing “Inland Empire” near Riverside. The ED sees 30,000 pts./yr. EMP offers a competitive hourly rate plus, democratic governance, open books, and excellent compensation/bonus plus shareholder status after one year. Compensation package includes comprehensive benefits with funded pension, CME account ($8,000/yr.), and more. Contact Bernhard Beltran direct at 800-359-9117 or 800.828.0898 or fax 330-828-0898 or e-mail: bbeltran@emp.com.

Connecticut, Meriden: MidState Medical Center was built in 1998, and this modern community hospital has a brand new ED seeing 55,000 EM pts./yr. Proximate to Hartford, New Haven and coastal residential options, MidState is also just 2 hours from New York City and Boston. EMP is an exclusively physician owned/managed group with open books, equal voting, equal profit sharing, equity ownership, funded pension, full benefits and more. Contact Ann Benson (careers@emp.com), Emergency Medicine Physicians, 4535 Dressler Rd. NW, Canton, OH 44718. 800-828-0898 or fax 330-493-8677.

Connecticut, New London: Lawrence & Memorial is on the coast near Mystic and sees 48,000 pts./yr. and an affiliated freestanding ED seeing another 30,000 pts./yr. Level II Trauma Center has supportive medical staff/ back up. EMP is an exclusively physician owned/managed group with open books, equal voting, equal profit sharing, equity ownership, funded pension, full benefits and more. Contact Ann Benson (careers@emp.com), Emergency Medicine Physicians, 4535 Dressler Rd. NW, Canton, OH 44718. 800-828-0898 or fax 330-493-8677.

Delaware, Seaford: EPMG is currently interviewing BC/BP EM physicians for opportunities at Nanticoke Memorial Hospital. EMP manages EDs at 4 community teaching hospitals seeing 32,000 – 71,000 pts./yr. with trauma center designations and EM residency teaching options. We are an exclusively physician owned/managed group with open books, equal voting, equal profit sharing, equity

West Virginia University
School of Medicine

Emergency Medicine Physician
West Virginia University School of Medicine announces an immediate opportunity for an emergency medicine physician at the St. Joseph’s Hospital, Buckhannon, WV location. The successful applicant will join four full-time EM physicians, and will have completed an accredited residency program in EM or EM/IM and be board certified/prepared. Besides direct patient care, responsibilities will include education of residents and medical students, and the opportunity for basic/clinical research does exist. St. Joseph’s Hospital, a 53 bed facility, is located in the Allegheny highlands of central West Virginia. The recently-renovated emergency department consists of 8 main ED beds (6 private and two semiprivate) and 4 fast track beds. At full staff, the EM department is comprised of five physicians offering single coverage 24 hours/day, 7 days/week. Physician coverage is augmented by 10 hrs per day of Mid-Level Provider coverage. 22,000 EM patients are treated yearly. St. Joseph’s provides 24/7 radiology services including CT and Xray, surgical back-up, obstetric/gynecology backup, and a hospitalist service. Appropriate candidates can also explore clinical opportunities at our other locations in Bridgeport, WV (51,000 visits) and Morgantown, WV (44,000 visits). Buckhannon, WV is town that combines a vibrant college culture with a rural small town feel. Abundant social and recreational opportunities are available in the area including skiing, boating, golfing, and hiking. WVU offers a highly competitive and comprehensive recruitment package. The position will remain open until filled. If interested, please submit an electronic CV and three references to:

Christopher Groode, MD
Vice Chair of Business Operations, Emergency Medicine
cgroode@hsc.wvu.edu
http://www.hsc.wvu.edu/som/em/
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Emergency medicine physicians, please contact Amy-Catherine McEwan at 301.944.0049 or e-mail to ACMcEwan@emergencydocs.com.
**Louisiana, Lake Charles:** FT/PT BC/BP EM physician sought for private group in 35,000 volume ED. **Total package over 500k compensation.** Practice site Lake Charles Memorial Hospital, region's largest family-centered medical complex, serving healthcare needs of Southwest Louisiana and Southeast Texas. Established in 1952, consists of 324-bed facility at main campus. Area’s recognized leader in trauma care, most BC residency trained EM physicians, most medical specialties & subspecialties, only PEDI ICU, only PEDI intensive care specialist, most ER trauma trained specialists on staff, only psychiatric triage center, and the only family medicine residency program in the area. Located in Calcasieu Parish, Louisiana with a population of just under 200,000, Lake Charles is home to McNeese State University and the 12th largest seaport, the Port of St. Charles. Low crime, great schools and an easy drive to New Orleans and Houston. Contact Robert Anderson, MD, FACEP, ED Director, 337-824-6000 or email todaysok@aol.com.

**Maryland:** Is variety the spice of your life? Join the MEP Travel Physician Team! Variety is just one benefit of this unique position. Enjoy working at our 6 distinctive campuses, earn top-of-the-market compensation, and be part of the most dynamic Emergency Medicine practices in the mid-Atlantic! MEP is seeking ambitious, experienced BC/BC Emergency Medicine Residency-Trained Physicians to join the MEP Travel Physician team. Candidates must have ED experience to be considered, and willing to travel to our various sites. MEP offers a generous guaranteed hourly rate and benefits package totaling in excess of $340k. Sign on bonus, per diem and additional quarterly performance bonuses are also provided for this position. Only 120 hours of clinical work per month required. MEP Travel Physicians are cross credentialed and work at all MEP campuses. From the mountains of Western Maryland to the Chesapeake Bay, you will be an integral part of each MEP campus. MEP sees more than 350,000 patients per year in our EDs, from 50k community hospitals to Level III Regional Trauma Centers. If you crave something different, and have the experience and cultural fit we seek, this is the job for you! Visit EmergencyDocs.com to learn more about MEP and our facilities. For more information and to apply, contact Sharon Doggett at 214-860-6008 or e-mail CV to SDoggett@EmergencyDocs.com.

Lehigh Valley Health Network's Emergency Medicine Department—now managing 5 sites in Pennsylvania—has grown. Our 70+ salaried Emergency Medicine physicians and 30+ PAs and NPs enjoy a collegial atmosphere and evaluate over 200,000 patients annually. Whether you want to work in a large 48-bed ED in a Level I trauma center or in a smaller ED with a more community-type setting, we have the fit for you. Credibility, respect, fairness and pride are values that are at the heart of everything we do for our patients and each other. We know that creating a place where the best people want to work is what makes it possible for us to provide the best possible care to our community.

Candidates must be clinically excellent, patient focused, EM Board Prepared or Board Certified. We have a paperless ED, a dually accredited 56-resident Emergency Medicine Residency, the largest Level I Trauma program in Pennsylvania with Primary Angioplasty, a Stroke Alert, and an MI Alert Program, and an 18-bed Burn Center, along with 13 additional accredited programs. We have just opened a new 12-bed Children’s ER—staffed with Pediatric Emergency Medicine fellowship-trained physicians. We offer a competitive salary, wonderful work environment with excellent physician and mid-level coverage, and robust benefits including healthcare with no employee contribution, 3 methods of retirement saving, medical liability coverage, 6 weeks of PTO plus 1 week of CME annually, ACEP/ACOEP boards paid, + more. Opportunity for teaching, research, and career advancement. Our ED locations are in the Lehigh Valley and in Hazleton, PA. All locations are within 1.5 hrs. of NYC and 1-2 hrs. of Philadelphia. Our members find a healthy lifestyle, moderate cost of living, excellent public schools and pleasant neighborhoods. No long commutes.

For 16 years in a row, we’ve been recognized by U.S. News & World Report as one of the nation’s best hospitals. LVHN’s unique culture fosters dedication, communication, respect and teamwork and values the contribution of every physician, nurse and staff member. Our passion for better medicine is what drives us to excel.

Qualified, energetic, and interested candidates should contact Deb D’Angelo at 610-969-0216 or send CVs to: Debra.D’Angelo@LVHN.org
Two of Texas’ primary emergency medicine groups, Dallas-based Questcare and GHEP of Houston, have teamed up to create a higher level of EM services in San Antonio.

Level 5 Healthcare is a joint entity of these two Texas EM groups. We are offering physicians the chance to get in on the ground floor. Ownership opportunities are now available in all 3 groups. Level 5, Questcare, and GHEP are owned and operated by practicing emergency medicine physicians.

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✓ Earn up to $165/hour (depending on the site)
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  • Home purchase assistance  • Early signing stipend
✓ Career development/advancement opportunities
✓ 11 different sites to choose from with volumes ranging from 12K to 40K
✓ Many sites are commutable from the New York City metro area

MedExcel USA, Inc. offers unparalleled opportunities for EM residents looking to practice in the Northeast. From low volume rural EDs to state of the art urban trauma centers MedExcel USA, Inc. provides physicians with a wide variety of potential practice settings. An extremely competitive compensation package includes a base salary, modified RVU and profit sharing.

MedExcel USA, Inc. is a quality-driven physician owned emergency medicine management group. We offer many innovative programs, including a “no-Wait ED” and a “Pain Sensitive ED” as well as unparalleled career opportunities and professional development. We offer a nurturing, physician friendly environment in which to develop your future. Career development opportunities are available for those interested in an administrative career track.

For additional information, contact Mark Douyard at 800-563-6384 x.258 or careers@medexcelusa.com

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Tallahassee Memorial HealthCare seeks full time BC/BP Emergency Medicine Physicians

Join an established and growing hospital employed department of 18 physicians and 8 extenders.

TMH is a 772-bed, regional tertiary-care and Level II Trauma Center with many designations such as Accredited Chest Pain Center and Accredited Stroke Center. Our main ED has 53 beds and sees over 70,000 patients per year. In 2012, we will break ground on our new 16-bed Freestanding ED. We are looking for enthusiastic and clinically excellent physicians who wish to be part of our expansion and providing a high level of care for our community.

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To learn more about this exceptional career opportunity contact Sandra Lee at 301-944-0049 or email CV to SLee@EmergencyDocs.com

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

North Carolina, Charlotte: EMP is partnered with 8 community hospitals and free-standing EDs in Charlotte, Gastonia, Lincoln, Pineville and Statesville. A variety of opportunities are available in urban, suburban and smaller town settings with EDs seeing 20,000 -70,000+ pts/yr. EMP is an exclusively physician owned/managed group with open books, equal voting, equal profit sharing, equity ownership, funded pension, full benefits and more. Contact Ann Benson (careers@emp.com), Emergency Medicine Physicians, 4535 Dressler Rd. NW, Canton, OH 44718. 800-828-0898 or fax 330-493-8677.

North Carolina, Hickory: We are seeking an EM resident graduating 2012 for a growing, progressive, ED with 50k+ visits/year. Opportunity to earn over $350k with excellent benefits. Well established, democratic group for almost 30 years. Full partnership within 2 years. No “senior partnership”. No “buy in”. Award winning hospital with U/S, PACS, 64 slice CT, fast track, and full dictation all in ED. Our current managing
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FEP is currently seeking BC/BP Residency Trained Emergency Medicine Physicians, to join the ED team at Florida Hospital Zephyrhills in Zephyrhills, FL. Zephyrhills is a 154-bed full-service hospital with full-range of inpatient and outpatient services including the only Nationally Accredited Heart Failure Institute in East Pasco County. Our state-of-the-art emergency department sees over 34,000 patients annually, has 26 monitored beds with overflow capability of adding 24 more beds for transitioning to inpatient care. For more information please visit our website at www.floridaep.com.

Contact
Brian A. Nobie, MD, FACEP or David Sarkarati, DO, FACEP at (800) 268-1318

To apply, please email CV to Susan Yarcheck at syarcheck@floridaep.com or fax to (407) 875-0244
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North Carolina, Kinston: Located in the center of eastern North Carolina, Kinston is less than 60 miles to the east are some of the most beautiful beaches of the Carolina coast and 35 miles from Greenville. 200-bed full-service community hospital treats 41,000 ED pts./yr. Outstanding partnership opportunity includes equal profit sharing, equity ownership, funded pension, open books, full benefits and more. Contact Ann Benson (careers@emp.com), Emergency Medicine Physicians, 4535 Dressler Rd. NW, Canton, OH 44718. 800-828-0898 or fax 330-493-8677.

North Carolina, New Bern: Respected 313-bed regional medical center located at the intersection of the Trent and Neuse Rivers just off the central coast. 73,000 ED pts./yr. Outstanding partnership opportunity includes equal profit sharing, equity ownership, funded pension, open books, full benefits andmore. 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.

North Carolina, Kinston: Located in the center of eastern North Carolina, Kinston is less than 60 miles to the east are some of the most beautiful beaches of the Carolina coast and 35 miles from Greenville. 200-bed full-service community hospital treats 41,000 ED pts./yr. Outstanding partnership opportunity includes equal profit sharing, equity ownership, funded pension, open books, full benefits and more. Contact Ann Benson (careers@emp.com), Emergency Medicine Physicians, 4535 Dressler Rd. NW, Canton, OH 44718. 800-828-0898 or fax 330-493-8677.

North Carolina, New Bern: Respected 313-bed regional medical center located at the intersection of the Trent and Neuse Rivers just off the central coast. 73,000 ED pts./yr. 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.

Southern NJ democratic group incorporated for over 10 years looking for BC/BP EM physician. Physicians interested in stability and lifestyle wanting to join a group of physicians dedicated to providing top-notch EM services at our Regional Medical Center in Vineland, Elmer Hospital in Elmer, and a SED in Bridgeton. This family-oriented community is close to city and shore with the option of suburban, urban or shore living. Salary competitive with an excellent benefit package. Full partner/shareholder eligibility after one year with EM board certification. Opportunities to work with residents are available.

Contact: Scott Wagner, MD
Emergency Medicine, South Jersey Health System
856-641-7733 / e-mail wagners@sjhs.com
Ohio, Barberton and Wadsworth: SUMMA Health System-Barberton Hospital is a full-service community hospital in southern suburban Akron with 44,000 ED visits/yr. WRH Health System in Wadsworth sees 20,000 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 Ann Benson (careers@emp.com), Emergency Medicine Physicians, 4535 Dressler Rd. NW, Canton, OH 44718. 800-828-0898 or fax 330-493-8677.

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

Ohio, Lima: Meet your financial and practice goals. Named among Top 100 Hospitals, this 57,000 volume, level II ED will complete an expansive, state-of-the art renovation in 2012. Excellent coverage and great compensation make this opportunity ideal. Package includes guaranteed hourly plus RVU and additional incentives, malpractice, employer-funded pension, family medical plan CME/expense account, and shareholder opportunity at one year with no buy-in. Premier’s outstanding record of physician and client retention, plus stable risk management program add to the appeal. For additional information contact Kim Rooney, Premier Health Care Services, (800) 726-3627, ext 3674, e-mail krooney@phcsday.com, fax (937)312-3675.

Ohio, Marion: Appealing Columbus area opportunity. Enjoy equity ownership with democratic group in 48,000 volume ED.
45 miles north of Columbus. State-of-the-art ED, excellent coverage of 62 physician & 18 PA hours daily. Terrific package includes guaranteed hourly plus additional incentive and outstanding benefits including employer-funded pension, family medical plan, expense account and malpractice; plus shareholder opportunity at one year with no buy-in.

Contact Amy Spegal, Premier Health Care Services, (800) 726-3627, ext 3682, aspegal@phcsday.com, fax (937) 312-3683.

**Oklahoma, Tulsa**: Modern 800+ bed community hospital sees 81,000 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 Ann Benson (careers@emp.com), Emergency Medicine Physicians, 4535 Dressler Rd. NW, Canton, OH 44718. 800-828-0898 or fax 330-493-8677.


**Pennsylvania, Erie**: Emergency Medicine positions with UPMC Hamot in Erie, Warren, Kane and St. Marys, Pennsylvania. Opportunity in Erie at 412-bed level II trauma center. EM volume over 66,000 patients per year and growing. EM residency onsite. Also rural positions in 30 to 90 bed acute care facilities located in the Allegheny Mountains. Positions...
Getting to know the people at TeamHealth has changed my view of what I perceived a large group would be. They let me lead, and they support our team. I now know TeamHealth and its leadership to be of the highest integrity, and that is essential when I am looking for the best people to be part of my team.

Kip Wenger, DO, FACOEP, FACEP, Medical Director (far right), takes a break with colleagues Dr. David Linn, left, and Todd Allen, RN, during a team-building hike.

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

Pennsylvania, Greenville/Sharon: UPMC Horizon, with hospital sites in Greenville and Farrell, PA, serves the Mercer County region in northwestern PA and offers a wide range of services at both campuses. The Greenville Campus ED sees 17,000 patients annually with 24 hours of physician coverage (12 hour shifts) and 10 hours of mid-level provider coverage. The Shenango Valley Campus ED sees 15,000 patients annually with 12-hour physician shifts. The cost of living is low, the patient population is pleasant, outdoor activities are plentiful, and the amenities of Pittsburgh are easily accessible. We offer an excellent salary with full benefits including: paid malpractice insurance with tail, employer-funded retirement plan, paid health insurance, CME allowance, and much more. Board certification/prepared in EM is required. Call Dr. Robert Maha at 888-647-9077/Fax 4124327480 or e-mail: mahar@upmc.edu.

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Sharon:
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Pennsylvania, Greenville/Sharon: UPMC Horizon, with hospital sites in Greenville and Farrell, PA, serves the Mercer County region in northwestern PA and offers a wide range of services at both campuses. The Greenville Campus ED sees 17,000 patients annually with 24 hours of physician coverage (12 hour shifts) and 10 hours of mid-level provider coverage. The Shenango Valley Campus ED sees 15,000 patients annually with 12-hour physician shifts. The cost of living is low, the patient population is pleasant, outdoor activities are plentiful, and the amenities of Pittsburgh are easily accessible. We offer an excellent salary with full benefits including: paid malpractice insurance with tail, employer-funded retirement plan, paid health insurance, CME allowance, and much more. Board certification/prepared in EM is required. Call Dr. Robert Maha at 888-647-9077/Fax 4124327480 or e-mail: mahar@upmc.edu.
Pennsylvania, Pittsburgh: Alle-Kiski Medical Center in Natrona Heights boasts a brand new ED to see 36,000 emergency pts./yr. Proximate to Pittsburgh’s most desirable residential communities, the area also affords easy access to abundant outdoor recreation and nationally ranked schools. Outstanding partnership opportunity includes equal profit sharing, equity ownership, funded pension, open books, full benefits and more. Contact Ann Benson (careers@emcp.com), Emergency Medicine Physicians. 4535 Dressler Rd. NW, Canton, OH 44718. 800-828-0898 or fax 330-493-8677.

Pennsylvania, Uniontown: Outstanding financial opportunity with Emergency Resource Management. Uniontown Hospital is a full service community hospital with a modern ED and excellent physician and mid-level provider coverage. The surrounding community offers a great lifestyle with plentiful outdoor activities, a low cost of living and the amenities of Pittsburgh are easily accessible. We offer an outstanding compensation/benefit package including: paid malpractice insurance with tail, employer-funded retirement plan, paid health insurance, CME allowance, and much more. Board certification/prepared in EM is required. Call Dr. Robert Maha at 888-647-9077/Fax 412-432-7480 or e-mail: mahar@upmc.edu.

Texas, Cypress: North Cypress Medical Center, Cypress, TX (10 Miles North of Houston). Cypress Emergency Associates (CEA) is an independently owned physician group in Cypress, Texas. CEA is seeking BC/BP Emergency Medicine Physicians to join our group. NCMC is a 170-bed acute care hospital with a 26-bed ED and an annual volume of 42,000. State-of the art equipment, acute MI/stroke programs, ER ultrasound program. Physician coverage is 44 hours per day with mid-levels covering 12 hours in fast track. Willowbrook Freestanding ER, 6 miles east of main campus, 14 beds, CT, U/S, lab onsite, annual visits 12,000. Spring Cypress Freestanding ER OPENING FALL 2011, 6 miles north of main campus, 10 beds, CT, U/S, lab onsite. What’s in it for you? Hourly guarantee plus productivity; Independent Contractor status; Paid Malpractice Insurance with tail coverage. Interested candidates should contact Teri Geen at (800) 346-0747 ext. 6054 or email CV to tgeen@psrinc.net.

Texas, Odessa: EM Opportunity in Odessa, TX! Wonderful immediate opportunity for a BC ER physician who desires to live in Odessa, Texas and succeed in a busy Emergency Room (24,000 annual visits). This would be a hospital-based employment arrangement. Hospital offers Level IV Trauma, Novarad PAC System, Level III Nursery and 10 Operating Rooms along with an active Hospitalist program. Physician coverage is 24/7 with 12 hours of mid level coverage outside winter months – 2 mid levels during peak winter season. Admission rate is low for most ERs (11-15%) including observations. There is a high pediatric volume, although there is a Pediatric After Hours Clinic which attempts to capture non-emergent Pediatric volume. Facility recently obtained Chest Pain Accreditation and should have Stroke Accreditation soon. Intensivist coverage will be added effective September, 2011. The Hospital has earned a 5-star rating from HealthGrades for three straight years. The faculty is located in the beautiful “Open Sky” country of Odessa/Midland in west Texas. Enjoy the great sense of community, excellent schools, and reasonable cost of living in this quality medical community. Area has a wide variety of cultural and sporting events. Odessa is known for its diversity, contrasts and hospitality. Please e-mail CV: ihudson@iasishcare.com, fax: 615-467-1293 or call Irene Hudson at 877-844-2747, x1280.

Texas, San Antonio Area: NEW OPPORTUNITIES AVAILABLE! Emergency Service Partners, LP is seeking top-quality BC/BP emergency medicine physicians to support the expansion efforts of an existing contract in the north San Antonio area. ESP is a physician-owned and physician-operated partnership dedicated to providing quality care and patient satisfaction. Enjoy competitive productivity-based compensation, excellent work environments, partnership opportunity, equitable scheduling, and paid malpractice/tail coverage. Call us today at (888) 800-8237, e-mail mdjobs@eddocs.com, or visit www.eddocs.com for more information.

Texas, Texarkana: Emergency Medicine Opportunity – Waldy Regional Medical Center, Texarkana, TX – A 370-bed hospital with 40,000 emergency room visits per year has an opportunity for two (2) BC Emergency Medicine Physicians desirous of an employment arrangement with HPP. Facility is working to earn Level III Trauma designation in TX and AK. Primary service area has population of 65,000 and secondary has population of 250,000. All specialty physicians available for consult. Very strong hospitalist group with UAMS FP residents rotate in hospital. Experience using CORAL helpful, but not
required. Seeking candidates interested in making Texarkana “home.” As the oldest hospital in Texarkana, Wadley Regional Medical Center has a century-long tradition of providing compassionate, high-quality healthcare. As part of its commitment to provide innovative and outcome-based care, the hospital has pioneered many medical firsts for Texarkana. As the area’s first Joint Commission II certified Primary Stroke Center, Wadley also is proud to offer Texarkana’s only hospital-based prenatal clinic and geriatric behavioral health unit, as well as the area’s only da Vinci Si Surgical System. In 2010, Texarkana Independent School District was ranked No. 4 on Forbes magazine “Best Schools for Your Housing Buck” in cities where the median home value is less than $100,000. Its diversified economy is supported by manufacturing, agriculture, medicine, transportation, education and retail. A thriving metro-center serving nineteen counties in four states, it is conveniently situated one hour from Shreveport, two hours from Little Rock and three hours from Dallas. Please e-mail CV: ihudson@iashishcare.com, fax: 615-467-1293 or call Irene Hudson at 877-844-2747, x1280.

**West Virginia, Charleston:** BP/BC EM physician opportunity within academic environment. This three-hospital system has 100,000 annual ED visits including a Level 1 facility. There are numerous allopathic & osteopathic residencies including a solidly established Emergency Medicine Residency Program. Equity-ownership group provides outstanding package including family medical, employer-funded pension, CME, malpractice, plus shareholder status at one year with no buy-in. Contact Rachel Klockow, Premier Health Care Services, (800) 406-8118, rklockow@phcsday.com, fax (954) 986-8820.

**West Virginia, Huntington:** $400,000 package – significant sign-on bonus – Equity Ownership – Scribes. Established group has a very appealing opportunity for BP/BC EM physician in newer ED with a patient volume of 73,000 annual visits. This Level II facility has 66 hours of physician coverage, plus 48 MLP hours daily; and new scribe program. An excellent package of $400,000 plus additional sign-on bonus is offered. Package includes guaranteed hourly plus RVU, family medical plan, malpractice, employer-funded pension, additional incentive income, shareholder opportunity at one year with no buy-in, plus additional benefits. Located 45 minutes from Charleston on the Ohio River, Huntington is home to Marshall University. For additional information, please contact Rachel Klockow, Premier Health Care Services, (800) 406-8118; e-mail rklockow@phcsday.com; or fax CV to (954) 986-8820.

**West Virginia, Wheeling:** Ohio Valley Medical Center is a 250-bed community teaching hospital with a brand new-ED under construction. AOA approved Osteopathic EM and EM/IM residency program. Enjoy teaching opportunities, full-specialty back up, active EMS, and two campuses seeing 29,000 and 24,000 pts./yr. Outstanding partnership opportunity includes equal profit sharing, equity ownership, funded pension, open books, full benefits and more. Contact Ann Benson (careers@emp.com), Emergency Medicine Physicians, 4535 Dressler Rd. NW, Canton, OH 44718. 800-828-0898 or fax 330-493-8677.

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New Orleans is one of the most exciting and vibrant cities in America. Amenities include multiple universities, academic centers, professional sports teams, world-class dining, cultural interests, renowned live entertainment and music.

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

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The most frequently used illegal drug in the United States is marijuana, based on a recent government survey. Regardless of the nearly 7,000 published scientific and medical studies documenting the damage that marijuana poses, not one study has shown it to be safe; nearly 69 million Americans over the age of 12 have tried marijuana at least once. The average age of first experimenting with the drug is 14 years old.

Today, an increasing number of teens are turning to an herb-based product to get high, and unlike marijuana, it’s perfectly legal. See Toxicology Corner one page 24 to read more about this alarming new trend.

Source: http://www.marijuana-addiction.info/Marijuana_Statistics.htm

The most important thing is to enjoy your life – to be happy – it’s all that matters.

Audrey Hepburn

Debt management tips and tricks

Getting a handle on debt management has become very problematic for most Americans. Here are a few simple ideas to keep in mind to help you get your debts under control in no time.

$ Start a savings account – put a little in each week, even if it’s only $5 or $10 and don’t use it unless it’s an emergency, it will grow quicker than you think.

$ Prioritize your bills – put in order of higher interest rates and pay these off first. Next pay off the lowest amount, this will lower the number of creditors.

$ Make a budget – know what you can afford and track your purchases. A budget really puts expenses in perspective.

To find out important information regarding your student loan debt and how best to handle it with the new legislative and regulatory updates, see GL Advisor’s article Student Loan News on page 28.

Source: http://www.ehow.com/way_5280520_debt-management-tips.html
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