“Family” Medicine: The perks and pitfalls of providing medical care to the people you love

Karyn Ridgeway, MD, Loma Linda University Medical Center, Loma Linda, CA

It was New Year’s Eve and I was celebrating with my wife, Kari, and 2-year-old son, Maks. Happily ignoring the CAUTION – SMALL PARTS! warning on the box, we opened his new game, “Operation,” and began to play. In one of my brilliant parenting moves, I placed the plastic “booger” piece at the edge of my nose and said, “Look Maks, a booger!” Just as I heard my wife say, “Do you think you should be showing him that?” Maks placed the booger piece into his nostril. My terror grew as the booger moved into the deep recesses of his nasal passage. What followed was a series of frantic maneuvers, including sucking all of the snot out of his nostril and blowing into his mouth (a giant kiss!). I even used the game tweezers to try to fish the “booger” out. Kari tried to help, while mildly admonishing me for causing the scenario. It wasn’t long before she said the dreaded words, “Looks like we need to go to the emergency department.”

As a third-year emergency medicine resident, I assumed I’d be the one to determine if – and when – our child needed to go to the emergency department. I tried a few more furtive kissy-sucky maneuvers, while Kari looked on doubtfully and began packing the diaper bag. I suggested she take Maks to his pediatrician the next day (while I was at work), since this wasn’t a “real” emergency. This suggestion was met with a loud silence, broken only by the rattle of car keys.

We agreed soon after Maks was born that Kari (not a doctor) could rush our son to his pediatrician with any concerns, and I also could treat him for minor conditions. I used my new prescription-writing powers for eye drops (conjunctivitis) and Zofran (flu). I didn’t have to look far to find cautions, and even restrictions, against such practices.

American Medical Association (AMA) policy 8.19 makes recommendations regarding treatment of loved ones. It outlines some commonly expressed concerns including:

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### Upcoming events

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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.

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

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The right answer

What is the most amazing thing you’ve seen in the ER?” If you’re like me, you’ve heard this question a hundred times. And those asking certainly don’t want to hear about the time you found a care facility for that seemingly unplaceable psychiatric patient, or the shift when you – miraculously – cleared out the waiting room at your county hospital.

What they’re really asking is, “Tell me about the most horrifically gory trauma patient you’ve seen or the most sexually perverse ‘accident’ that has wandered into your ER.” Clearly, there’s a fundamental disconnect between what we, as physicians, find impressive, and what the public finds impressive. This further highlights the need to bridge the gap between the public perception of emergency medicine and what it actually is. As we move into 2013, our membership is working diligently to further define our specialty.

The Legacy Initiative is an EMRA-directed, unique film documentary that chronicles the development of our specialty through in-depth testimonials from our founders and leaders. Not only will it preserve our history and inspire current and future generations of emergency medicine physicians, the documentary also will educate the public about our specialty, with the goal of closing the aforementioned knowledge gap.

The highly motivated Legacy Task Force – along with the film’s Emmy-nominated producer and director – are working to create 1) a world-class, one-hour documentary to air on a national television network, 2) a video archive of interviews with emergency medicine founders and a historical archive of photos and documents available to the entire medical community, and 3) a short video created for policymakers and the public, which will outline the role and value of our specialty.

The documentary will premiere at ACEP’s Scientific Assembly in 2013. The screening event will feature a panel of the founders of emergency medicine. I invite you to view and share the film’s inspiring trailer at www.247365doc.com. Aside from its foray into the silver screen, EMRA has been changing the public perception of emergency medicine through its advocacy efforts. A record 136 residents attended the Leadership and Advocacy Conference (LAC) in 2012, meeting with congressmen to fight for legislation to protect patients and our specialty. We expect an even larger number at LAC in Washington D.C. this May.

Other resident leaders, many of whom sit on the EMRA Health Policy Committee, are further supporting these efforts through the upcoming 3rd edition of the EMRA Emergency Medicine Advocacy Handbook. This great text will be made available free to the general public, and I implore you to read it and familiarize yourself with the policy challenges affecting our specialty.

To reach as many minds as possible, EMRA counts on its members; you are our most powerful tool. While EMRA as an organization can publish educational information, donate to the Emergency Medicine Action Fund, or represent you in dealings with other key stakeholder organizations, only you – as an individual – can share the meaningful stories with the voting public that highlight the important issues.

Ultimately, who defines and publicizes the specialty? You do!

You are both the face that patients see and the steering force behind a nearly 12,000 member-strong organization. It is through your tireless work on one of nine EMRA committees/divisions, as an EMRA representative to an ACEP committee, as a contributing author in one of our four new publications or six upcoming mobile apps, or as a regional or program representative, that you dictate to your colleagues and the public who we are as emergency physicians. We set the standards for our specialty and identify the challenges; we must share this with the public to motivate change.

EMRA and its individual members are at the frontlines of emergency medicine, and are working to define what the public needs to know about us. So, the next time someone asks you to describe the most amazing thing you’ve seen in the emergency department, dive a little deeper and give them the right answer: One that will catalyze change.
Mission Statement

The Emergency Medicine Residents’ Association is the voice of emergency medicine physicians-in-training and the future of our specialty.
Jordan Celeste, MD, EMRA President-Elect, Brown Emergency Medicine, Providence, RI

Jordan was born and raised in Harrisburg, Penn., where she got an early start in leadership, serving as student council president in junior high and class president in high school; she also was captain of the soccer and tennis teams. She graduated summa cum laude from the University of Maryland in 2004 with a bachelor of arts in anthropology, and earned a medical degree from the university in 2010. As a medical student, Jordan served as vice president of Talks and Mentoring for the Emergency Medicine Interest Group, and was a regional representative for EMRA’s Medical Student Council.

Jordan began her emergency medicine residency at Brown University in Providence, Rhode Island with her husband, Pete, and her dog, Flint, by her side. She was elected to the EMRA Board of Directors during her intern year, and served for two years as the ACEP representative. Through this experience, she learned about many aspects of emergency medicine, and represented the interested of EMRA members to the ACEP Board of Directors.

Jordan is now a PGY-3, and continues to serve as a resident representative to the Rhode Island Medical Society; she also is a member of ACEP’s Rhode Island Chapter. In her new role as EMRA’s president-elect, Jordan is planning to increase EMRA’s regional presence, invest in technology, and expand funding of member activities. EMRA’s goal is to help create and train fully developed emergency medicine clinicians and physician leaders, and Jordan wants to fully engage the organization’s membership in this pursuit.

Ijeoma Akunyili, MD, MPA, Vice Speaker of the Council, University of Texas HSC, Houston, TX

Ije grew up in a small city in Eastern Nigeria and moved to the United States at the age of 17 to attend college; she now calls Houston home. She earned a bachelor of arts degree in comparative literature from the University of Pennsylvania, and a master’s degree in public administration and international development from the Kennedy School of Government at Harvard University. After graduate school, she began a career in policy with World Bank, where she worked on health, social and economic policies for the world’s poorest countries.

Two years later she decided to attend medical school to better understand health policies and inequalities. Ije loved the pace and variety of emergency medicine and was intrigued by the fact that emergency physicians were at the gateway of the entire U.S. health system, especially for the underserved. As a third-year medical student she joined EMRA, where she has served as a program representative for UT Health, as well as a Region 5 representative.

As vice-speaker, Ije aims to expand on EMRA’s advocacy efforts and strategic alliances in the house of medicine. She also hopes to engage a greater number and variety of EMRA’s members through enhanced regional programming.

Her most important role to date is as a wife and mother of two young children. She enjoys weightlifting, yoga and reading memoirs.
Sarah Hopper, JD, MD, Legislative Advisor, Washington University in St. Louis, St. Louis, MO

Sarah grew up in Cedar Rapids, Iowa. She attended the University of St. Thomas in St. Paul Minnesota, where she developed a passion for travel. After graduating from college, Sarah taught biology in Slovakia and then spent a year traveling through Africa, India, Nepal, Southeast Asia and Indonesia. On her return to the United States, Sarah worked in a pediatric genetics lab.

Inspired by Madeleine Albright, Sarah had early aspirations of becoming secretary of state, but her travel experience opened her eyes to the need for quality medical care around the world, including the underserved in the U.S. Sarah’s passions lead her to study medicine and law at the University of Iowa. She is now a fourth-year resident at Washington University in St. Louis.

Sarah began her involvement with EMRA as a program representative, and eventually went on to hold positions as a regional representative and chair of the Health Policy Committee. She has written resolutions and chaired research committees and also has been an active author for EM Resident and EMRA’s Health Policy Handbook.

As EMRA’s legislative advisor, Sarah plans to bring health policy advocacy to regional meetings to enable residents who are not able to attend national meetings to learn the importance of advocacy. She also is expanding EMRA’s Advocacy Week to Advocacy Month, which will coincide with ACEP’s Leadership and Advocacy Conference in May 2013.

John Anderson, MD, ACEP Representative, Denver Health Medical Center, Denver, CO

As EMRA’s ACEP representative, John hopes to continue to advance and protect the specialty of emergency medicine. He is a third-year resident at Denver Health, and completed medical school at the University of Colorado. Prior to embarking on a medical career, he graduated from the University of Montana with degrees in English and philosophy, and spent several years traveling around the world seeking experiences ranging from volunteerism to raft-guiding.

John has been involved with EMRA since 2008. He has served as a student regional representative; as a medical student chair; and, most recently, as the representative to the ACEP Emergency Medicine Practice Committee, a position he has held for two years. He also has served on several committees and is a contributing author to EMRA’s forthcoming Resident as Educator book.

He plans to advocate to protect vital pieces of resident education, and has pledged to keep members informed to ensure that emergency medicine training is effective in the current practice environment. He is excited to serve the organization and its members, and encourages members to contact him with any ideas, questions or concerns.

Kene Chukwuanu, MD, Membership Coordinator, St. Louis University School of Medicine, St. Louis, MO

A native of St. Louis, Missouri, Kene completed his undergraduate studies and earned a medical degree from the University of Missouri-Columbia (MIZ-ZOU!) in 2010. He also played football for the Missouri Tigers (MIZ-SEC!).

As a medical student, Kene was active in organized medicine, community service, and health policy as a former regional director and member of the Student National Medical Association’s Board of Directors. He was involved in multiple community service initiatives, was a mentor and tutor for local junior high and high school students, and worked as an academic mentor for the Total Person Program in the university’s athletics department. In addition, he served as president of his medical school government during his senior year.

Kene is currently a second-year resident at the Saint Louis University School of Medicine, as well as an MPH candidate in the university’s School of Public Health. During his short time in EMRA, he has served as a program representative, is a member of the Health Policy Committee, and is also a resident member of the Missouri College of Emergency Physicians (MoCEP) Board of Directors.

His interests include critical care, medical student education, health disparities, and health administration and policy. In his free time, he roots for everything St. Louis, is an avid Missouri Tigers fan, and enjoys football, strength training, and boxing. After residency, he plans to pursue a fellowship in administration and health policy.

As membership coordinator, Kene hopes to evaluate and better address member needs and increase membership. He also hopes to promote the benefits of EMRA and maximize membership value through strengthening corporate partnerships and expanding regional programming.
Can we cut medical costs, and can we agree on how?

Editor’s Note: You may not have heard about this debate; or perhaps you have, but are unclear about the details. Cost-effective care is an important concept for emergency physicians to understand. Dr. Anderson recognized this and penned this primer about the history and current state of “Choosing Wisely.” It is not an opinion piece.

The booths at ACEP’s Scientific Assembly (SA) are packed up until next year, and while SA may be closed, certain issues remain wide open. Each issue will undergo an intensive period of discussion and action. Right out front is the American Board of Internal Medicine (ABIM) Foundation’s Choosing Wisely campaign, and its counterpart, ACEP’s Cost-Effective Care Task Force.

The movement was spurred by an editorial in the New England Journal of Medicine entitled “Medicine’s Ethical Responsibility for Health Care Reform – The Top Five List.” The Choosing Wisely campaign was launched in December 2011.

ABIM sees the project as a “multi-year effort to help physicians be better stewards of finite health care resources.” It aims to promote conversations between physicians and patients by helping both choose care that is necessary, supported by evidence, not redundant of care already received, and not harmful to the patient. The initiative directs physicians and specialty organizations to create a list of five tests or procedures that may be unnecessary, with the goal of eliminating the costs associated with those tests.

The National Physician’s Alliance (NPA) initially piloted the concept and created a set of three lists of specific steps physicians could take to improve the efficient use of limited health care resources. This pilot program was limited to family medicine physicians, internal medicine physicians, and pediatricians. It has since become a formal agreement among nine specialties – from cardiology to radiology – each specialty publishing its own list of five potentially unneeded interventions.

The lists vary from highly specific for unique diseases to broader directives aimed at long-term management. The full lists for each specialty involved in the campaign can be found on the ABIM website. To provide examples, these are two of the items on the family medicine list:

- Don’t routinely prescribe antibiotics for acute mild-to-moderate sinusitis unless symptoms last for seven or more days, or symptoms worsen after initial clinical improvement.
- Don’t use dual-energy x-ray absorptiometry (DEXA) screening for osteoporosis in women younger than 65 or men younger than 70 with no risk factors.

Another two issues, somewhat more broad, on the nephrology list:

- Don’t initiate chronic dialysis without ensuring a shared decision-making process between patients, their families, and their physicians.
- Don’t perform routine cancer screening for dialysis patients with limited life expectancies without signs or symptoms.
Consumer Reports, a product-testing organization, has partnered with certain specialties in the project to produce patient handouts regarding some of the items on the lists. The campaign now has commitments from additional specialties, and will provide similar lists of five items over the course of the next year. At the time of press, there are 26 specialties formally involved with the Choosing Wisely campaign. Emergency medicine is not one of these specialties.

This issue has been discussed within ACEP since late 2011, and continues to generate thoughtful and sometimes heated discussions. Some emergency physicians are advocates of the program, while others feel that – though well-intentioned – it does not provide the best solution to the problem.

The campaign has been brought before the ACEP Council as well as the board of directors multiple times. All agree that there is a need for cost control, and that medical providers should continue to seek solutions. The consensus stands that Choosing Wisely is simply not the best path. ACEP’s reasoning:

- Choosing Wisely does not involve negotiation with other specialties regarding a test’s potential necessity.
- Medicare/Medicaid/insurance companies may refuse payment for a test based on its presence on the list, despite potential medical necessity.
- As summarized by ACEP Immediate Past-President, Dr. David Seaberg, “Emergency physicians approach our patients with the goal of eliminating anything life-threatening. We cannot afford to miss anything, even something that seems like a long shot.”

To ensure emergency physicians can continue to provide the best care for patients and seek cost-cutting solutions, the ACEP board created the Cost-Effective Care Task Force. It will provide recommendations and guidance on efficient and cost-effective emergency medical care.

There are myriad pros and cons and countless concerns – from patient-centered outcomes to legal issues to financial issues – involved at every level of conversation. These perspectives will be addressed in a future article. The concept of cost-effective care will undoubtedly be a major part of our future medical practice; we are obligated to actively participate in discussions that will decide what role emergency medicine physicians will play in shaping the components and delivery of that care.

References

If you have an idea, an issue, or an experience about which you would like to write, submit an abstract (limit 250 words, double-spaced) outlining your idea. Give the names of your coauthors, if any.

If your idea is chosen, you will be asked to write an article for the “Residents’ Perspective” section.

Submit your abstract to Stephanie A. Eucker, MD, PhD Resident Fellow Annals of Emergency Medicine 1125 Executive Circle, Irving, TX 75038-2522 Fax: 972-580-0051 annalsfellow@acep.org.
“Family” Medicine: The perks and pitfalls of providing medical care to the people you love

continued from cover

Karyn Ridgeway, MD
Loma Linda University Medical Center
Loma Linda, CA

1. Compromise of personal objectivity (“My son always cries like that; it’s nothing.”)
2. Failure to do a complete physical exam (“No rectal bleeding? If you say so.”)
3. Treatment of problems beyond one’s scope of practice (“Your cardiologist is a fool; don’t take those medications.”)
4. Reluctance to refuse care or treatment (“Sure, friend, I’ll be GLAD to write your husband a prescription for his herpes.”)
5. The policy also states: “Except in emergencies, it is not appropriate for physicians to write prescriptions for controlled substances for themselves or immediate family members.” (“Hi, Dear. Can I write you a prescription for 500 Percocets to fill for me?”)

Like the AMA, most state licensing boards—and some hospitals—have prohibitions against treating self or family. Disciplinary actions have been brought against physicians for such practices. Medicare and many other insurance providers (likely fearing fraud) refuse payment for treatment or prescriptions provided for immediate family. Yet with all of the cautions and admonishments, “family” medicine is still a very common practice.

A study done in 1991 at a large community hospital surveyed 693 physician staff members. Of the 465 respondents, 83% admitted to providing prescriptions for kin, and 80% admitted to diagnosing conditions that required treatment for family members. Some even performed procedures (9% elective surgery). A recent polling of North Carolina practitioners showed that 84.6% had treated or prescribed medications for an immediate family member, significant other, or close friend.

According to the studies, reasons offered for treating family members included convenience and cost. (Why send grandma to the emergency department to wait for five hours and pay a huge bill for a refill on her anti-hypertensive that was lost with her luggage?) Many argue that their intimate knowledge and concern for immediate family helps them provide improved care.

Some see treating loved ones as an honor and privilege—a way to share their skills and resources. Others bristle at what they see as unreasonable restrictions on the profession: Why, if within the scope of one’s training and practice, should it be restricted for family?

In a strong rebuttal of AMA policy, Dr. Kenneth Christman writes, “AMA ethics policy on physicians caring for themselves and family members conflicts with common sense and common practice. It is nonetheless accepted by licensure boards and other authoritative bodies, even though virtually all physicians are in violation. It is time to change this policy and to recognize the right of patients to choose their own physician, even a physician who is a family member.”

Back in the ED, I was dismayed to see the tracking board read, “Bed 18, Ridgeway, booger in nostril.” But my colleagues are awesome; they removed the FB (foreign booger) easily. At one point the fellow asked me, “Do you want to do this?” as he gestured towards the Foley catheter. Under different circumstances, I would have grabbed it without hesitation. I looked at my son (who was enjoying all the attention) and my spouse (who wasn’t that amused). I considered the potential risks (poor outcome, domestic strife, hurting my son) and deferred.

References
Reflecting on 2012 Scientific Assembly

I am proud to write my first column as EMRA’s new speaker of the council! Every fall, ACEP’s Scientific Assembly elicits mixed feelings as we say farewell to departing EMRA board members who have contributed countless hours over their terms to make the organization as strong as it is today, while welcoming new, enthusiastic members to EMRA — ranging from new program representatives to our newly elected board members.

As a resident-centered organization, turnover in membership and leadership is a regular occurrence. While this poses some challenges, I also see our rapid turnover as one of our greatest strengths. Last year’s National Resident Matching Program data highlights the fact that emergency medicine is becoming an increasingly desirable and sought-after specialty for medical students, and emergency physicians are rising noticeably in the ranks of hospital, community, and national leadership. EMRA members have been, and will continue to be, leaders in our specialty and in the house of medicine for decades to come.

What attracted me to EMRA as a medical student was its uniqueness as one of the only independent and purely resident-driven medical organizations in existence. While EMRA has developed strong partnerships with other emergency medicine organizations and beyond, being an independent, resident-driven association gives us the flexibility and focus to uniquely meet our members’ needs and adapt as those needs change.

This freedom also gives us the ability to stand up for medical students and residents, and speak with a clear and unified voice. EMRA can proudly support its almost 12,000 members, drawing strength from its representation at 95% of the emergency medicine residency training programs in the United States.

EMRA was hard at work in Denver, striving to exceed the expectations of its members. This year’s Scientific Assembly marked the highly anticipated release of our 2013 EMRA Antibiotic Guide, as well as our newest handbook, PressorDex (both available in print, and now being developed as mobile apps). The EMRA board was thrilled to approve an additional $12,000 in new annual awards and scholarships for its membership, as well as an increase in funding support for our regional representatives, committee/division leaders, and Medical Student Council.

A truly inspiring highlight of our meeting was the release of the teaser trailer for EMRA’s new documentary, 24/7/365, part of the EMRA Legacy Initiative that began as an EMRA Representative Council resolution just over one year ago. (The trailer can be viewed and shared online at www.247365doc.com.)

Highlights from EMRA programming and events range from record attendance at our Medical Student Governing Council meeting to a standing-room-only job fair, and sessions led by leaders in our field, such as cardiology expert Dr. Amal Mattu and past ACEP speaker Dr. Todd Taylor. EMRA also hosted its inaugural alumni reception, which brought together the organization’s past leaders, who have gone on to serve in coveted leadership roles all over the country – from the American Medical Association to ACEP to the U.S. government.

While much is uncertain about the future of health care, what is certain is that we have the ability to take the lead in making the future brighter through the selfless dedication and enthusiasm of our membership and incredible EMRA staff.

In closing, I’d like to thank our outgoing speaker, Dr. Hamad Husainy, for his support this past year. Thanks to his mentorship and encouragement, I have been given the privilege of serving as an EMRA leader.

I welcome your comments and ideas, and look forward to working with you.
The rain is falling and the leaves are swirling outside my window as I sit pondering what the next year will hold. Like many of you, I am in the midst of seeking the perfect job. “Academic or community medicine” and “independent contractor or employee” are some of the first key questions we each must answer. But when it comes to medical liability insurance, there is no question – a good liability policy is an absolute necessity.

There are four types of medical liability insurance coverage: occurrence, claims-made, extended reporting period/prior acts coverage, and modified occurrence. When considering liability insurance it’s important to remember that many states have a seven-year statute of limitations on medical liability cases. That means that a patient can bring a suit against a physician seven years after the patient was made aware that an incident occurred – even at a time when the doctor no longer remembers the patient and may not have the same job or liability insurance. Each state has its own statute of limitations, which may be less than – or, in a few instances, more than – seven years.

Occurrence coverage provides protection against incidents that happen during the term of the policy, regardless of the length of time that passes before a claim is filed. This includes incidents that are reported after the policy has been terminated. **This is the broadest coverage available, but it is also the most expensive.**

For example, Dr. Smith’s first job was in Iowa with a private firm. Five years later, Dr. Smith moved to an academic position in Missouri. When he moved to Missouri, Dr. Smith terminated his occurrence-based policy and got a new policy with his new position. While he is in Missouri, a suit is filed against him for an incident that happened while he was working in Iowa. The occurrence-based policy that Dr. Smith held in Iowa will cover the claim since the incident happened during the life of that policy, even though he no longer holds a policy with the company.

Claims-made coverage is the most widely available form of medical liability insurance. It provides coverage of incidents that occur and are reported to the carrier **during** the policy period.

Back to Dr. Smith: Again, he starts his practice in Iowa, but this time with a claims-made policy. Now, five years later he moves to Missouri and cancels his original policy. While he’s in Missouri, a suit is filed against him for an incident that happened while he was working in Iowa. This time his claims-made policy will not cover the suit (even though it happened during the life of the first policy) because the company did not have notice of the claim until after the policy was canceled.

Claims-made insurance starts out as the least expensive type of policy; however, as the policy “matures,” covering more and more years of physician practice, the premium will increase. A policy is mature when it includes five to eight years of coverage. At this point, the cost of a claims-made policy is similar to an occurrence-based policy.

For example, Dr. Smith was hired directly out of residency at an Iowa community hospital 10 years ago. He has had only one job and has kept the same claims-made policy his entire career. His liability premium for his first year was the least expensive. As his career progressed, the cost of his premium continued to rise in proportion to the number of patients he encountered, since the insurance carrier knows that his likelihood of being sued increases with every patient he sees. Now, the cost of Dr. Smith’s premium is similar to that of an occurrence-based policy.

Extended reporting period and prior acts coverage are policies that bridge the gap between the end of a claims-made policy and the start of a new policy. These policies cover claims that
occurred during the previous claims-made policy, but were not brought forward until after the termination of the policy.

- Extended reporting period coverage (also known as tail coverage) is a policy that is bought from the previous insurer at the time of the policy expiration.

- Prior acts coverage (also known as nose coverage) is a type of policy that is bought from the subsequent insurer at the start of the new policy.

If Dr. Smith had tail or nose coverage at the end of his claims-made policy, then the suit filed while he was in Missouri (but based on an incident that happened while he was in Iowa) would be covered by his tail or nose policy.

Modified occurrence coverage combines claims-made and occurrence policies. Coverage is provided on a claims-made basis with an included tail that generally lasts for a limited amount of time after the expiration of the policy, usually seven years. If Dr. Smith had been covered by a modified occurrence policy while he was in Iowa, he would have been covered for the incident that occurred while he was in Iowa (but was not filed until he had moved to Missouri), as long as the claim was filed within seven years of the end of the first policy.

For most states, a seven-year tail will cover the statute of limitations – the amount of time a patient has to bring a lawsuit. However, the statute of limitations starts when the patient had reasonable notification of injury.

For instance, Dr. Smith puts in a chest tube and accidently pushes a piece of the petroleum gauze into the wound; when the bandage and chest tube are removed, the petroleum gauze remains in the patient’s body. Three years later the patient begins to have pain at the site of the chest tube. The patient has the site evaluated and learns that the gauze was left in place. From this date, the patient has seven years to bring a suit. Under these circumstances, Dr. Smith’s modified occurrence coverage may not cover the claim because it is possible the claim could be brought 10 years after the incident occurred and more than seven years after the termination of his policy.

In review, the most comprehensive policy is an occurrence policy. If you are offered a claims-made policy you need to know who will pay for the tail or nose policy if you get a new job. Tail policies can be used as a way to ensure an employee will stay with the group for a minimum amount of time.

For example, if Dr. Smith’s contract in Iowa (with a claims-made policy) stated that the group would pay for a tail/nose policy only if he had been with the group for five years, it will be to his detriment to leave the group before that period ended – a decision that would make him responsible for his own tail/nose coverage. This contractual clause strongly encourages employees to work for the group for a minimum of five years.

It is important to know what type of liability insurance you are being offered, because unlike changing your car insurance, changing your liability insurance can drastically affect your future. So examine your contract and be sure to inquire about the malpractice coverage available and who will pay for the extended coverage, to avoid any unintended surprises.

References
3. Medical Malpractice Insurance for Medical Professionals. www.camedicalmalpractice.net/purchasing.htm
Notfallmedizin: Emergency medicine in Germany

Background
Emergency medicine (EM) has a long-standing history in Germany. Early developments in modern EM, especially in the pre-hospital field, evolved in the 1950s when the first organized emergency medical services systems were developed. Since then, physicians have been constantly involved in prehospital emergency medicine; however, research in the field is predominantly carried out by anesthesiologists. Independent emergency medicine residency training for physicians does not exist.

Prehospital emergency care
Germany has a sophisticated emergency medical services (EMS) system called “Rettungsdienst” (“rescue service”). Everyone who calls the unified emergency number “112” is interviewed by a paramedic-trained dispatcher who decides, with the help of certain algorithms, which response is appropriate.

- **Basic Life Support (BLS) ambulances**: Staffed with two emergency medical technicians (EMT) or one EMT and one paramedic, equipped with standard emergency medical supplies, including an automatic suction unit and automated external defibrillator.
- **Advanced Life Support (ALS) ambulances**: Two paramedics, plus additional equipment, including a 12-lead EKG, defibrillator, end tidal CO2 monitor, advanced ventilator, and about 30 different medications.
- **Emergency Physician Response Vehicle**: Staffed with one EMS physician and one paramedic; carries same equipment as ALS, plus chest tubes and a wider range of medications. However, these vehicles have no capacity to transport patients, and are usually dispatched together with – or requested by – ALS ambulances.
- **Helicopter**: Equipment is similar to the physician response vehicle but can transport one patient. Nearly the entire country is covered by air rescue services; the helicopters are dispatched directly to a scene or can be requested by ground EMS personnel, e.g., for transport to a trauma center.

There also are ALS ambulances and helicopters available with special equipment to transport critical care patients.

Paramedics (“rettungsassistent”) are required to have two to three years of training, are allowed to start IVs, handle certain drugs, and intubate patients in cardiac arrest. If an EMS physician (“notarzt”) is not yet at the scene, paramedics may also proceed with more invasive measures or other medications.

The physicians
EMS physicians in Germany usually are residents in anesthesiology, internal medicine, or surgery who acquired additional certification in emergency medicine after their third year in residency.

The emergency department
Smaller hospitals usually have one central ED. Patients are seen by residents of the different specialties under the supervision of an attending physician; so even though rooms and nursing staff are “shared” among the specialties, treatment is strictly separated. In larger
Bright and loud colors have been shown to increase safety, particularly while responding with lights and sirens.

The public health insurance system is predominantly funded by shared employer and employee dues, which also cover the unemployed and those with low incomes. Private insurance also is available, which may be a more affordable option for young and healthy professionals; yet it still offers some service benefits, such as earlier appointments for elective procedures.

**Future prospects**

Many hospitals have opened so-called “interdisciplinary emergency departments” that are staffed by anesthesiologists, internists, surgeons, and family medicine practitioners. They not only share facilities and resources, they also work hand-in-hand across specialty barriers.

The German Society of Interdisciplinary Emergency Departments proposed a curriculum for a five-year emergency medicine residency program. Unfortunately, this proposal was not approved, due to formal barriers and resistance by the established specialties. Many physicians at the frontlines of German emergency care, however, continue to advocate for the establishment of emergency medicine as a specialty.
Can’t miss ECGs

**Wide-complex tachycardia: What do you see?**

This 51-year-old male patient complained of chest pain before going into cardiac arrest. He was resuscitated and brought to the emergency department. He was found to be in ventricular tachycardia and cardiogenic shock. His ECG is shown below (Figure 1).

This wide-complex tachycardia could easily be misdiagnosed as ventricular tachycardia (VT). However, there are P-waves – and this is a classic right-bundle branch block (RBBB) with left anterior fascicular block (LAFB) morphology (see Figure 2 below for an annotated ECG).

When VT originates in the left ventricle, there may be a RBBB-like complex. But, because VT originates in the myocardium of the left ventricle – and does not originate in the left bundle, (while RBBB does originate in the left bundle) – VT is not identical to RBBB on ECG!

The LAFB can be diagnosed by the left axis deviation – it shows a negative QRS in II, III, and aVF; and a positive QRS in I and aVL.

Note that RBBB alone would have S-waves in I and aVL. But since there are late, large R-waves in I and aVL, there is also LAFB.

With these definitions in mind, we can agree that this ECG shows sinus tachycardia with RBBB and LAFB.

**Is there ST elevation? How can you tell?**

You must find the end of the QRS to determine if there is ST elevation, as I have shown in the ECG in Figure 2. The end of the QRS is easy to find in lead V1. Then draw a line (Labeled Line 1 here) down to the Lead II rhythm strip at the bottom of the ECG – Line 1 meets the end of the QRS in lead II.

Once you identify what the end of the QRS should look like in Lead II in this particular ECG, use lead II as a guide to in turn find the end of the QRS in any lead. The vertical lines labeled Line 3 and Line 4 cross aVL and V4, which indicate ST elevation.

Once you’ve found the end of the QRS, you can see on this annotated ECG, ST elevation in V2-V4, I, and aVL is discovered – which is diagnostic of anterolateral STEMI. You’ll also note reciprocal ST depression in II, III, and aVF.

New RBBB resulting from STEMI is a sign of a very large STEMI. Patients with left main occlusion rarely make it to the ED alive. Less than 1% of angiograms in STEMI show left main occlusion. When they do make it to the ED alive, the ECG often has RBBB and left anterior fascicular block, as in this case.

These cases with RBBB are often misdiagnosed because the end of the QRS is not accurately identified. The ST elevation may be missed. In this case, the interventionist did not recognize STEMI.

Some authors recommend cath lab activation for any new RBBB because ST elevation can be difficult to read in this context. I believe that an informed physician can easily discern ST elevation in RBBB, but only by accurately finding the end of the QRS, which is the beginning of the ST segment.

Unlike uncomplicated LBBB (meaning no acute MI), uncomplicated RBBB does not have any ST elevation; if there is ST elevation, especially if it’s greater than 1mm, it’s almost certainly due to MI. In fact, most RBBB has some ST depression (up to 1 mm at the...
J-point), with a negative T-wave, in leads V2 and V3. See an example in Figure 3.

Why did the interventionist not recognize it?

Contrary to widespread belief, cardiologists, and even interventionists, are not infallible when it comes to interpreting the ECG. In their defense, it’s not their primary job. It is, however, the job of emergency physicians and even paramedics. Cardiologists spend the vast majority of their time dealing with patients after they have all the data (troponins, echocardiograms, angiograms, etc.), and are rarely pressed to make this decision.

If you aren’t often put under pressure identifying critical ECGs, you won’t be pressed to learn it. Even interventionists are mostly reacting to cath lab activation, and many will do the cath when called upon even if they are skeptical of the clinical and ECG findings. So they, too, are not pressed to make an accurate ECG diagnosis. Unless emergency physicians are aware of the ECG shortcomings of cardiologist and interventionist, emergency physicians will not understand that the buck actually stops with them!

An interesting paper on this topic

Tran et al looked at the ECGs and records of 240 consecutive cath lab activations for STEMI (primary PCI, pPCI). They excluded patients with LBBB or paced rhythms and others whose ST elevation criteria did not meet guideline-based criteria for acute STEMI. They did detailed chart reviews to determine if there was or was not actually a STEMI in retrospect (they did so by looking at cath results, echocardiograms, biomarkers, etc.).

They then showed the ECGs to seven experienced interventional cardiologists, asked them to interpret the ECGs, and asked whether they would recommend immediate pPCI, assuming that the patient had appropriate ischemic symptoms. They were blinded to outcome and other patient data.

Of 84 subjects, there were 40 patients with a true STEMI and 44 without (13 of whom had non-STEMI). Recommendations for immediate PCI varied widely, from 33-75%.

— Sensitivities for true STEMI: 53 - 83% (mean 71%)
— Specificities for cases without STEMI 32 - 86% (mean 63%)
• PPV of 52 - 79% (mean 66%)
• NPV of 67 - 79% (mean 71%)

Conclusion

You, the emergency physician, must be the expert when it comes to reading the ECG! No one can take your place. It’s perhaps the most difficult, critical, time-sensitive diagnosis in emergency medicine, and is a worthwhile investment in both time and effort.

My blog – Dr. Smith’s ECG Blog – is dedicated to helping improve your ECG interpretation. It’s free, has no advertising, and is an online ECG atlas with an index, 250 posts (sometimes more than one case per post), and many ECGs per case. Learn more about ECGs at hqmeded-ecg.blogspot.com!

Reference

In July 2011 Dr. Abraham Verghese declared at TEDGlobal that “the most important innovation in medicine to come in the next 10 years...is the human hand.”1 Although somewhat facetious, he discussed how a thorough physical examination remains the great key to superior patient care and medical insight.

Equally as thought-provoking as Dr. Verghese’s talk are the viewer comments posted under the video. They illustrate the tensions in medicine between effective diagnoses and the art and frustration of the physical examination. A patient may appear perfectly normal with a benign exam, but have a terrible malignancy only detectable through blood tests.

Conversely, a patient may be taken to CT scan only to find a palpable breast malignancy missed many times during rushed, superficial physical exams. Advanced technology gives exact and quantifiable answers often undetectable by exam, but a comprehensive physical provides context and focus to the ordering of expensive tests. For a patient, the physical examination shows one thing: The doctor’s concern.

Before the recent explosion of medical technology, examining the patient exemplified care and established diagnosis. After Dr. René Laennec invented the stethoscope in 1816, physicians began to spend significant time listening to their patients’ chest, neck, and abdomen. “Inspection, auscultation, percussion, and palpation” was the foremost and final test. No radiographic test could illuminate what a cursory exam had missed because the stethoscope was the be all and end all. The act of examining required such intense focus and time, patients could feel nothing but great worth in the eyes of a doctor.

Now, according to a 2010 study, patients actually feel more confident in a physician’s diagnosis if a CT scan is performed during their workup.2 So often today, if the lungs sound “junky,” no further time is spent at bedside because the pulse-ox, x-ray, and CT scan are assumed to show the quantifiable answer. Although technology has changed, the approach to examination and addressing patient concerns and fears remains the same.

The solution to reinvigorating the physical exam lies between the ways of the ancients and the great advantages modern medicine affords. A perfect method of examination efficiently provides quantitative results and allows for thorough exploration of the signs and symptoms. The key to the modern physical exam is not just the human hand; it is one hand on the patient and another holding a radiographic image.

The key to the modern physical exam is not just the human hand, it is one hand on the patient and another holding a radiographic image.

References
After returning from three meetings in September at the The Accreditation Council for Graduate Medical Education (ACGME) in Chicago, I face the challenge of communicating the excitement spreading through the world of graduate medical education (GME). The new changes in emergency medicine (EM) about to take place are not only consuming the attention of the ACGME, but also organizations like EMRA, the Council of Residency Directors (CORD), and ACEP.

1. **Milestones** – The first draft of the ACGME milestones was recently released on EM stakeholder organization websites, including EMRA. This first draft was based upon data obtained from the American Board of Emergency Medicine (ABEM), then further developed by the organization’s Milestones Working Group. The data resulted from 2,571 respondents and 313,000 data points. Despite the strength of the data supporting the first draft, ABEM, in conjunction with the Milestones Working Group, performed a validation study of the milestones document. Program directors and core faculty were asked to place the milestones into levels 1 through 4. As a result, a revised draft is now being released with implementation anticipated July 1, 2013. Resident evaluation data will be submitted semiannually.

2. **New Accreditation System** – EM will be one of the pilot specialties to implement the new accreditation system July 1, 2013. The goal of this new system will be to change from a process-driven model to an outcome model. Programs that demonstrate consistent and strong “outcomes” for their residents will be given the flexibility to innovate as the detailed program requirements are relaxed. Every program will undergo annual accreditation based upon data submitted to the ACGME. Also being developed is a process to identify programs with potential problems that would lead to a review by the RRC.

3. **Clinical Learning Environment Review (CLER)** – In 2008, the Institute of Medicine (IOM) report called for the ACGME to visit **every program, every year!** This was obviously not feasible. But in 2009, the ACGME Board of Directors approved a program to visit sponsoring institutions every 12-18 months. These visits, now known as **CLER Visits,** will be linked to accreditation status, but will not be an “accreditation site visit.” Data on the visit will be provided to the institution as a quality-improvement tool and to the Institutional Review Committee (IRC). The goals of the program will be to: 1. Integrate residents into patient safety programs; 2. Demonstrate the impact of this integration on quality improvement programs and efforts to reduce disparities in health care; 3. Establish and implement supervision policies; 4. Review oversight of transitions of care; and 5. Review oversight of duty hours.

4. **Critical Care Medicine** – On September 15, 2012, the American Board of Anesthesiology (ABA) and ABEM applied to the American Board of Medical Specialties (ABMS) for co-sponsorship of certification in Anesthesiology Critical Care Medicine (ACCM). Approval of this co-sponsorship is an ABMS decision that is anticipated by April 2013. EM residency graduates will need to complete five years of postgraduate training to qualify for the ACCM certification examination. Physicians who completed a three-year residency will need an additional 12 months of ACGME-accredited training if they want to apply to a one-year fellowship program.

5. **New Programs in Emergency Medicine** – I am happy to announce that two new programs in emergency medicine were approved at the September meeting. Welcome to **Kaweah Delta Health Care District** in Visalia, Calif., and to the **University of Texas School of Medicine in San Antonio**! The number of applicants to EM programs is growing every year.

6. **Resident Mistreatment** – The Council of Review Committee Residents (CRCR) have been given the task of examining the issue of resident mistreatment. In a recent survey of residents, more than 80% of respondents reported being mistreated or witnessing mistreatment. The majority of respondents indicated such mistreatment took the form of belittlement or humiliation. As a result, this issue has become a priority for the CRCR. It is unclear, however, whether mistreatment is as great a concern for EM residents. If you feel that such mistreatment is a concern for EM residents and should be addressed, I would love to hear from you at rrcemrep@emra.org.

The Accreditation Council for Graduate Medical Education (ACGME), the American Osteopathic Association (AOA) and the American Association of Colleges of Osteopathic Medicine (AACOM) have entered into an agreement to pursue a single, unified accreditation system for graduate medical education programs in the U.S. beginning in July 2015. Over the coming months, the three organizations will work toward defining a process, format and timetable for ACGME to accredit all osteopathic graduate medical education programs currently accredited by AOA. AOA and AACOM would then become organizational members of ACGME. Currently, the ACGME accredits over 9,000 programs in graduate medical education with about 116,000 resident physicians, including over 8,900 osteopathic physicians (DOs). The AOA accredits more than 1,000 osteopathic graduate medical education programs with about 6,900 resident physicians, all DOs. The transition to a unified system would be seamless so that residents in or entering current AOA accredited residency programs will be eligible to complete residency and/or fellowship training in ACGME accredited residency and fellowship programs.
Now that the application timetable has shifted, it may be beneficial for students to complete their emergency medicine rotations earlier in the fourth year.

Among the more common subjects of conversation were the recent Medical School Performance Evaluation (MSPE) submission change, and finding new and better ways to increase medical student involvement in EMRA.

For those students not already familiar with the residency application alphabet soup, ERAS stands for the “Electronic Residency Application Service.” ERAS provides a common application for allopathic residency programs, encompassing a candidate’s transcript, licensing examination scores, letters of recommendation, and CV. In many ways, it is like the AMCAS application we all completed when applying to medical school.

The MSPE, commonly referred to as the “Dean’s Letter,” is a fundamental component of the ERAS application. The MSPE traditionally was released on November 1, and residency interview offers quickly followed. This year the date was moved back to October 1, further complicating an already anxiety-ridden process.

Medical students applied to a larger number of programs this year, and many felt that they were going to wear out the refresh buttons on their smart phones when checking for interview notices. The shared experience of medical students and program directors at the annual EMRA Residency Fair showed that both parties are adjusting.

Of course, these changes may also affect how third-year medical students schedule their away rotations. Now that the application timetable has shifted, it may be beneficial for students to complete their emergency medicine rotations earlier in the fourth year.

Interview offers are often on a rolling schedule – released at different dates by different programs. While adjusting to this new submission cycle, the wait for interview invitations has become slightly longer than before. By the time that many of you read this, most fourth-year students will be well into the interview season and gearing up to make their rank lists.

Many medical students at Scientific Assembly expressed an interest in becoming more active in EMRA. Fortunately, there are many levels of involvement available. Students are encouraged to contribute original articles to EM Resident. We also invite students to participate in any of EMRA’s breakout groups, from the Research Committee to the newly established Wilderness Medicine Committee.

For students who want to get involved at the leadership level, we urge you to become a part of EMRA’s Medical Student Council. Applications for council positions open up in early 2013, and descriptions of the various positions available can be found at www.emra.org.
I’d like to think that my first IV placement was a more frightening and painful experience for me than it was for my patient. Luckily, the second attempt went better, and the third better still. With practice and experience comes expertise and skill. Friedrich Nietzsche once said, “He who would learn to fly one day must first learn to stand and walk…one cannot fly into flying.” This idea has come up repeatedly in my recent quest for the ideal emergency medicine residency program, but not in the form I thought it would. It has embodied – and simultaneously, confronted – the idea of the dreaded scut work.

There are many ways to rank a residency program. Commonly, one’s rank list seems to result from the amount of emphasis placed on a few key categories. Everyone knows the usual suspects. They can be found under the “FAQs” on program websites, or as keywords on forums like Student Doctor Network, or the ironically named Scutwork.com. Emergency department visits per year, trauma level, number of program residents, and shift length are some of the more commonly discussed topics. Another popular area of discussion is scut work.

Now I realize that not all scut work is created equal. No one wants to spend the majority of their training physically transferring patients to the floor for every admission or fetching their attendings’ dry cleaning. That type of work is aptly named.

Lately, however, the term scut work has expanded to encompass jobs like drawing labs, placing Foley catheters, and placing IVs. This is where my opinion differs.

One of the most confusing observations is the existence of some magical moment between the third year of medical school and graduation, when certain procedures turn into scut work. Is placing an IV as awesome as putting in a chest tube? Each requires practice for proficiency. Each may be lifesaving. One requires more skill, anatomical knowledge, and has fewer opportunities for practice. A physician should become proficient at withdrawing blood with a 21-gauge needle before attempting to withdraw blood with a 22-French chest tube.

The second reason I’m sticking up for basic medical procedures is my approach to work in general. If I’m going to ask someone to do something, I’d better know how to do it myself. What’s going to happen in the future when the nurse I ask to place an IV returns with a bucket full of bloodied catheters and empty lab tubes?

I have a fairly good idea of the type of physician I want to be, and it’s not the kind that punts; not to surgery for a chest tube, not to radiology to read a chest x-ray, nor to the IV team to start a line. I want those working with me to know that I have the medical knowledge and skills to handle everything within my scope of practice and consult only when I’m out of my realm. I want the ancillary staff to know that I appreciate and respect what they do – because I’ve done it myself. That type of work environment improves morale and increases productivity and efficiency. All of which are important values in the emergency department.

There is no doubt that routine medical procedures can be time-consuming; they might even get a little boring. But, they get easier with practice. Soon, putting in an IV will only take a second or two – or some eager medical student will volunteer. Most importantly, the confidence and skill attained from practice will far outweigh the small amount of time spent.

Ten years from now I won’t be putting in all my patients’ Foley catheters or starting all their lines, but I’d like to say with confidence that I could. I’ve worked with residents who were not only intelligent, but could also place a 14G catheter in a dehydrated, 80-year-old addict. Someday I’d like someone to say the same thing about myself.

To scut, or not to scut: That is the question

Drew Scribner, MSIV
Kansas City University of Medicine and Biosciences
Kansas City, MO

“I have a fairly good idea of the type of physician I want to be, and it’s not the kind that punts...”
We’ll take the ballroom, please

More than 5,000 emergency medicine physicians filled the halls of the Denver Convention Center for ACEP’s 2012 Scientific Assembly (SA) in October. The four-day event offered hundreds of lectures on topics such as leadership, clinical skills, health care reform and evolving practice models. A smaller, yet equally significant population, also attended the conference in record numbers this year: medical students. In fact, more than 100 fresh faces flocked to the EMRA-sponsored events, including (much to our surprise), board meetings. For the first time in EMRA’s history, the only thing missing at the annual Medical Student Governing Council (MSGC) meeting was space. For next year’s meeting in Seattle, we might need to reserve the ballroom!

David Reid and Keith Schenker are just two of the dozens of students who provided feedback, dialogue and new energy to our council meeting. Here, David explains the perks of getting off campus, while Keith reminds us that a trip to Scientific Assembly isn’t just good for your CV – it can be a spa retreat for your emergency medicine-loving soul, too.

Get off Campus!
by David Reid, MSII

I discovered a very common theme in many of the EMRA-sponsored medical student lectures at this year’s Scientific Assembly: emergency medicine is a competitive specialty. Board scores for successful EM applicants are increasing yearly; and last year, 100 percent of the ACGME residency spots were filled in the match. Ouch, the truth hurts.

So, besides conquering boards, what is a student to do? When the time comes for interview selection, you might wonder how you can stand out as an applicant. Well, after attending ACEP’s SA, may I suggest this: get out of the library, get off campus and attend an emergency medicine conference!

EMRA is the great supporter of emergency medicine interest groups (EMIGs) around the globe – and rightfully so, as these organizations provide students with some great exposure to emergency medicine. But just like learning a new language, there is no better method than total immersion – forcing yourself to “walk the walk” as you “talk the talk.” Events like Scientific Assembly are truly unique experiences that allow you to network with physicians and students from all over the country and learn almost anything you want – all in one place. Program directors recognize when you are going above and beyond; when they are interviewing applicants, that enthusiasm is a quality every one of them will be looking for.

Traveling is expensive and time-consuming, so it’s easy for medical students to talk themselves out of attending conferences and professional events. But for every excuse, there is a better reason to show how serious you are about your career.

My attendance as a second-year student may have seemed premature to some, but in the coming years – when it’s my turn to face the upcoming interview season – I’ll be much more comfortable than a conference rookie. I hope to see you in Seattle 2013!

Dear Denver, my cup runneth over
by Keith Schenker, MSIV

Being an international medical graduate has presented many unique challenges. The serene atmosphere of my small basement apartment in the Caribbean facilitated deep thought, but it wasn’t the best environment for studying or networking with other emergency medicine residency programs. Luckily, with the help of EMRA, these opportunities were just a hop, skip, jump, and plane ride (or two) away.

At ACEP’s Scientific Assembly this year I was able to attend EMRA’s medical student government council meeting and mixer. I was also able to attend the guest lectures the following day about matching, SLOR’s, fellowships and managing loans; as well as the networking luncheon and the residency fair. It was a privilege to be among the students, residents and faculty at such an event. The level of integrity and the commitment to education I witnessed was simply amazing.

As a medical student, I believe conscious reflection is imperative; it is important to be present each day. This meeting allowed me to unplug from day-to-day activities, and reminded me of how lucky I am to be pursuing my goals. I left Denver feeling humbled, but also energized; I’m ready to concentrate on my goals and enjoy the wondrous journey of my medical education.
SAEM is looking for 17 energetic, self-starting, responsible, and enthusiastic medical students to work with the SAEM Program Committee at its Annual Meeting in Atlanta, May 15–18, 2013. The program committee is responsible for the planning, coordination, and execution of SAEM’s Annual Meeting. It is comprised of nearly 40 faculty members selected by the President of SAEM from emergency medicine programs all over the country.

Benefits for medical student committee members:

- Waiver of your registration fee to the SAEM Annual Meeting.*
- Learn much more about the current research and educational activities taking place in the field of emergency medicine.
- Have the opportunity to form relationships with faculty members from EM programs around the country.
- A personal letter from the committee chair will be sent to your dean of student affairs, acknowledging your contributions to the program committee.

Requirements and expectations of medical student committee members:

- Arrive the late evening of May 14 and stay through 3pm on May 18.*
- Attend daily program committee meetings.
- Seeing to assigned tasks and responsibilities, which include, but are not limited to:
  - Approximately 6-8 hours of responsibilities per day
  - Soliciting reviews
  - Assisting in AV needs
  - Facilitating workshops
  - Being responsive and flexible to the needs of the program committee

Interested medical students should submit their name and contact information to the SAEM office by emailing Michelle Iniguez at miniguez@saem.org. Please write “Medical Student Ambassadors” in the subject line and attach a very short statement of interest (<150 words) as well as an updated electronic copy of your CV. Deadline is February 1, 2013. Recipients will be notified by February 20, 2013.

*Travel and hotel will be the responsibility of the individual student; however, SAEM will provide the emails of other selected students to facilitate consolidating lodging expenses.

Great Medical Student Opportunity! Jumpstart a Career in Academic Emergency Medicine!

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Time to get involved in EMRA’s educational activities

Fresh and energized from the EMRA events held during ACEP’s 2012 Scientific Assembly in Denver, I encourage you to get involved in EMRA’s educational offerings and to become better acquainted with changes in emergency medicine education. These transformative developments within our specialty include the recent release of the Emergency Medicine Milestones by the Society for Academic Emergency Medicine (SAEM), and the American Board of Emergency Medicine’s (ABEM) establishment of new guidelines for board certification eligibility.

During Scientific Assembly, EMRA unveiled several new publications, including the updated 2013 EMRA Antibiotic Guide and the brand new PressorDex, an important critical care reference handbook for treating our sickest patients. The EMRA Antibiotic Guide – along with EM Basics and EM Rashes – has also been released as a smartphone application. The PressorDex app is currently in the works, with an anticipated release date just weeks away.

These fantastic member benefits are the result of the inspiration and hard work of fellow emergency medicine residents. Want to carry on the tradition? If you’d like to be the next EMRA member to impact our education, now is the time!

Residents with an interest in medical education or academic emergency medicine are encouraged to join the EMRA Education Committee. One of EMRA’s newest and most active groups, the committee has launched a variety of projects to help residents establish the foundation for a successful career.

These projects include identifying the educational products most used by EMRA members, proposing new resources to add to its growing library of member benefits, and planning for the EMRA quiz competition (known as “EMRA Jeopardy”), which will be held in May during the 2013 SAEM Annual Meeting in Atlanta. We will recruit teams to participate in this exciting competition and social event soon!

There are many exciting educational opportunities ahead for residents in the new year. First, the CORD Academic Assembly will be held in Denver from March 5–9, 2013. This conference offers the opportunity to meet and learn from program directors and other leaders in emergency medicine education from around the country. The organization’s Resident Track has been expanded to include a full day of interactive sessions, with topics from how to be a successful bedside educator, to dealing with difficult consultants, to building a professional profile and CV. EMRA will again sponsor several CORD Faculty Development Scholarships to provide financial support to EMRA residents who are attending the CORD Academic Assembly (see www.emra.org/Content.aspx?id=161 for more information on how to apply).

In addition to the resident events at the annual CORD conference, EMRA plans to host a variety of resident-focused lectures and activities at the SAEM Annual Meeting. Again, EMRA will sponsor multiple travel scholarships to SAEM for residents who are interested in attending the meeting and participating in the EMRA events (see www.emra.org/content.aspx?id=169 for more information on how to apply).

Please consider joining the EMRA Education Committee or participating in one of the many benefits available to you as an EMRA member. Your involvement could change the course of your career in emergency medicine. If you have questions about any of these exciting opportunities, please feel free to contact me at AcademicAffairsRep@emra.org.

Chadd K. Kraus, DO, MPH
Academic Affairs Representative
Lehigh Valley Health Network
Bethlehem, PA
Glasses not required

EMRA’s Technology Committee. When you hear this phrase what sorts of images get conjured up? More likely than not you probably imagined a group of myopic individuals with thick glasses, huddled around computers furiously typing away, faces alit by the warm glow of LCD monitors. Nothing could be further from the truth. Well, except for the myopic part.

The committee serves to carry out EMRA’s vision of educating and serving emergency medicine residents through technologic means. This roughly translates to: we use technology to help emergency medicine residents. This very broad goal is achieved through several different methods. One way we strive to do this is through our website. It’s been just about one year since we re-launched emra.org. While the old website was functional, only with tremendous will power and CSI-level detective work could relevant and important content be found. As a result, the Technology Committee and the EMRA Board of Directors decided to completely redesign the website to give it a modern, fresh look and organize the content to deliver it in a more intuitive manner.

Scientific Assembly or at SAEM’s Annual Meeting, typing lines and lines of XML/HTML5. For the committee, this meant finding the right third-party website developer, deciding on wire frames of basic structure of the website, brainstorming various elements of redesign, beta-testing the preliminary site and then systematically testing the live site for bugs.

One of the more interesting tasks that the EMRA Technology Committee performs is brainstorming about ideas for mobile apps that would benefit emergency medicine residents. The ubiquitous EMRA Antibiotic Guide was turned into an app and has been wildly popular even outside of emergency medicine.

We recently released a Basics of EM app for iOS (based on the book), which helps medical students and interns manage and remember the incredible wealth of information that emergency physicians are expected to know. Another recently developed mobile application is EM Rashes, which visually helps providers at the bedside decipher random blotches on patients’ skin. Coming soon will be an app version of the PressorDex, which will aim to provide the same level of quick, high-yield information for managing critically ill patients with some of the most complicated medications that we use.

These are just a few of the things we have been working on for our membership. If you have an interest in developing technological solutions to enable emergency medicine physicians to provide better clinical care either through education or clinical decision support, then we encourage you to join EMRA’s Technology Committee. Glasses not required.
Managing post cardiac arrest care in the ED

**Introduction**

In a recent EM:RAP episode, Dr. Mel Herbert tells of exchanging “high-fives” following a successful cardiac arrest resuscitation, only to find himself wondering, “what the **** do we do next?” Although we have all memorized the ACLS algorithms for cardiac arrest resuscitation, not all of us are comfortable answering Dr. Herbert’s question. The following case is intended to shed some light on an oft-neglected, but important, aspect of cardiac arrest resuscitation: Post-resuscitative care.

**The case**

A 58-year-old male was brought to the emergency department by friends for malaise and “seizure-like activity.” He was found to be in ventricular fibrillation on arrival to the emergency department (ED). ACLS protocol was initiated. Return of spontaneous circulation (ROSC) occurred approximately 25 minutes later, following seven defibrillation attempts, three doses of epinephrine, and a total of 450 mg of amiodarone.

What do we do now?

“Post-resuscitation syndrome” results from improved cerebral blood flow following a period of inadequate cerebral perfusion. It is characterized by hyperemia and variable perfusion to different areas of the brain that can persist for hours or days following ROSC.

The ACLS basics of airway, breathing, and circulation remain crucial components in the management of post-cardiac arrest patients, especially in the prevention of reperfusion-related injury.11

**Airway**

Aspiration is common, so airway optimization includes head-of-bed elevation, early oral gastric tube placement, and chlorhexidine oral rinses. Early empiric antibiotics should also be considered in appropriate patients.

**Breathing**

Breathing optimization includes maintaining adequate oxygen saturation (greater than or equal to 94%), normalizing partial pressures of carbon dioxide (pCO₂), and initiating low-stretch (low tidal volume) protocols. Hyperoxia increases mortality, most likely due to increased free radical formation.2, 3 Therefore, oxygenation should be closely controlled via continuous pulse oximetry monitoring and serial arterial blood gas measurements.

Hyperventilation should be avoided, with ventilatory rate adjusted to maintain a goal pCO₂ of 40mmHg. Even with therapeutic hypothermia, the cerebral vasoconstriction response remains intact, so hyperventilation can worsen cerebral perfusion. Monitor pCO₂ levels closely, since the decreased metabolism associated with hypothermia therapy itself can cause relative hyperventilation as less CO₂ is produced.5

**Circulation**

Optimization of post-resuscitation circulation focuses on maintaining adequate perfusion of the brain, heart, and other end-organs. Unfortunately, hypotension is common following cardiac arrest.

While many clinicians support maintaining a mean arterial pressure (MAP) of at least 65mmHg, some investigators support maintaining MAPs of greater than 80mmHg.1,10 Norepinephrine is the recommended vasopressor of choice due to dopamine’s tendency towards arrhythmogenesis.

Cardiogenic shock can be treated with inotropes. Intra-aortic balloon pumps can
Therapeutic hypothermia has been shown to improve neurologic outcomes following cardiac arrest. The goal of therapeutic hypothermia is to lower the core temperature to 32–34°C for at least 12-24 hours after cardiac arrest. This is intended to decrease metabolism during the most hyperemic phase of ischemia-reperfusion injury. Neurologic outcomes are significantly improved within this range of temperatures, as compared to control.

Case outcome
After ROSC, the patient’s repeat EKG showed an accelerated junctional rhythm with 3-mm ST depressions and T-wave inversions in V1–V3 – concern for posterior STEMI. A central line was placed and a norepinephrine drip was started to maintain adequate MAP of 80mmHg. An amiodarone drip was also started.

The patient was not immediately taken for PCI due to a concern for potential intracranial injury secondary to his seizure-like activity prior to ED arrival. Head CT was negative. A second seizure was appreciated, though repeat head CT was normal.

The patient was sedated with lorazepam and propofol after the second seizure. He was then transferred to the CCU, where therapeutic hypothermia treatment was continued. The patient eventually underwent PCI with multiple stent placements. After several acute issues in the CCU, he was discharged home two weeks later, neurologically intact.

References
The once-common rash: A case of chickenpox in a 2-week-old patient

Introduction

In 1796, Edward Jenner brought the idea of preventative vaccinations to the medical community. He inoculated a young boy with fluid from a cowpox vesicle, later showing that the child was immune to the fatal smallpox disease that had killed thousands before him.

Subsequent advances in medical knowledge have given us vaccines for a multitude of once-deadly diseases. Cases of smallpox, polio, *Haemophilus influenzae*, and measles are all rarities today. As with these other highly contagious pathogens, primary varicella zoster virus (VZV) infection – chickenpox – has become an increasingly uncommon cause of human disease.

Case

A 2-week-old full-term male with no past medical history presented to the children’s emergency department (ED) one week after developing a new pustular rash. The rash started on his face and was diagnosed as “milia” by his pediatrician. However, over the subsequent week, the rash had spread across his entire body and the child had become increasingly irritable. The parents became concerned when he developed a fever.

Upon presentation to the ED, vital signs included rectal temperature 38.4°C, heart rate 162, respirations 34, and weight 4.32 kg. On physical examination, the child had a diffuse vesicular rash over his entire body, with intermixed papules and crusted lesions. The lesions were noted to be most prominent over the face (see Figure 1).

He was irritable, but maintained a good cry throughout the exam. No meningeal signs or other abnormalities were noted. His initial workup included CBC, BMP, blood cultures, urinalysis and urine cultures, chest X-ray, and lumbar puncture. He was started empirically on ampicillin, cefotaxime, and acyclovir.

Originally thought to be infected with systemic herpes simplex virus (HSV), the patient was admitted to the neonatal intensive care unit (NICU). In the NICU he was managed by a senior attending physician, who immediately recognized the rash as chickenpox. The child was sent to the infectious disease floor for further management.

CSF showed no RBCs or WBCs, glucose of 46 mg/dL, and protein of 58 mg/dL. His CSF cultures later returned positive for VZV and negative for HSV.

Upon further discussion, the mother recalled that she’d noticed skin lesions suggestive of varicella on her own hands and trunk about three weeks before delivery. The mother reported having previously had chickenpox at the age of nine.

The patient was continued on broad-spectrum antibiotics and antivirals until all of his cultures were reported out. After that, only the acyclovir was continued. His rash continued to improve during the hospital stay. He was discharged four
days later with instructions to complete a full course of acyclovir therapy.

**Discussion**

Pinpointing the cause of a pediatric rash can be quite difficult, and many young physicians are uncomfortable making a definitive diagnosis in the ED. While the majority of rashes seen in the pediatric population are benign, a few can be deadly. With most rashes, identification of the culprit comes with experience, after visualizing a multitude of cases. But just like measles before it, many young physicians today simply haven’t seen enough cases of chickenpox to recognize it at a glance.

Chickenpox is a highly communicable infection caused by VZV, with an infection rate of near 90% in close contacts. After an incubation period of 14-21 days, low-grade fever, headache, and malaise begin. The characteristic exanthem appears one to two days after the onset of initial symptoms. The progression of the rash is macules, to papules, to vesicles, and then to crusting – all within a six- to eight-hour window. One of the hallmarks of VZV is the presence of lesions in all stages of development simultaneously. The vesicles are said to have a “dewdrop on a rose petal” appearance, with a clear vesicle overlying an erythematous base.

Varicella is a dsDNA virus that causes an acute primary disease (chickenpox) and a recurrent disease (herpes zoster or “shingles”). It becomes latent in after the initial infection, but can be reactivated later in life. On reactivation, it causes severe pain and a vesicular rash in an area of skin supplied by the nerves from a single ganglion. VZV infection is usually diagnosed clinically, but can be confirmed with a Tzanck smear of vesicular fluid.

Complications are more frequently seen in adults or in the very young. These include encephalitis or meningitis, pneumonia, staphylococcal or streptococcal cellulitis, thrombocytopenia, and glomerulonephritis.

Fetal infection after maternal varicella in the first or second trimester of pregnancy has been shown to result in fetal malformations and eventual fetal demise. Maternal varicella occurring near delivery may result in disseminated disease in the newborn.

Treatment for otherwise healthy patients consists of supportive care, including antipyretics, cleansing with soap and water to prevent bacterial superinfection, antihistamines for itching, and monitoring for complications. Acyclovir is reserved for patients with signs of encephalitis or pneumonia, or those at high risk for these complications. Chickenpox is generally self-limited, and patients are no longer contagious once the vesicles have crusted over.

The varicella vaccine is a live attenuated vaccine approved by the FDA in 1995. The first dose is administered at 12 to 15 months, the second dose at four to six years old. For patients 13 years and older, the two doses are administered four to eight weeks apart. Clinical trials have shown the vaccine to be 70-90% effective for preventing disease, and more than 95% effective for preventing severe varicella. But this efficacy can be short-lived, as children can lose their immunity in as little as five to eight years after vaccination.

Pediatric rashes can be a diagnostic challenge for emergency physicians, especially since many once-common rashes are seen less and less. Despite its recent decline, however, chickenpox should remain on every ED physician’s differential. This is especially true when treating unvaccinated and immunocompromised patients to prevent disease progression to its potentially fatal sequelae.

**References**

Skin-crawling agitation

You are working a busy Friday night shift when you get your next patient: a 27-year-old Hispanic female with an overdose of ibuprofen and cuts to her bilateral wrists. You exhale a secret sigh of relief and think: good – it’s only ibuprofen. You glance quickly at her vital signs and note she is tachycardic in the 140s. The rest of her vitals don’t impress you terribly (her temperature is 37.9, blood pressure is 130/80, and respiratory rate is 18 – 100% on room air). You know there could be many reasons for the tachycardia, including pain from the cuts, anxiety, co-ingestion, and dehydration.

When you walk into the room you see an agitated woman, and a quiet husband in the corner. The patient does not want to cooperate with the nurse who is trying to start an IV. As you do a limited physical exam, you assume the language barrier is causing the patient’s reluctance to talk to you. You finally get your Spanish translator on the phone, but unfortunately, your patient won’t cooperate. On exam, the patient is agitated, in no distress, pupils are 5mm bilaterally and reactive to light, her lungs are clear, her heart rate is tachycardic but regular with no murmur, her abdomen is soft, her skin is dry and flushed, her face is symmetric, and she is moving all of her extremities. She has a 2-cm superficial laceration to her right wrist, and a 2-cm partial thickness laceration to her left wrist. The silent husband finally speaks up in broken English, and tells you that his wife took about 30 Advil PM pills about one hour ago. Other than that, he has no further history to offer.

Oh, PM. Now the tachycardia and agitation make a lot of sense to you.

The nurse is miraculously able to perform an ECG, which shows a sinus tachycardia with normal PR, QRS, and QTc intervals. Labs are drawn; however, the patient is unable to give a urine sample and is too agitated for the placement of a Foley catheter. You are unable to properly address her wounds, which luckily are not too deep. You begin to realize that this is not a quick and easy ibuprofen overdose.

The anticholinergic toxidrome

“Blind as a bat, dry as a bone, red as a beet, hot as a hare, mad as a hatter, full as a flask.” As one of my favorite attendings put it, everything you need to run away from a dinosaur.

Pathophysiology

The anticholinergic toxidrome should really be called the “anti-muscarinic toxidrome.” Anticholinergic agents competitively inhibit the neurotransmitter acetylcholine (Ach) at the muscarinic receptor sites; they do not act on the nicotinic acetylcholine receptors. Muscarinic receptors are found on peripheral postganglionic cholinergic nerves in smooth muscle (intestine, respiratory, cardiac), secretory glands (sweat, salivary), the ciliary body of the eye, and the central nervous system. This results in increased blood flow to the skin and skeletal muscles (so you can run away from the dinosaur), dilation of pupils (to see where you are going), increased cardiac activity and bronchodilation (think ipratropium, which is an anti-cholinergic agent frequently used to treat asthma), and reduced gastrointestinal motility and detrusor muscle contraction (you don’t need that happening while you’re running).
The blockade of Ach in the central nervous system can result in anxiety, agitation, hallucinations, paranoia, delirium, seizures, and coma. A naked patient running around in your emergency department should make you consider three things: 1) schizophrenia, 2) PCP abuse, and 3) anticholinergic toxicity.

### Epidemiology

Drugs with anticholinergic properties are ubiquitous. Anticholinergic agents include antihistamines, sleep agents, neuroleptic agents, tricyclic antidepressants, anti-Parkinsonian drugs, antispasmodics, pupil dilators, and plants. Jimson Weed (*Datura stramonium*), also known as “devil’s weed” among other names, is a strong source of anticholinergic agents, including scopolamine, hyoscymamine, and atropine. The earliest settlers in Jamestown had an unfortunate experience with this plant when they used it to make their first meals.

According to the American Association of Poison Control Centers, more than 2.4 million exposures were reported in 2007. Over 8,000 were single-agent exposures; 94% of these were unintentional, with no deaths reported. There were more than 78,000 antihistamine exposures in 2007. Approximately 33,000 were specifically diphenhydramine; five deaths were reported. There were approximately 20,000 exposures in 2009, but no deaths were reported.

### Management

As with any overdose, the initial treatment is supportive care. Start with the ABCs, IV, oxygen, and monitor. Obtain an ECG and pay close attention to the QRS and QTc intervals. Labs should include a FSBG, acetaminophen and salicylate levels. You should always suspect co-ingestion, until proven otherwise. Remember that tricyclic antidepressant (TCA)-overdose patients tend to appear sedated, as opposed to severely agitated.

Anxiety, mild agitation, and seizures should be treated with benzodiazepines. Patients may require high doses; don’t be afraid. Patients also may require intubation for airway protection.

The antidote for anticholinergic toxicity is the cholinergic agent, physostigmine. Physostigmine is a carbamate acetylcholinesterase-inhibitor, which binds reversibly to acetylcholinesterase (AchE) and results in an increase in acetylcholine. This agent crosses the blood-brain barrier, which is why it is preferred over pyridostigmine (commonly used to treat myasthenia gravis).

Physostigmine usually is used when the patient displays significant peripheral and central toxicity (i.e., the patient is very agitated or delirious). The recommended dose is 0.5-2mg IV slow push in adults (0.02mg/kg, max 0.5mg IV in pediatric patients). Have atropine ready at the bedside in case the patient develops bradycardia. There have been case reports of patients with TCA overdoses developing asystole after receiving physostigmine, so it is wise to always get an ECG before giving the medication and – if there is a wide QRS – start sodium bicarbonate. The half-life of physostigmine is approximately 15 minutes; you can repeat the dose after 20 minutes under close monitoring if the first dose is not effective.

Patients with a mild presentation should be observed for 4 to 6 hours, and can be safely discharged to home if they remain asymptomatic and the overdose was unintentional (otherwise, consult your psychiatry department). Patients who require high doses of benzodiazepines or who remain agitated will require ICU admission. With proper supportive care and discontinuation of all anticholinergic agents, the prognosis is very good.

Your patient received physostigmine, but unfortunately remained severely agitated. The intern was not happy when you grazed him with a needle while he was holding the patient down as you sutured her laceration. The patient required intubation for sedation and was admitted to the ICU. Your attending, who happens to be a toxicologist, quickly chastised you for even thinking the overdose was “just” ibuprofen, and reminded you of the seizures, coma, renal failure, massive GI bleeds, metabolic acidosis, and cardiopulmonary arrest that may occur with massive NSAID overdoses. But that’s another story.

### References

**Rashes: two case studies**

**Case 1 (dyshidrotic eczema, also known as pustular eczema)**

A three-year-old boy of East-Indian origin presented with his father in the emergency department (ED) with a chief complaint of “itchy hands,” which had been bothering him for three months. After obtaining further history, we learned that the boy has been scratching his hands and forearms for as long as the parents could remember; as an infant he was diagnosed with eczema by his family physician. The young patient was seen by his family doctor two months ago, and was prescribed a one-week course of corticosteroid cream for the hands. On examination, the boy is in no distress; his vital signs, cardiorespiratory exam, and lips/mucosa are normal. Both hands appeared as they do in Image 1; he did not have any symptoms on his feet.

We suspected dyshidrotic eczema and referred the boy to the dermatology department, where he was seen the same day. A short course of prednisone was given – followed by a steroid ointment – to complete resolution of the pustules.

**Case 2: (scromboid poisoning rash)**

A 28-year-old male presented to the ED with headaches, flushing, nausea, diarrhea and a cutaneous eruption after eating a fish meal. Upon further questioning the fish was determined to be tuna, which was pan-seared and purchased a local grocery store. The patient recalled a funny odor from the fish, but no strange or peppery/burning taste. On exam the patient was in no distress; his vital signs were normal and a cardiorespiratory exam revealed no wheezing. An abdominal exam revealed hyperactive bowel sounds without tenderness.

The rash on the patient’s back – as in Image 2 – was mildly raised, blanching, and non-pruritic. The patient was presumed to have scromboid food poisoning. After a single dose of IV diphenhydramine (Benadryl) 50mg, the patient’s symptoms disappeared; he was discharged home 30 minutes later.
EMRA gratefully acknowledges these organizations for their generous support of the many activities during Scientific Assembly.

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Thousands of residents and medical students joined EMRA at ACEP’s 2012 Scientific Assembly to network, learn, job-seek, compete, and revel in the camaraderie of fellow emergency medicine colleagues. Pictured here are just a few of the ways EMRA served its members at the annual conference, which has become one of the most anticipated events of the year for emergency medicine physicians across the country.
Residency Fair

Bloody Mary Breakfast

Resident Seminars

Congratulations to the 2012 National Emergency Medicine CPC Competition Winners!

Congratulations to The University of Florida College of Medicine – Jacksonville!
Pictured left to right: Brian Baird, MD; Heidi Ashbaugh, MD; Tracy Graham, MD; and Steve MacDade, MD. Not pictured: Program Director David Cato, MD.

SimWar Winners

Congratulations to The University of Florida College of Medicine – Jacksonville!
Pictured left to right: Brian Baird, MD; Heidi Ashbaugh, MD; Tracy Graham, MD; and Steve MacDade, MD. Not pictured: Program Director David Cato, MD.

Alumni Reception

Congratulations to the 2012 National Emergency Medicine CPC Competition Winners!

The winners are: Best Resident Presenter: Nir Harish, MD, Denver Health; and Best Faculty Discussant: Charlotte Wills, MD, Alameda County Medical Center

Resident Presenter Runner-Up (not pictured): Katie Sprinkel, MD, Carolinas Medical Center

Faculty Discussant Runner-Up (not pictured): Anand Swaminathan, MD, NYU Bellevue Hospital Center
Call for 2013 EMRA Spring Award Nominations

It’s time to nominate yourself or a colleague for an EMRA Award. Visit the website for application instructions. Deadline for submission is February 15, 2013. Awards will be presented at the EMRA Award Reception, May 17, 2013, during the SAEM Annual Meeting in Atlanta.

EMRA Travel Scholarships to SAEM
EMRA will sponsor six $500.00 travel scholarship for active resident members to attend the 2012 SAEM Annual Meeting.

Travel Scholarships to Leadership and Advocacy Conference
EMRA will sponsor three $500.00 travel scholarship for active resident members to attend the 2012 ACEP Leadership and Advocacy Conference.

Robert J. Doherty, MD, FACEP, EMF/ACEP Teaching Fellowship Scholarship
This scholarship provides tuition for the ACEP Teaching Fellowship, an intensive course in faculty development.

Dr. Alexandra Greene Medical Student Award
The Dr. Alexandra Greene Medical Student Award recognizes a student who displays a significant dedication to emergency medicine.

Residency Director Award
This award recognizes a residency director who serves as a role model for residents and exemplifies those qualities residents value in a mentor.

Assistant Residency Director Award
This award recognizes an assistant or associate residency director who serves as a role model for residents and exemplifies those qualities residents value in a mentor.

Jean Hollister EMS Award
This award recognizes a resident who has made valuable contributions to pre-hospital care and emergency medical services.

Academic Excellence Award
This award is given to a resident who has done outstanding work in research or other academic pursuits.

Dedication Award
This award recognizes an EMRA member who has demonstrated significant dedication in promoting the goals and objectives of EMRA at local, state and national levels.

Residency Coordinator Award
This award is given to the residency coordinator who regularly goes above and beyond the call of duty for the good of the program and its residents; supports resident endeavors in extracurricular activities like community service, research, etc.; and actively supports resident involvement in their specialty organizations.

Local Action Grant
This grant is awarded to promote the involvement of emergency medicine residents in community service and other activities that support the specialty of emergency medicine.

For more information visit www.emra.org.

Board Certification in Emergency Medical Services

The American Board of Emergency Medicine has been approved to grant certification in the subspecialty of Emergency Medical Services (EMS). Certification in EMS is open to any physician who is certified by an American Board of Medical Specialties (ABMS) Member Board and fulfills the ABEM Policy on Medical Licensure and the EMS Eligibility Criteria. Both of these documents and the Core Content of EMS Medicine are available on the ABEM website.

The application period for the first EMS certification examination opened October 1, 2012, and will continue through June 30, 2013. The first EMS subspecialty certification examination will be administered October 23-25, 2013, at Pearson VUE professional testing centers.

ABEM is also preparing for the EMS Maintenance of Certification (MOC) program. Each physician who attains certification in EMS in 2013 will begin participating in EMS MOC in 2014. One component of MOC is Lifelong Learning and Self Assessment (LLSA). LLSA addresses issues of relevance to current practice. The LLSA tests are multiple-choice, open-book tests based on a number of relevant readings.

ABEM encourages EMS organizations and individual physicians to submit suggestions for readings. The form for submitting articles and additional information are available on the ABEM website (there also are links from the home page).

ABEM has also developed FAQs on EMS certification and EMS MOC. Additional information can be found on the Emergency Medical Services section of the ABEM website. If you still have questions after checking these sources, please call ABEM at 517.332.4800 ext. 387, or email subspecialties@abem.org.

Be a part of EMRA’s Legacy Initiative

www.247365doc.com
Watch the documentary trailer and support EMRA
Wants You!

Mark your calendars for the new EMRA committee application deadlines this spring!

Apply by April 15 to serve on the Health Policy, International, Technology, Research, Critical Care, Education, and EM Resident Advisory Committee and take on projects as determined by the Board of Directors.

Feeling really passionate? Apply by February 15 to be considered for the position of Vice Chair. The Vice Chair of each committee for 2013-2014 must accept a two-year commitment, as they will continue as Chair for the 2014-2015 year.

All applicants must be EMRA members and must submit a Letter of Intent stating their interest in serving on the committee (and express their interest in running for Vice Chair, if applicable), as well as their Curriculum Vitae.

Apply online at www.emra.org/committeeapp.aspx or by emailing your application materials to committees@emra.org.

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For more information and a full schedule of events, please visit www.cordem.org
Risk management pitfalls for mild traumatic brain injury

From the September 2012 issue of Emergency Medicine Practice,” Management Of Mild Traumatic Brain Injury In The Emergency Department (Trauma CME).” Reprinted with permission. To access your EMRA member benefit of free online access to all EM Practice, Pediatric EM Practice, and EM Practice Guidelines Update issues, go to www.ebmedicine.net/emra, call 1-800-249-5770, or email ebm@ebmedicine.net.

1. “The GCS score was normal. How can he have a head bleed?”
   Even in patients with a GCS score of 15, there is a small—but definite—risk for an intracranial lesion. About 6% to 8% of patients with mild TBI and a normal GCS have ICI on CT, and less than 1% will require neurosurgical intervention.

2. “But I told the patient everything at discharge.”
   Patients discharged from the ED after mild TBI can be expected to recall no more than 30% to 50% of verbal instructions, and a significant number will suffer from both short-term and long-term postconcussive symptoms. This holds true even for those patients who appear completely neurologically intact. Consequently, all discharge instructions should not only be written down, but also told to a responsible third party.

3. “But the skull films showed no fracture.”
   Numerous studies have demonstrated the low sensitivity of skull films for predicting intracranial lesions. Though the presence of a fracture on a skull film increases the incidence of a traumatic intracranial lesion, the absence of a visible fracture does not decrease the incidence of an intracranial lesion. CT with bone windows is the imaging strategy of choice for patients with suspected TBI.

4. “The babysitter initially said that the baby fell down the steps, and then changed her story and said the baby fell off the sofa.”
   Child abuse is a frequently reported cause of TBI in infants. Emergency clinicians should be on their guard and recall that an inconsistent history is often associated with child abuse. When in doubt, it is best to err on the side of caution and involve the proper child protective services.

5. “But the CT was negative.”
   CT is an excellent test for identifying lesions in need of neurosurgical intervention, but it is not very good at identifying brain stem lesions, basilar skull fractures, or nonhemorrhagic injuries. In fact, about 25% of focal axonal injuries, 50% of brain stem lesions, and 30% of basilar skull fractures are missed on CT. These injuries typically involve a great deal of energy and are therefore not commonly found in a patient with mild TBI or found in isolation. It is extremely rare for an initially undetected lesion on CT to evolve into a lesion that requires neurosurgical intervention. Patients and families should be given discharge instructions that describe symptoms that require a repeat visit to the ED.

6. “The patient is malingering. His CT was negative, and the neurologic examination was normal.”
   Many patients diagnosed with mild TBI have deficits on cognitive testing despite a normal CT. Most of these deficits resolve within 3 months of the injury, but some do not. It is very stressful for patients with persistent symptoms that do not seem to be supported by objective evidence. Follow-up with a neurologist can be very helpful to determine the need for further neuroimaging or neuropsychological testing.

7. “The coach asked me if he could play in the tournament tomorrow.”
   There is no longer any role for same-day return to play, and the assessment for return to play involves the individual evaluation of the player by his or her primary care or sports medicine physician with consideration to the severity of concussion, past injuries, and expected future impact injuries. Discharge instructions must include both physical and cognitive rest until cleared by the player’s physician.

8. “I thought the patient was just drunk.”
   Alcohol users are at increased risk for TBI, and evaluation is made difficult by their intoxication. These patients require serial neurologic evaluations, and if there are any associated high-risk criteria, a CT is indicated.

9. “He didn’t get knocked out. How could he have a subdural hematoma?”
   In many cases of mild TBI, there will be no loss of consciousness, and only about 10% of sports TBI is associated with loss of consciousness. A period of unconsciousness or amnesia to the event is not required for ICI, and the absence of loss of consciousness is not protective against ICI or future symptoms of postconcussive syndrome.

10. “I know he was on warfarin, but his CT was normal, so I sent him home.”
    Delayed hemorrhage is a rare, but important, concern in anticoagulated patients. All patients on anticoagulants must be educated about the risk of delayed hemorrhage and instructed to return for a repeat CT in the setting of any new or worsening symptoms.
Risk management pitfalls for croup in children

From the September 2012 issue of Pediatric Emergency Medicine Practice, “An Evidence-Based Approach To The Evaluation And Treatment Of Croup In Children.” Reprinted with permission. To access your EMRA member benefit of free online access to all EM Practice, Pediatric EM Practice, and EM Practice Guidelines Update issues, go to www.ebmedicine.net/emra, call 1-800-249-5770, or email ebm@ebmedicine.net.

1. “But I needed to document his blood pressure.”
   Avoid causing further agitation in a child with stridor. Observation of the child on the parent’s lap and an oxygen saturation monitor is all you need to do.

2. “He’ll be fine. His saturations came right up with oxygen.”
   If a child requires oxygen to maintain adequate oxygen saturation, consider serious upper airway obstruction with impending respiratory failure or lower respiratory tract parenchymal involvement, such as laryngotracheobronchopneumonitis, or pneumonia.

3. “This kid just had a barky cough yesterday. Why did his parents bring him back today?”
   Evidence shows that treating even mild croup with oral dexamethasone prevents repeat ED and other healthcare visits and improves sleep.

4. “The child vomited the dexamethasone. What do I do now?”
   Pay attention to the form of oral dexamethasone that is administered or dispensed in your practice setting. Many of the commercially available oral solutions of dexamethasone are quite dilute. This means that a child will have to take a large volume of medication. For example, a 10-kg child who is prescribed 0.6 mg/kg of the 0.5 mg/5 mL oral dexamethasone solution would have to ingest 60 mL of the solution to get his dose. Most of the studies on oral dexamethasone in croup have used the much more concentrated parenteral-injectable form of the drug given orally. The small volume is absorbed rapidly and is well tolerated, with vomiting in fewer than 5% of patients. In children with persistent vomiting, dexamethasone can be given IM or IV. Nebulized budesonide is another option when a child cannot tolerate oral medications.

5. “Antibiotics can’t hurt…”
   Antibiotics should be reserved for suspected cases of bacterial tracheitis (high fever, toxic appearance, acute onset of stridor, poor response to epinephrine) or pneumonia (focal findings on auscultation such as crackles, wheezing, or infiltrate on chest radiograph). There is no role for antibiotic prophylaxis in croup.

6. “This is the third time this kid has had croup this winter.”
   It is important to consider other causes of stridor in children with recurrent symptoms or who present with stridor in the absence of a viral prodrome or who do not improve with treatment with epinephrine.

7. “She looked so good after that dose of epinephrine that I let her go…”
   Physicians should observe children who have been treated with epinephrine for at least 2 hours before discharging them home. The effects of epinephrine typically wear off after about 2 hours, and the child may develop recurrence of symptoms similar to the ones exhibited prior to treatment with epinephrine.

8. “He still had symptoms 4 days later, so I gave him more dexamethasone.”
   There is no evidence to support the use of multiple doses of dexamethasone in the treatment of croup. Croup generally lasts 2 to 5 days. If a child is still having moderate symptoms days after receiving a dose of dexamethasone, other diagnoses must be considered, such as bacterial tracheitis or anatomic abnormalities of the airway.

9. “They’re calling a code blue in radiology!”
   Children with signs of worsening upper airway obstruction should not leave the ED for diagnostic imaging. They may decompensate rapidly if they become upset or are laid down for radiographs.

10. “What size endotracheal tube should I use?”
    If a child with signs of severe croup does not improve with nebulized epinephrine and/or if they show signs of increasing agitation or lethargy, they should be referred to a pediatric critical care unit. If intubation is necessary, it should be done under controlled circumstances by someone with expertise in managing difficult pediatric airways. It is advisable to start with auffed endotracheal tube a half-size smaller than would be predicted for the child’s age. It may be necessary to size down even more, depending on the degree of subglottic edema.
PEER (Physician’s Evaluation and Educational Review in Emergency Medicine) is ACEP’s Gold Standard in self-assessment and educational review. These questions are from the latest edition of PEER—PEER VIII—which made its debut at the 2011 Scientific Assembly. To learn more about PEER VIII or to order it, go to www.acep.org/bookstore.

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

1. A 46-year-old man presents with dense right hemiparesis, right hemisensory loss, and global aphasia of 20 minutes’ duration. He is looking to the left. Where is the lesion located?
   A. Anterior cerebral artery
   B. Basilar artery
   C. Middle cerebral artery
   D. Posterior cerebral artery

2. A 42-year-old man presents with intermittent painful rectal bleeding over the past 4 days. Which of the following physical examination findings should prompt further workup for underlying disease?
   A. Firm external hemorrhoid with bluish discoloration
   B. Internal hemorrhoids requiring manual reduction
   C. Left lateral anal fissure
   D. Posterior midline anal fissure

3. A 32-year-old man presents by ambulance after a motor vehicle crash. He was hypotensive in the field and responded to administration of 2 L crystalloid solution. Vital signs include blood pressure 118/80, pulse 95, and respirations 20. He has ecchymosis over his upper abdomen, which is tender to palpation. Which of the following statements regarding CT scanning in this situation is correct?
   A. It is extremely sensitive for diagnosing hollow viscus injury
   B. It is superior to ultrasonography for diagnosing solid organ injury
   C. Oral contrast is not helpful for evaluating the abdominal trauma
   D. Ultrasonography is superior for diagnosing hemoperitoneum

4. In which of the following arrhythmias is immediate synchronized cardioversion indicated?
   A. Accelerated idioventricular rhythm after reperfusion
   B. Multifocal atrial tachycardia
   C. Unstable atrial fibrillation
   D. Ventricular fibrillation

5. In a patient with a new pleural effusion, which of the following laboratory findings suggests that it is an exudate?
   A. pH level less than 7.1
   B. Pleural fluid LDH level less than 200 units/L
   C. Pleural fluid LDH level-to-serum LDH level ratio less than 0.6
   D. Pleural fluid protein level-to-serum protein level ratio greater than 0.5

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

Ohio, Cincinnati: New Hospital Opens Soon! Mercy West, a 250-bed hospital will be opening in 2013 with an anticipated ED volume of 50,000-60,000. Located in the western suburbs, this will be a state-of-the-art facility with great opportunities for BP/BC EM physicians. Premier Physician Services provides an outstanding model offering equity-ownership at one year with no buy-in; giving you a voice and ownership in your company. Excellent package includes guaranteed rate plus additional incentives, family medical plan, employer-funded pension, CME/expense account and additional benefits. For additional information contact Kim Rooney (800)726-3627, ext. 3674, e-mail krooney@premierdocs.com, fax (937) 312-3675.

Ohio, Columbus: The Ohio State University Wexner Medical Center’s Department of Emergency Medicine is offering the following Fellowship positions beginning in July 2013: ACGME Accredited: EMS, Toxicology. Non-ACGME Accredited: Ultrasound, Education, Administration. All fellows will receive appointments at The Ohio State University College of Medicine. Non-ACGME fellows will receive an auxiliary faculty appointment and ACGME fellows will receive a PGY-4 appointment. Fellows must have successful completed an Emergency Medicine residency program and be eligible to obtain an Ohio medical license. We offer a competitive salary with a full university benefit package. A CME allowance and tuition assistance are also provided. Complete descriptions of all fellowship programs can be found at http://www.osuem.com. Send CV and cover letter to Mark G. Angelos, MD, Professor and Interim Chairman, Department of Emergency Medicine, The Ohio State University Wexner Medical Center; mary-jayne.fortney@osumc.edu; 614-366-8693. AAEOE.

Ohio, Columbus: The Ohio State University Wexner Medical Center

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Ohio, Columbus: Enjoy working in a rural community hospital within 30 minutes of downtown Columbus. Annual ED volume of 34,000 with 40 hours of physician daily coverage. Guaranteed hourly plus additional incentive, malpractice, family medical plan, employer-funded pension, CME/Expenses plus equity-ownership at one year with no buy-in! Contact Amy Spegal, Premier Physician Services, (800)726-3627, ext. 3682, aspegal@premierdocs.com, fax (937) 312-3683.

Ohio, Dayton: BP/BC EM physician sought to join solidly established, democratic group at 42,000 volume ED in northern suburb. Enjoy working in a collegial environment and outstanding physical plant. Excellent package includes guaranteed hourly plus incentive, malpractice, employer-funded pension, family medical plan, CME, and more. Contact Greg Felder, Premier Physician Services, (800) 726-3627, ext 3670, e-mail gfelder@premierdocs.com, fax CV (937)312-3671.

Ohio, Findlay: Premier Physician Services announces a new opportunity in 40,000 volume ED. Located 45 minutes south of Toledo, this Level III Trauma Center is a Top 100 Hospital with an appealing environment and excellent support services. Enjoy the benefits of an outstanding model offering equity-ownership at one year with no buy-in: giving you a voice and ownership in your company. Terrific benefits include family medical plan, employer-funded pension, expense account & additional benefits including loan repayment opportunity; plus the advantage of guaranteed rate AND additional incentive. For additional information contact Amy Spegal, Premier Physician Services, at (800)726-3627, ext 3682, e-mail aspegal@premierdocs.com, or fax CV to Premier at (937)312-3671.

Ohio, Lima: Meet your financial and practice goals. Named among Top 100 Hospitals, 57,000 volume, level II ED will complete expansive, state-of-the art renovation in 2012. Excellent coverage and terrific package including guaranteed hourly plus RVU and additional incentives, malpractice, employer-funded pension, family medical, CME, shareholder opportunity. Contact Kim Rooney, Premier Physician Services, (800)726-3627, ext. 3674, krooney@premierdocs.com, fax (937) 312-3675.

Ohio, Marion: Appealing opportunity 45 miles north of Columbus in 48,000 volume ED. State-of-the-art facility has excellent coverage of 62 physician & 18 PA hours daily. Equity-ownership model provides guaranteed hourly plus additional incentive, family medical, employer-funded pension, shareholder status with no buy-in and more. Contact Amy Spegal, Premier Physician Services, (800) 726-3627, ext 3682, aspegal@premierdocs.com, fax (937) 312-3683.

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

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

Ohio, Toledo: New Opportunity – Premier Physician Services announces new opportunities in suburban Toledo college town. This ED has an annual volume of 26,000; excellent coverage includes resident and MLP support. A director opportunity is also available. Highly appealing compensation package includes guaranteed rate plus RVU and additional incentive; family medical plan, employer-funded pension, expense account and more including shareholder status at one year with no buy-in. For additional information contact Amy Spegal, Premier Physician Services, at (800)726-3627, ext. 3682, e-mail aspegal@premierdocs.com, fax (937) 312-3683.

Oklahoma, Clinton, Durant & Madill: Hospital Physician Partners has several new partnerships with exceptional hospitals throughout Oklahoma. Full and Part Time Emergency Medicine opportunities are available for Physicians, Residents and Mid-Level Providers. Get in on the ground floor of these new contracts and take advantage of newly increased hourly rates! Must be BC/BP in EM. Offering lucrative compensation, paid malpractice with tail, free & discounted CME, state licensure assistance and clinically-led leadership. Contact Terri Harper: (800) 815-8377 ext. 5296; email tharper@hppartners.com or visit www.hppartners.com.

Oregon, Salem: Partnership opportunity with independent, democratic, and well established group at 95K annual volume Salem Hospital, Level II trauma center with excellent specialty support. New ER built in 2009, sophisticated EMR, extensive career opportunities. Benefits include scribes, flexible scheduling, CME stipend, malpractice, medical, 401K, and more. Must be EM BC/BP. Salem is located 45 minutes south of Portland, in the heart of Oregon’s wine country. We love it here and you will too. Send CV, cover letter and recent photo to sepspc@salemhealth.org or call us at 503-561-5634.

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Pennsylvania, Pittsburgh: Allegheny Valley Hospital in Natrona Heights boasts a brand new ED seeing 36,000 emergency pts./yr. Forbes Regional Hospital is a respected facility in Monroeville seeing 48,000 ED pts/yr. Both sites are proximate to Pittsburgh’s most desirable residential communities; areas afford easy access to abundant outdoor recreation and nationally ranked schools. Outstanding partnership opportunity includes equal profit sharing, equity ownership, funded pension, open books, full benefits and more. Contact Ann Benson (careers@emp.com), Emergency Medicine Physicians, 4535 Dressler Rd. NW, Canton, OH 44718. 800-828-0898 or fax 330-493-8677.

Emergency Physicians of Tidewater (EPT) is a democratic group of BC/BP (only) EM physicians serving 7 EDs in the Norfolk/VA Beach area for the past 40+ years. We provide coverage to 5 hospitals and 2 free-standing EDs. Facilities range from a Level 1 Trauma, tertiary care referral center to a rural hospital ED. Members serve as faculty for an EM residency and 2 fellowships. All facilities have EMR, PACS, and we utilize MPs. Great opportunities for involvement in ED Administration, EMS, US, Hyperbarics and medical student education. Very competitive financial package leading to full partnership/profit sharing. Outstanding, affordable coastal area to work, live, and play. Visit www.ep911.com to learn more.

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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. 39,000 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, York: Staff and Assistant Director/Assistant Residency Director positions at Memorial Hospital. Sites has new ED, respected osteopathic EM residency, and sees approximately 42,000 ED pts/yr. Outstanding partnership opportunity includes equal profit sharing, equity ownership, funded pension, open books, full benefits and more. Contact Ann Benson (careers@emp.com), Emergency Medicine Physicians, 4535 Dressler Rd. NW, Canton, OH 44718. 800-828-0898 or fax 330-493-8677.

West Virginia, Huntington: Work in 2 locations – Top Compensation – Equity Ownership – With this opportunity you no longer have to choose between lifestyle and compensation. Established group has very appealing position working between 72,000 volume ED in Huntington, and affiliated free-standing low volume ED in Ironton, Ohio. This opportunity will allow you to earn superior compensation while spending significant time within a slower-paced ED. Plus the busier Huntington ED offers the support of 66 physician hours, 48 MLP hours as well as scribe support. 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 and additional benefits. A sign-on bonus is also available. Contact Rachel Klockow, Premier Physician Services, (800) 406-8118; e-mail rklockow@premierdocs.com; fax (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.

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

The Ohio State University Wexner Medical Center is one of the largest and most diverse academic medical centers in the country and the only academic medical center in central Ohio. We’re internationally known for our superior quality, depth of expertise and leadership in personalized health care. A new Cancer Hospital and Critical Care Tower which includes a new Emergency Department (71k annual visits) designated as a Level 1 Trauma Center, Burn Center, Cardiac Center and Stroke Center and/or a Community-based Emergency Department (50k annual visits).

Minimum qualifications: MD or DO; successful completion of an Emergency Medicine residency program; Board certified or eligible; Ohio medical license; interest in working in an academic medical center providing clinical care and bedside teaching.

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