

EM Resident

Official Publication of the Emergency Medicine Residents' Association

December 2016/January 2017

VOL 43 / ISSUE 6



A Record-breaking ACEP16

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Palliative Care, Part 2

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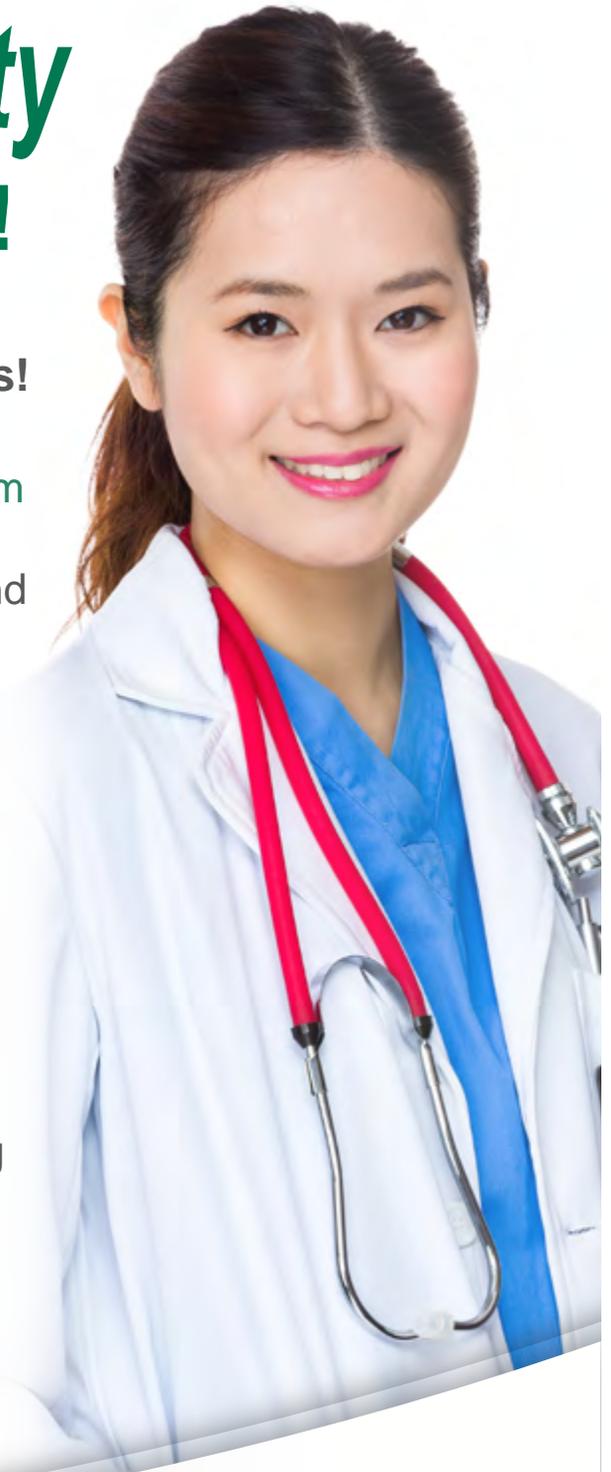
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Letter from the Editor



Abby Cosgrove, MD
Editor-in-Chief, EM Resident
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Samuel Beckett Bridge
Dublin, Ireland

Some days I feel like quitting. I always imagine it happening in the same way. It will be the end of an exhausting 12-hour overnight shift. I will have just been yelled at by a sleep-deprived consultant. A previously apneic heroin addict dropped off by his buddies will now be screaming at the top of his lungs, flinging his arms wildly at the bedside nurse, calling me every name in the book. Three large security guards will attempt to wrestle him down, and I will back away slowly. The intercom will then start blaring “Don’t You (Forget About Me)” from *The Breakfast Club*. The glass doors to the ambulance bay will fling open, the naloxone-induced uproar in the background will fade, my stethoscope will fly off my shoulders, and I will enter into the blinding light, never to return again.

While I use this example somewhat facetiously, the truth is that most of us have probably felt this way at some point in our training. And it isn’t because we are lazy, weak, or cold-hearted; it is because our job is *really hard*. This is made worse by that fact that few people, many of whom are respected colleagues, truly understand the physical and emotional stamina required to be a great emergency medicine physician — one who must continuously operate with composure, efficiency, and grace in the setting of unanticipated chaos and uncertainty.

With this in mind, I headed into the ACEP16 *Scientific Assembly* in October feeling somewhat burnt out. I was tired

from the daily grind — the overcrowding, the drug addicts, the night shifts, the endless interruptions, the turf wars, the malfunctioning electronic health record. One evening, after a particularly tragic patient outcome, the wheels came flying off.

I needed to refocus. I needed to feel like I had purpose, and that I could actually make a difference. After all, isn’t that what called me to medicine in the first place?

I found myself re-reading Dr. Paul Kalanithi’s *New York Times* bestseller, “When Breath Becomes Air.” For those who aren’t familiar, this is a phenomenal memoir written by a neurosurgery resident who faced a terminal illness and sought to discover what truly makes life meaningful. One particular line struck me: “I remember the moment when my overwhelming uneasiness yielded. Seven words from Samuel Beckett, a writer I’ve not even read that well...began to repeat in my head, and the seemingly impassable sea of uncertainty parted: ‘I can’t go on. I’ll go on.’”

How was I supposed to “go on?”

That’s when you showed up.

More than 1,500 of you arrived in Las Vegas in October with passion, excitement, and resolve. You spoke with leaders and role models in the field, attended groundbreaking lectures, participated in one of the most exciting Representative Council meetings to date, competed brilliantly in SIMWars

and 20 in 6, brainstormed new ways to engage members within your committees and divisions, and successfully pulled off EMRA’s first-ever MedWAR. To put it simply, you showed up. You showed up not only for yourself, but for your respective programs, your specialty, and most importantly, for your patients.

So why does that matter? Because the reason emergency medicine was born and thrived as a specialty, and the reason a patient who is having a life-threatening coronary artery occlusion can call 911, have an ambulance arrive at their home, be transported to a hospital, receive a diagnosis, and undergo a life-saving intervention in less than 60 minutes, is because thousands of emergency medicine physicians like you and before you, through all kinds of adversity and setbacks, awakened every day saying, “I’ll go on.”

You are brilliant, compassionate, and caring individuals with the unique privilege and honor of caring for anyone who presents through the glass doors of the emergency department at any time and for any reason, regardless of race, religion, gender, or socioeconomic status. That is so incredibly powerful and should never be minimized or forgotten.

Therefore, I ask of you: If at any point along this journey you find yourself feeling hopeless, battered, or lost, please remember this:

You can go on. Your specialty, and your patients, need you. ★

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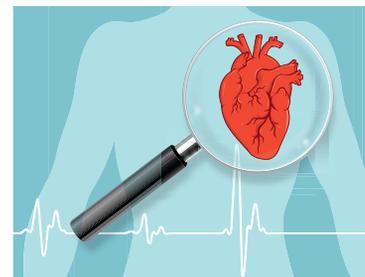
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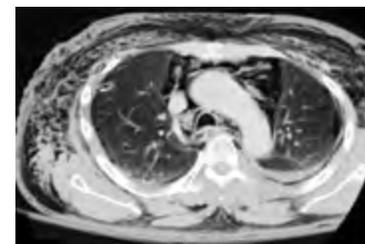
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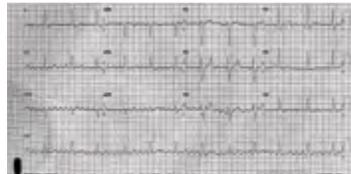
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Who will be our EMRA Superstars?

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Spring Awards Deadline
JANUARY 15

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emra.org/awards

Why Does EMRA Membership Matter?



Alicia Kurtz, MD
EMRA President
Chief Resident, UCSF Fresno
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Hey there EMRA!

This is my first letter to you as this year's president, and I honestly could not be more excited to write it.

EMRA is an incredible organization. **We are more than 14,000 members, including over 90% of all ACGME EM residents in the country.** Over 90%! So when we say we represent the voice of EM residents, we absolutely mean it.

Why does that matter? Because there are all kinds of people out there making decisions that directly affect your training and your future clinical practice. For example:

- The ACGME is changing how programs are accredited, especially for DOs as we move toward a single accreditation pathway.
- ABEM is changing the board certification process, moving toward e-Oral boards and an online in-training exam for residents.
- ACEP is constantly making decisions on which issues to focus their attention and developing clinical practice guidelines that represent the “standard” in EM.

And the list goes on and on.

In all of this, what YOU — our nation's future EM physician workforce — think should matter. Your interests need to be represented and your perspectives need to be heard.

This is one of the crucial things EMRA does for you. We meet regularly with leaders of these and other organizations to discuss goals and priorities and make sure they've considered what that means for residents and medical students.

We're Not All Talk

But EMRA does way more than just speak on your behalf. **EMRA consistently provides tools for clinical improvement and fosters collaboration with motivated and talented residents and students across the country.**

Seeing the work of our EMRA board members, committee and division leaders, and program representatives is inspiring and energizing. From educational products like the *EMRA Antibiotic Guide* and new critical dosing badge cards to national events like the EMRA Quiz Show and 20 in 6, our members accomplish things at the student and resident level that are unmatched by any other specialty.

Setting Priorities

Meeting and working with so many incredible leaders in EMRA has inspired me to set our board priorities for the year:

- 1. We need to continue to develop our members as national leaders in EM.** We are not only the leaders of the future; we are leaders now! In EMRA, in our departments, in our communities. This year EMRA will work to create more formalized and meaningful leadership development opportunities.
- 2. We must expand the work we're doing in physician wellness.** We will continue collaborating with other organizations to develop a model wellness curriculum and brainstorm ways to shift our culture to one of more open dialogue about the sad, horrific, and stressful experiences each of us has on a daily basis.
- 3. We will keep working to build community and improve our effectiveness and accessibility as an organization** — utilizing technology like streaming video and social media to bring information to you in the way YOU communicate and learn.

I can promise you this board will continue to work tirelessly for you over the coming year, and I can't wait to report back on their accomplishments.

But **WE CAN'T DO IT WITHOUT YOU!**

In 1974, our founder, Joseph Waeckerle, wrote in the very first edition of *EM Resident*, “To do a decent job, I must know what you want... you must communicate with me. If we speak firmly and responsibly now, we will be much stronger in the future.”

The same is true today. We depend on YOU to tell us what you need. What do you think? What concerns you? What do you dream for the future of our specialty?

This year, I challenge you to tell us! You can email literally any of us at any time; all of our emails are on the EMRA website. We *want* to hear from you.

Better yet, **get involved in EMRA** and make the changes you want to see. Join a committee or division. Sign up as a medical student mentor. Help plan the next Rep Council meeting at SAEM in Orlando.

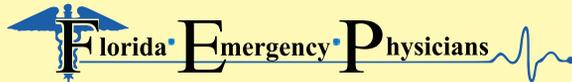
Please don't be strangers. We're all in this together, and I hope you know that's true.

My personal motto is “keep moving forward” -- which yes, I totally stole from a children's movie called *Meet the Robinsons*, but the sentiment is real. **No matter how good we are, we can always be better. I hope you'll help get us there. ***



To Our Partners,
Thank you for helping make EMRA's events at ACEP16 so extraordinary. We are humbled and appreciative of your continued support.

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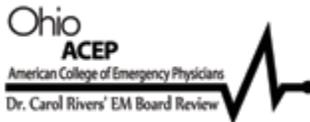
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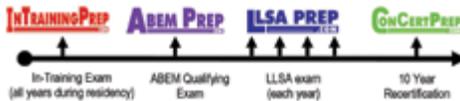
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With EMRA events spanning more than a week in Las Vegas, progress surged on multiple fronts.

Resolutions & Elections

The Representative Council discussed, debated — and ultimately voted in favor of — four resolutions:

1. Support high-fidelity simulation as a component of the ABEM oral certification exam.
2. Support diversity and inclusion for emergency medicine physicians in training.
3. Support awareness of and education about human trafficking.
4. Support gun violence research from a public health perspective.

Additionally, the Rep Council elected five positions on the EMRA Board of Directors, including **Zach Jarou**, MD, as president-elect; **Scott Pasichow**, MD, MPH, as vice-speaker; **Nida Degesys**, MD, as ACEP representative; **Shehni Nadeem**, MD, as membership development coordinator; and **Rachel Solnick**, MD, as legislative advisor.

The five will join President **Alicia Kurtz**, MD, and Immediate Past President **Ricky Dhaliwal**, MD, JD, in shepherding the association for the coming year.

National updates include the ACEP leadership transition to Rebecca Parker, MD, as president; COD partnering with ACEP on a Resilience Summit in February; and a reminder of ABEM's new online certification application.

Enjoy a few scenes from Las Vegas. Meanwhile, be sure to join us at the ACEP Leadership & Advocacy Conference, March 12-15, in Washington, D.C.



EMRA's Medical Student Forum and luncheon allows students to interact with program directors in lectures, small groups, and individually.



EMRA Program Representatives speak for the fellow residents while voting on resolutions and board candidates.



After working hard at the EMRA Residency Program Fair, the crew from UT Southwestern lets their true colors show at Studio EMRA.



With SIMWars, 20 in 6 Resident Lecture Competition, and the brand-new EMRA MedWAR, residents have plenty of opportunity to exercise their competitive natures.

Congratulations Award Recipients!



Abena Obenewaa Akomeah, MD; Jerome Rogich; Michelle Lynch: ACEP16 Travel Scholarships



Orlando Regional Medical Center's **Tory Weatherford, MD; Christopher Ponder, MD; Mandi Stone, MD; Amanda Tarkowski, MD; and Thomas Smith, MD:** Clinical Excellence Award (presented by program director Salvatore Silvestri, MD, FACEP)



Kevin Klauer, DO, FACEP: Joseph F. Waeckerle Alumni Award



Lt. Cmdr. Travis Deaton, MD: Steve Tantama, MD, Military Excellence Award (presented by Lt. Cmdr. Christine DeForest, DO)



Thiago Halmer, MD, and B. Bruce Graham, MD: EDDA Scholarships



Carrie Jurkiewicz, MD: Leadership Excellence Award (presented by Christine Babcock, MD, FACEP)



Shehni Nadeem, MD: Augustine D'Orta Award (presented by Alison Haddock, MD, FACEP)



Sean Dyer, MD: FOAMer of the Year



The CORD CPC Final Competition awards, presented by Amy Church, MD, FACEP, went to **Bryant Allen, MD; Chen He, MD; Guy Carmelli, MD; and Graham Brant-Zawadzki, MD, MA.**



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The week in Las Vegas included a packed schedule of education, fellowship, entertainment, and competition.

The second annual EMRA 20 in 6 Resident Lecture Competition brought together 15 worthy speakers and 4 dynamic judges: (from left) judges Mel Herbert, MD, FACEP, and Paul Jhun, MD, FAAEM, winners William Fox, MD (2nd Place), Nikolai Schnittke, MD (1st Place), and Caleb Sunde, MD (People's Choice), and judges Nikita Joshi, MD, and David Terca, MD (2015 winner).



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New EMRA Leaders

ALICIA KURTZ, MD PRESIDENT

Chief Resident, UCSF Fresno
Fresno, CA
president@emra.org
@aliciakurtz_md

Describe your leadership style in 20 words or less.

Oooo — this is a tough one! But probably would be a derivative of the Golden Rule: Be the kind of leader you want to follow. To me this boils down to being willing to do the work (not just assign it to others), being OK with being wrong and owning it, letting yourself dream big and be vulnerable, taking feedback well and growing from it, always working to improve and move forward, keeping the focus on what's best for the group, and maintaining a relentless positivity.

Best advice you've ever heard?

This is a tie:

1. "You never know where the road will go. My advice? Take the road." — Julie Veinbergs, MD (the OB/GYN who delivered me!)
2. "When all eyes are on you... wink." — Mike's Hard Lime bottle cap

Favorite life-balancing hack? I am a list maker! I live by my schedule and lists, which are organized by "urgent" (stuff that's due now), "important" (maybe not due right now but should get done ASAP because they matter), and "general to-do" (can happen whenever, or not, and that would be OK). All of this is color-coded, obv. The color-coding is key. (Plus makes it way more fun to look at!)

What goes on pizza? OK seriously, I could **never** answer this question! Pizza is literally my very favorite food and I could never choose just one set of toppings! Depends on the mood. And how hungry you are. And whether you're going to eat dessert after.

If your fellow residents picked a motto for you, what would it be?

Well, I can tell you that one of my attendings wrote on a shift eval of mine, "I wish Alicia would take a Valium before working with me." Haha! So it would probably be something about having energy, and overabundance of enthusiasm, and frankly being a little crazy...

Respecting HIPAA, tell us about your most memorable patient encounter.

So many to choose from! One that stands out is definitely this young male who had some really intricate tattoo sleeves on his arms that were all cut up from broken glass. I spent the better part of an hour doing a careful job suturing his lacs to make sure the tattoo was going to line up well and his scars would fit into the art. When he realized what I was doing, he turned to his girlfriend and said, "Babe! Are you seeing this?! This b*&! is a GI!" Later on his way out of the ED he was showing his stitches to all the hallway patients and just kept saying, "She's such a GI!" He may have been a *little* intoxicated... but it still makes me smile to remember how stoked he was!

Most-used app on your phone?

Text messaging and email. Efficiency!

Favorite board game?

I'm a fan of just about any that result in tons of laughter. Contenders would include Catch Phrase, Quelf, and Cards Against Humanity. ★



ZACH JAROU, MD
PRESIDENT-ELECT
 president-elect@emra.org
 @zachjarou

What's your primary goal in your new role with EMRA? To support our new President Alicia Kurtz in executing her vision and preparing myself to be the voice of our organization when I assume the presidency next year.

Describe your leadership style in 20 words or less. I lead by example. I like feedback, evidence, and being purposeful instead of rote.

If your fellow residents picked a motto for you, what would it be? Do something or get out of the way.

Favorite life-balancing hack? Multitasking to the nth degree, and then finding a local beerfest.

Best advice you've ever heard? As someone who normally likes to get things done as quickly as possible, a saying that I will be trying to keep in mind throughout my term is "If you want to go fast, go alone. If you want to go far, go together."

What goes on pizza? Banana peppers and feta OR sausage, grilled onions, and green pepper.

Wine, beer, coffee, water or something else? Coffee in the morning, beer in the evening. I'm really into sours and West Coast-style IPAs. I also like Cabernets... and have sometimes even been known to drink water.

Most-used app on your phone? Twitter! Be sure to follow: @zachjarou; @DenverEMed; @emresidents

Favorite board game? Old school: Monopoly or Clue. New school: Settlers of Catan ★

What's your primary goal in your new role with EMRA? Increased representative involvement in the Representative Council with webcasting of meetings and online voting.

Describe your leadership style in 20 words or less. Diplomatic leader who wants to hear people's ideas on how to accomplish a goal and build consensus.

If your fellow residents picked a motto for you, what would it be? Don't just do something, stand there!

Favorite life-balancing hack? Sharing calendars between family members.

Respecting HIPAA, tell us about your most memorable patient encounter.

My first really sick patient in the PICU. She had just had a massive brain bleed, and her parents were trying to find ways of involving siblings in her care. Her sister made bracelets for the whole team to wear. I still have one on my office desk at home. The way the team worked together to care for her is emblematic of the teamwork that makes me love emergency medicine.



Best advice you've ever heard? This too shall pass. It's hard with all the stresses of life to remember that the little things are just that: little. Keep focus on the bigger goals and the details will work out.

What goes on pizza? Pepperoni and mushrooms

Wine, beer, coffee, water or something else? Good day? Haufenweise. Bad day? Scotch.

Most-used app on your phone? Downcast

Favorite board game? Risk ★



SCOTT PASICHOW, MD, MPH
VICE-SPEAKER OF THE COUNCIL
 vicespeaker@emra.org
 @SPMD16

NEW EMRA BOARD



What's your primary goal in your new role with EMRA? To represent our 15,000 members to the ACEP board on issues that are important to physicians-in-training.

Describe your leadership style in 20 words or less. Direct, honest, assertive. (At UCSF we take a test, True Colors, describing our personalities in terms of colors, I am a "gold" — love lists, structure and organization — so I guess that impacts my leadership style.)

If your fellow residents picked a motto for you, what would it be?

Work hard, power through (with a smile — usually).

Favorite life-balancing hack? Have a baby (no seriously, it teaches you what real sleep deprivation is and how to deal... after that everything seems easy).

Respecting HIPAA, tell us about your most memorable patient encounter. Babies with burns — breaks my heart every time.

Best advice you've ever heard? While you think you can do it all, you can't, so pick things that are important to you and prioritize, outsource the rest

What goes on pizza? Lots of meat

Wine, beer, coffee, water or something else? Whiskey (preferably Scotch)

Most-used app on your phone? What's an app? Just kidding, Google Photos (I take like hundreds of pics/videos a day that require constant uploading to Google Photos)

Favorite board game? Boggle ★

What's your primary goal in your new role with EMRA? To develop a leadership curriculum for medical students and residents to utilize across the nation with enhanced resources, early mentorship, opportunities for involvement, and guidance for career development.

Describe your leadership style in 20 words or less. Innovative and integrative. In trying to create, I aim to take input and feedback from the whole team.

If your fellow residents picked a motto for you, what would it be? "A person's a person no matter how small." —Dr. Seuss

Favorite life-balancing hack? Schedule a date night once a week, whether it's with yourself or someone else.

Respecting HIPAA, tell us about your most memorable patient encounter.

Early in intern year, I had a young homeless patient who presented with heat exhaustion. After treating her, I gave her a large sun hat from our donated clothing closet. Tears welled up in her eyes, as she thanked me for treating her with respect. I felt I had done little for her, but when I saw her again two weeks later, she beamed at me and declared, "Look Doc. No sunburn!"

Best advice you've ever heard? To be yourself is to be enough.

What goes on pizza? Jalapenos!

Wine, beer, coffee, water or something else? Nothing beats a glass of water for me!

Most-used app on your phone? Google Calendar

Favorite board game? Monopoly ★





What's your primary goal in your new role with EMRA? I want to empower residents to see themselves as individual change agents, whether it be at the level of their residencies, hospitals, communities, state, or national. On every level there is room for positive change, and issues that are in dire need of someone who cares to come and shake things up. As doctors, and especially as emergency medicine doctors, we are excellent at quick diagnostics and being team leaders. We need to recognize we can apply these special skills beyond our direct patient care, and help improve the systems we operate in.

Describe your leadership style in 20 words or less. Create an environment that cultivates individual passions, and inspires contributions based on each person's own drive to want to be part of something bigger.

If your fellow residents picked a motto for you, what would it be? "Isn't this awesome?!" I'm the happy-go-lucky one.

Best advice you've ever heard? "Earn this." It's a quote from the movie "Saving Private Ryan." While it is a clip that shows a soldier dying on the battlefield, it captures so much more. My medical school class was shown this clip on one of our last days of fourth year, with the message that what we do is a privilege and a duty. This inspires me to approach life with the perspective of trying to build something bigger and leave something better.

Wine, beer, coffee, water or something else? All of them.

Most-used app on your phone? Medically: WikEM (love FOAM); Personally: Spotify

Favorite board game? Cranium for parties, Settlers of Catan. ★



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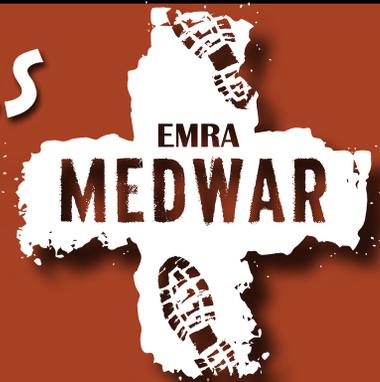
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EMRA MEDWAR ROLLS TO RECORD HEIGHTS IN RED ROCK CANYON



In its inaugural year, the 2016 EMRA MedWAR raced into the record books, with 30 competitors and nearly 40 volunteers staging a wildly successful event.

Kicking off with the sunrise in the Red Rock Canyon National Conservation Area on Oct. 19, EMRA's first-ever medical wilderness adventure race pitted 10 teams of residents against 12+ miles of desert trails, with seven medical challenge

stations as well as off-trail bonus opportunities.

Competitors encountered scenarios including multi-system trauma evaluation and evacuation, mass casualty lightning strike, anaphylaxis, heat injury, and a snake bite. Teams employed various wilderness techniques and airway skills demonstrated on mannequins provided by Gaumard. The groups who completed each medical challenge with no errors

continued racing; those who forgot key steps were tasked with another on-site challenge before being allowed to continue.

Scenarios were not shared in advance, and supplies were not provided; teams succeeded by anticipating and improvising. Every racer completed the course and enjoyed an awards ceremony hosted by Elvis, followed by an all-

teams pizza party.

"I'm so excited to see this come together for the residents," said Wilderness Medical Society founder Paul Auerbach, MD, MS, FACEP, of Stanford University School of Medicine. "It's a unique way to learn, and the competitors will undoubtedly use what they have learned at some point in their careers."

"I hope it will grow from here and that we can look forward to an annual event."

The EMRA Wilderness Division collaborated with the ACEP Wilderness Medicine Section to host the race. Gaumard partnered with EMRA to provide medical equipment for the challenges. ACEP Wilderness Medicine Section Immediate Past Chair Michael Caudell, MD, FACEP, helped facilitate logistics and train proctors for each medical challenge.

Special thanks goes to Matt Horbal, MD, Assistant Professor of Emergency Medicine at the University of Nevada Reno, for advance scouting of the venue and for key race day support. In addition, the EMRA Wilderness Division thanks all the volunteers who made the event possible.





MedWAR Victors

Congratulations to our EMRA MedWAR winners:

- **First place:** **Medical College of Georgia/Team Mzungus** – 01:55 (1 hr 55 min)
 - ◆ Carissa Chalut, DO
 - ◆ Darrel Douglas, MD
 - ◆ Parker Smith, MD
- **Second place:** **Stanford-Kaiser Emergency Medicine Residency/Know When to Fold ‘Em** – 03:11
 - ◆ Joseph Einhorn, MD
 - ◆ David Radler, MD
 - ◆ Ian Storch, MD
- **Third place:** **UCSF-SFGH/Trauma November** – 03:03*
 - ◆ Taylor Nichols, MD
 - ◆ Christian Rose, MD
 - ◆ Scott Tcheng, MD
- **Drama King** (best medical actor, male): Justin Hensley, MD, FACEP
- **Drama Queen** (best medical actor, female): Kathryn A. Lucas, MS-II, Touro University of Nevada College of Osteopathic Medicine
- **Best Team Name:** University of Mississippi/Don’t Suck Out the Poison

**Trauma November from UCSF-SFGH technically won second place based on their final time, which was calculated by actual time to complete the course minus time awarded for successfully completing bonus challenges. Trauma November ceded to Stanford’s Know When to Fold ‘Em team in recognition of Stanford’s assistance on the trail; the team provided crucial shelter-building material for Trauma November to use during the heat injury scenario – without which Trauma November would not have been able to finish the race. Kudos on this awesome display of support and camaraderie between our teams!*

Visit our **MedWAR**
photo galleries!
emra.smugmug.com

MedWAR Teams

In addition to the top 3 finishing teams, the EMRA Wilderness Division congratulates all participants who spent the day making EMRA's inaugural MedWAR a success.

- **Madigan Army Medical Center/
Rambo Medicine** – 03:44
 - ◆ Kyle Couperus, MD
 - ◆ John Cruz, MD
 - ◆ Zachary Sletten, MD
- **Thomas Jefferson University/
LexVegas Reunion Tour** – 03:53
 - ◆ Anna Condino, MD
 - ◆ Andrew Griffith, MD
 - ◆ Joshua Rudner, DO
- **Yale-New Haven Hospital/
Poison IV** – 04:00
 - ◆ Charlie Duke, MD
 - ◆ Jessica Walrath, MD
 - ◆ Michael Yip, MD
- **Texas A&M Corpus Christi/
Corpus Crabs** – 04:15
 - ◆ Richard Fleischer, MD
 - ◆ Ryan Joseph, DO
 - ◆ Joseph Yard, MD
- **Saint Louis University/
The Bair Huggers** – 05:12
 - ◆ Jake Sanning, MD
 - ◆ Dan Schwartz, MD
 - ◆ Sneha Topgi, MD
- **University of Mississippi/
Don't Suck Out the Poison** – 05:37
 - ◆ Tory Andrews, MD
 - ◆ James Cunningham, MD
 - ◆ Wade Swanson, DO
- **University of Chicago/
The Throckmortons** – 06:00
 - ◆ Colton Clay, MD
 - ◆ Jen Nykiel, MD
 - ◆ Nishma Sachedina, MD *



The EMRA Wilderness Division collaborated with the ACEP Wilderness Medicine Section to host the race.

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Manager of Academic Support Services
Florida International University Wertheim
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Miami, FL

Palliative Care, Part 2

A How-To Guide

Editor’s note: This is the second in a two-part series.

For the first installment, “The Importance of Early Implementation in the ED,” please see emresident.org/palliative-care-part-1.

Michael is tired. The emergency department (ED) is inconceivably busy. The waiting room census keeps growing by leaps and bounds, while the hospital census remains fixed at capacity. And today, Michael’s desire and efforts to provide the best care — both to his swiftly cycling discharges and numerous pending admissions — are repeatedly met with frustration. He meets his next patient, Emily, who is also tired. But not from a hard day at work. She is tired from battling an aggressive cancer for months, and from an inability to find relief from the constant pain and suffering. Michael wants to provide her with the best care possible, but wonders if he has the time and expertise to do it.

While studies have found that initiating palliative care in the ED can be beneficial in reducing departmental visits and offloading health care

expenditures, the reality is that the practical implementation of this can be challenging.^{1,2} What follows is a short guide to aid in the provision of palliative care within the ED. Included as part of this guide is a list of assessment tools providers can use to identify patients who may benefit from palliative care, symptom-based treatment guidelines, and a discussion on compassionate extubation of the acutely dying patient.

Informal Assessment Tools for Identifying Patients Who Might Benefit from Palliative Care

One method by which providers can rapidly identify patients who might benefit from palliative care treatments is by recognizing various factors or “red flags” that can be associated with increased palliative care needs. These flags can be categorized by symptoms, disease pathology, or signs.

A simpler approach, described in a recently published systematic review of palliative care assessment tools, is a process whereby providers ask themselves 2 simple questions: “*Would you be surprised if the patient died within the next year?*” and “*Would you be surprised if the patient died on this hospital visit?*”³ The answer “yes” to either of these questions can indicate that the patient could benefit from palliative care.

Symptom-based identification comprises recognition of complaints such as dyspnea, pain, fatigue, anorexia, confusion, asthenia, and worry.³⁻⁶ The **PAIN RULES** mnemonic (Figure 1) highlights these and other common red flag symptoms that can be useful to providers as they attempt to identify patients who may benefit from palliative care interventions.

Clinical assessment or comprehension

of ailment pathophysiology and associated prognosis can also be used to identify patients who can benefit from palliative care services. Zalenski and Zimny suggest a comprehensive disease-based list (Figure 2) to facilitate medical provider awareness and rapid identification upon presentation of patients with these diagnoses.⁴

Certain physical signs are particularly indicative of patients presenting in the acute stages of end of life. Recognizing the presence of these symptoms can be very useful to providers in determining which palliative care interventions may be appropriate for this special subset of patients. Although this assessment may be seemingly straightforward, specific studies have been performed examining patients with malignant disease and have found that the presence of the following specific signs has been associated with increased sensitivity and likelihood of death within a 72-hour period (Figure 3).^{5,6} Indicators specifically correlating with imminent death include increased drowsiness to awake ratio, increased use of opioids, cyanosis of the extremities, altered respirations with associated mandibular movement, and death rattle.⁷

Formal Assessment Tools: For the Exceptionally Detail-Oriented

Several formal multi-symptom and functional assessment tools have been developed to assist providers in quantifying symptom severity and identifying individuals who may benefit

FIGURE 1. Symptom-Based Identification⁴

PAIN RULES
Pain
Anorexia and other appetite or oral intake related issues
Incontinence and other genitourinary symptoms
Nausea and other gastrointestinal symptoms (constipation, vomiting, diarrhea)
Respiratory symptoms (dyspnea, cough)
Ulcerations and other skin complaints
Level of functioning
Energy and other related issues such as fatigue or asthenia
Sedation, sleep, and other side effects of treatment

from palliative care interventions. Tools commonly used include the Brief Pain Inventory (BPI) and the revised Edmonton Symptom Assessment Scale; the latter (along with the Rotterdam Symptom Checklist) has been translated into several languages.

While obtaining data from nonverbal patients can present additional challenges, the Critical Care Pain Observation Tool and Behavioral Pain Scale have been created to help facilitate this.

Other tools useful in assessing functional status and individual needs include the Needs at the End-of-Life Screening Tool (NEST), the Patient-Reported Outcomes Measurement Information System, and the Palliative Performance Scale (PPS).

The Palliative Care and Rapid Emergency Screening (P-CaRES) tool, recently designed specifically for use within the ED, employs a stepwise system to assess whether patients may benefit from referral to palliative care (Figure 4).^{8,9} The tool assists providers in first assessing the presence of life-limiting illness. If such illness is identified, the tool guides providers in ascertaining unmet palliative care needs.

Treatment Considerations: Advance Directives and Goals of Care

Various challenges exist regarding the possession, availability, and establishment of advance directives. Some researchers have found that only 21% to 46% of geriatric patients presenting to the ED possess written advance directives. Of these, existing advance directives were available to ED staff for only 1% to 44% of these patients.¹⁰ These data emphasize the need for providers to be confidently proficient in communicating with patients and family members regarding their goals of care in urgent situations.

Understanding patients' attitudes regarding quality of life can assist providers in communicating with patients about advance directives and goals of care, and can guide practitioners in making treatment recommendations. Data from studies may prove valuable to health care providers in constructing a framework for conversations about advance directives and goals of care. For example, in response to a survey

FIGURE 2. Diagnosis-Based Identification⁵

Neoplasm with widespread metastasis that is unresponsive to treatment
End-stage heart failure
End-stage chronic obstructive lung disease
Advanced dementia
Degenerative neurologic disease
End-stage acquired immunodeficiency syndrome
End-stage renal or hepatic disease
End-stage rheumatologic disease
Multisystem trauma with nonsurvivable injury
Multiorgan failure
Any chronic, progressive, debilitating disease

disseminated to patients aged 60 years and older with limited life expectancy, 74.4% of participants reported they would not prefer treatment if the outcome of the treatment was survival with severe functional impairment; 88.8% of participants reported they would not prefer treatment if the outcome was survival with cognitive impairment.¹¹

Treatment Guidelines: Symptom-Based Recommendations

Because inadequately managed symptoms are among the primary reasons patients seek treatment in the ED at the end of life, it behooves providers to be well versed in the management of these complaints. The following comprise recommendations that can be used to treat and manage symptoms commonly experienced by terminally ill patients.

Dyspnea

Opioid administration is an effective pharmacologic intervention that has been studied extensively for use in managing dyspnea in terminally ill and acutely dying patients. Additional therapies for managing dyspnea include the use of oxygen, fans, and other medications (including benzodiazepines and low-dose ketamine for some patients).¹² Intermittent positive pressure ventilation may be useful in treating dyspnea in the appropriate settings if symptoms are severe.¹³

Pain

While some literature has boasted theoretical synergistic analgesic effects

by combining nonopioid medications with opioids, opioids continue to be the primary means of managing pain in terminally ill patients.¹⁴⁻¹⁶ Terminally ill patients may benefit from administration of a combination of long- and short-acting analgesics to maintain stable analgesic concentrations and consistently control symptoms. Adjuvant medications that may be used, depending on underlying pathology or concomitant medical conditions, include gabapentinoids, antidepressants, glucocorticoids, or anticholinergics. Medications that may be used in the acute care setting include ketamine and alpha-2 agonists (e.g., dexmedetomidine), both of which have been described in literature on multimodal management of acute pain.¹⁷⁻¹⁹

Anxiety

Benzodiazepines are considered the first line of treatment for anxiety-related symptoms; as mentioned previously, they also may be used to alleviate anxiety associated with dyspnea. The choice of benzodiazepine should be dictated by desired time of onset and duration of action. Depending on the clinical situation, the faster onset of a medication such as lorazepam may be advantageous; in other situations, the longer duration of a medication such as midazolam may be optimal. Other agents that may be employed to alleviate anxiety include opioids such as morphine. In acutely dying patients with extreme anxiety that is refractory to these agents, palliative sedation with phenobarbital or propofol may be considered.²⁰

FIGURE 3. Sign-Based Identification in Acutely Dying Patients^{12,13}

- Decreased urinary output
- Drooping of nasolabial folds
- Hyperextension of neck
- Decreased responsiveness to verbal and visual stimuli
- Inability to close eyelids
- Grunting through vocal cords
- Respirations with rapid mandibular movement
- Presence of nonreactive pupils
- Presence of Cheyne-Stokes breathing
- Death rattle

FIGURE 4. Brief Description of Palliative Care and Rapid Emergency Screening (P-CaRES) Tool^{10,11}

Step 1 — Does the patient have a life-limiting illness?

Select all that apply and proceed to step 2 if one or more items are checked.

- Advanced dementia or central nervous system disease
- Advanced cancer
- Advanced chronic obstructive pulmonary disease
- Advanced heart failure
- End-stage liver disease
- Septic shock
- Provider discretion: high chance of accelerated death

Step 2 — Does the patient have two or more unmet palliative care needs?

Select all that apply. If two or more are checked, referral for palliative care is recommended.

- Frequent visits
- Uncontrolled symptoms
- Functional decline
- Uncertainty about goals-of-care and/or caregiver distress

Would you be surprised if this patient died within 12 months?

Nausea and vomiting

The sensation of nausea and vomiting is associated with the regulation of serotonin, dopamine, acetylcholine, and histamine; hence, pharmacological interventions are centered around the manipulation of these neurotransmitters. Various antiemetic options include: ondansetron and other serotonin 5-hydroxytryptamine-3 receptor antagonists; corticosteroids such as dexamethasone; metoclopramide, or dopamine antagonists such as haloperidol or droperidol; anticholinergics such as scopolamine; or antihistamines such as meclizine. These medications may be used in isolation or combination. Other options for controlling nausea include the use of agents such as dronabinol or tetrahydrocannabinol.

Secretions: Death Rattle and Xerostomia

Management of terminal secretions, through use of agents such as scopolamine, atropine, or glycopyrrolate, can be key in minimizing turbulent respirations and death rattle. Although data are limited, glycopyrrolate poses a theoretical benefit in that its structure, unlike that of other medications, does not allow passage through the blood-brain barrier; minimizing the potential for exacerbation of delirium. On the opposite spectrum, terminally ill patients may suffer from xerostomia, which can be treated by utilizing artificial saliva-like solutions, sprays, or gels, or pilocarpine.

Psychosis/Delirium

Antipsychotics are the first-line treatment for psychosis and both spectrums of delirium, and have been shown to be beneficial for terminal patients with various malignant and nonmalignant conditions. Agents such as chlorpromazine or haloperidol (both available in intramuscular forms), or second-generation antipsychotics such as quetiapine, may be used. Although not considered an additional treatment option for the general population, the use of opioids may additionally be utilized for terminally ill patients, particularly in cases in which symptoms may coexist with or be exacerbated by significant pain and associated agitation.

Hydration

Debate exists surrounding the practice of providing intravenous hydration to patients whose death is imminent, and data are mixed.^{21,22} Despite these mixed data, general recommendations hold that the decision to administer hydration to patients at the end of life should be made based on provider assessment of the potential risks of volume overload and worsening of bronchial secretions with the benefits of hydration.

Constipation

Iatrogenic or disease-induced constipation is a frequent complaint among terminally ill patients and should be considered upon commencement

or escalation of opioid analgesic regimens. Stimulant laxatives, such as sennosides or bisacodyl, may be used to treat constipation. Options for osmotic laxatives include lactulose, sorbitol, polyethylene glycol, magnesium hydroxide, and magnesium citrate.

Treatment Guidelines — Compassionate Extubation

When extubation is indicated for patients at the end of life, the removal of ventilators should be done carefully, and extubation should be centered around patient and family values. Prior to withdrawing mechanical ventilation, loved ones should be allowed time with patients whose deaths are imminent.²³

In managing extubation of terminally ill patients, providers should individualize treatment to ensure that the clinical situation, the values of the patient, and the patient's preferences are considered.²⁴ Because of the increased need for aggressive management of the patient's symptoms after extubation, algorithms to guide the provision of care (as well as the providers administering this care) should allow for adequate preparation

for extubation. Such preparation includes ensuring that medications for managing pain, anxiety, and dyspnea are readily available.²⁵

Withdrawal of ventilator support can occur rapidly or via slow titration to allow the patient to adapt to spontaneous breathing upon extubation.²⁶ Providers may experience discomfort or hesitation upon increasing the frequency and dosage of medication post-extubation; however, frequency and dosage of medication should first and foremost be dictated by a patient's symptoms. Providers should be aware of and potentially prepare families for the possibility of increased respiratory distress caused by:

1. The patient's transition to spontaneous ventilation
2. Soft-tissue upper-airway obstruction
3. Underlying pathological disease
4. A combination of the aforementioned

After extubation is complete, providers must continually reassess patients to ensure symptoms are adequately controlled. If symptoms are refractory, providers may consider use of palliative sedation.²⁷

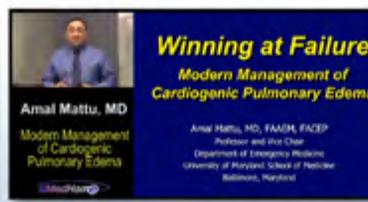
Studies have been performed examining how soon death occurs after the withdrawal of mechanical ventilation. One study found that patients typically die within 0.25 to 5.5 hours of extubation.²⁸ The amount of time between extubation and death has been associated with the number of the patient's organs involved in multisystem organ failure, requirements for vasopressors or intravenous fluid, and diagnosis on admission.²⁹

Concluding Thoughts

Through this series and the stories of symbolic figures like Emily and Michael, it is our hope that we have demonstrated how the administration of palliative care may be beneficial for patients at the end of life, their medical providers, and the emergency departments to which they present. Although implementing palliative care in the ED may be difficult and challenging due to logistical barriers, it is additionally our hope that providers can use the ideas and recommendations outlined in this article to efficiently administer compassionate care to this significantly prevalent subset of our patients. ★



Free For All EMRA Residents

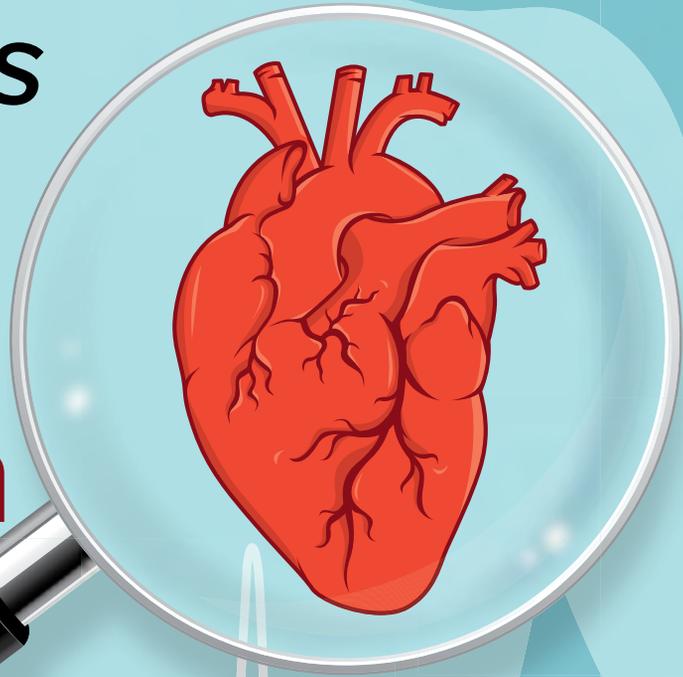


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SPONTANEOUS Coronary Artery Dissection



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Not Your Average Heart Attack

A 32-year-old female presents to the emergency department (ED) with a chief complaint of severe chest pain. The pain started 3 hours prior in the center of her chest. It is non-radiating, constant, 9/10 on the pain scale, is worse with walking, and has associated dyspnea and vomiting. She denies any past medical history or significant social history and takes no medications. Vital signs are unremarkable. Physical exam reveals a woman who appears uncomfortable, is diaphoretic, and is clutching her left chest in pain. An ECG is immediately performed, which reveals ST-elevation in the inferior leads (Figure 1). Cardiology refuses to take this patient to the cardiac catheterization lab due to her young age. How should you respond?

Background

Spontaneous coronary artery dissection (SCAD) is an uncommon but critically important cause of acute coronary syndrome (ACS). Missing this diagnosis has a high risk of fatality if not appropriately treated. SCAD is responsible for 0.1-0.4% of all ACS cases, but has been uniquely associated with females under 50 years old, potentially causing up to 25% of all ACS cases in this patient population.⁵

Two categories of risk factors are commonly associated with SCAD:

1) Predisposing Arteriopathies

1 or more in 80% of cases.⁵ Examples include fibromuscular dysplasia (72% in one study of 168)¹, peripartum status, connective tissue disorders, etc.

2) Precipitating Stressor

Occurred in 56% of cases.¹

Examples include recreational drug use, iatrogenic causes, etc.

Experts believe SCAD has been historically underdiagnosed because it is difficult to recognize and is associated with sudden cardiac death. SCAD usually affects only a single vessel, most commonly the LAD (40-70%).⁵ Typically, pressure-driven expansion of the intramural hematoma eventually leads to occlusion of the true lumen and subsequent myocardial ischemia.

Physical Exam and Imaging/Labs

1. Physical exam will reveal the textbook heart attack patient: diaphoretic, in significant pain, ill-appearing
2. EKG — ST elevation (25-50%), Ventricular arrhythmias (4-14%)⁵
3. Echocardiogram — often reveals abnormal wall hypokinesis
4. Elevated cardiac troponin
5. Lactic acidosis — may be elevated depending on the amount of ischemia

Diagnosis

These patients require emergent cardiac angiography.

Management

Recent evidence supports conservative treatment for patients without ongoing or recurrent myocardial ischemia. This is because of the high rate of spontaneous healing (100% at >25 days in one study of 168) and the low success rate of percutaneous cardiac intervention with

coronary stenting (only 33% had durable long-term results).¹ Overall, conservative treatment is associated with 80% positive long-term outcomes.¹ Conservative treatment consists of blood pressure control, dual anti-platelet therapy, and beta-blockers.

For patients with ongoing or recurrent myocardial ischemia due to SCAD, coronary revascularization by percutaneous coronary intervention (PCI) or coronary artery bypass (CABG) surgery is indicated (Figure 2). Fibrinolysis is not recommended because of risk of increased progression of the intramural hematoma and increased risk of rupture or bleeding.^{8,10}

The recurrence rate for another adverse coronary event is relatively high, estimated at 10-17%.¹ This means that close clinical monitoring is necessary with long-term medical treatment with aspirin, beta-blocker, and clopidogrel.⁵ Close follow-up, particularly with cardiac echo, is important for monitoring long-term cardiac

function. Many of these patients can have significantly reduced cardiac ejection fractions and will require aggressive heart failure medical management and cardiac transplant referral.

Overall, however, if the patient makes it through the acute stage of this disease, then there is a good chance of positive long-term outcomes.

Summary

SCAD is a rare phenomenon that typically occurs in patients in their 20-30s, particularly in women, and in patients without any typical ACS risk factors. Making the diagnosis and advocating for a cardiac catheterization in these patients sets them up for positive long-term outcomes. Treatment options include conservative medical therapy unless the patient is experiencing ongoing or recurrent myocardial ischemia, necessitating coronary revascularization by PCI or CABG surgery. *

FIGURE 1. ECG Reveals ST-elevation in the Inferior Leads

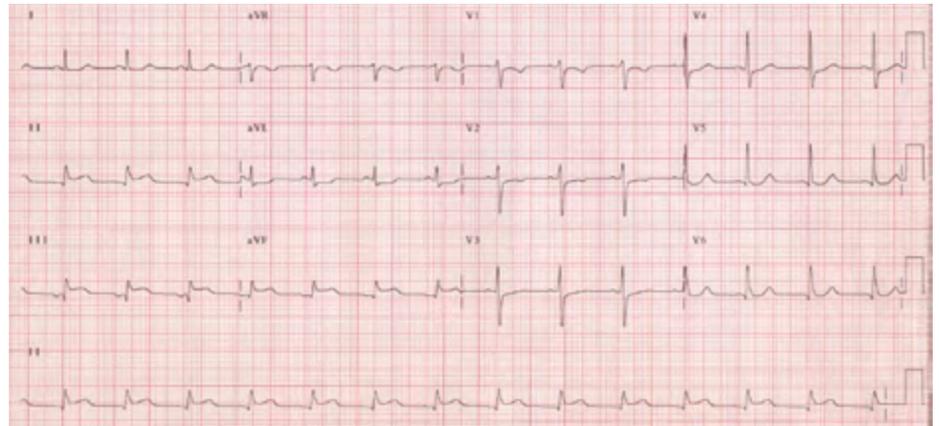


FIGURE 2. Angiography demonstrating LAD occlusion with the tram-track appearance of dissection (left). Favorable angiographic appearance following stent deployment (right).



Arnold J, West N, van Gaal W, Karamitsos T, Banning A. The role of intravascular ultrasound in the management of spontaneous coronary artery dissection. *Cardiovasc Ultrasound*. 2008;6:24.

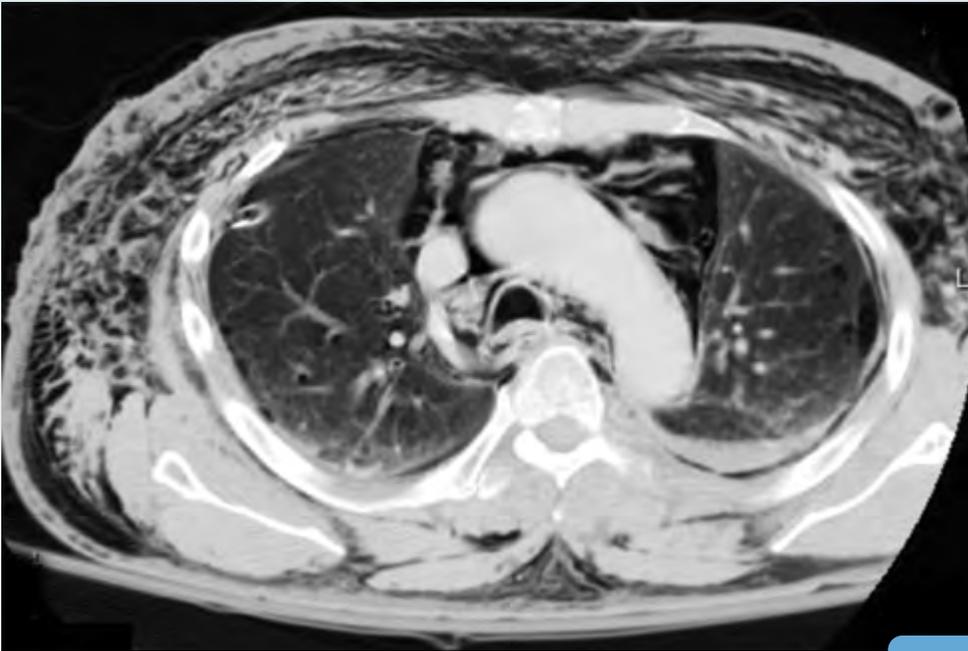


IMAGE COURTESY OF GRUNTD0C



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EDITOR'S NOTE

Please visit emresident.org for a fascinating case report of pneumomediastinum and pneumoperitoneum caused by a tracheal tear during intubation.

There's *Air* in there!

Diagnosis and Treatment of Pneumomediastinum

A 22-year-old female arrives in your trauma bay in respiratory distress. She appears slightly anxious and is mildly tachypneic. Vital signs are as follows: heart rate of 129 beats per minute, blood pressure of 149/96, respiratory rate 23, and pulse oximetry of 87% on room air. She reports that she has been frequently coughing over the past few weeks but became acutely short of breath since this morning, and has since experienced significant chest discomfort. She has no past medical history and takes no medications.

Unfortunately, supplemental oxygen and albuterol do not provide significant improvement. ECG confirms sinus tachycardia without signs of ischemia.

A portable chest x-ray looks clear with no suggestion of pneumonia. The decision is made to obtain a computed tomography (CT) angiogram of the chest for the suspected diagnosis of pulmonary embolism (PE).

The CT is negative for PE but instead shows “mild-moderate pneumomediastinum of unclear etiology.” Now what?

Pathophysiology

Pneumomediastinum is a rare disease that is defined by air in the mediastinal space. It can be classified as either spontaneous or secondary in nature. Spontaneous pneumomediastinum (SPM) is usually the result of a sudden increase in intrathoracic pressure that causes a

subsequent increase in intra-alveolar pressure, leading to alveolar rupture and leakage of air throughout the interstitium, bronchovascular tissue sheath, and mediastinum.¹

Studies show that the preceding event is often a sustained valsalva maneuver, such as what occurs with coughing, emesis, forceful defecation, prolonged expiratory phase (asthma), sneezing, or inhalation drug use.¹ Secondary pneumomediastinum often is the result of blunt or penetrating trauma, complications from surgical interventions in the esophagus or tracheobronchial tree, intubation, or invasion by gas-forming bacterial organisms.¹

References available online.

Presentation

The presentation of SPM resembles many common complaints seen on an average shift in the emergency department. One study found that in patients with SPM, 54% have chest pain, 39% have dyspnea, and 32% have a cough. The trigger event is emesis 36% of the time, asthma exacerbation in 21%, and unknown 21% of the time.¹ The typical patient will most likely be male, with an average age ranging from 20 to 27 years old.¹⁻³ On exam, 32% of these patients will have subcutaneous emphysema.¹

Diagnosis and Treatment

The gold standard for diagnosis is CT scan, because up to one-third of cases are not visualized on x-ray.¹⁻³ Once identified, secondary causes must be ruled out. For example, Boerhaave syndrome, a longitudinal tear of the esophagus secondary to an increase in intraesophageal pressure, must be considered as a potential source given the significant morbidity and

mortality associated with this disease.⁴ Accumulation of corrosive gastric contents and gastric flora within the mediastinal and pleural spaces may result in fulminant mediastinitis and septic shock.⁵ Contrast esophagogram is the study of choice to visualize esophageal rupture.²

Unrecognized SPM could lead to tension pneumomediastinum due to air entering the mediastinum through a valve-like mechanism that is then unable to exit, similar in physiology to a tension pneumothorax.⁶ Retained air may result in reduced lung capacity and secondary atelectasis as well as compression of the right atrium and vena cava.⁷

Fortunately, SPM is an exceedingly rare and self-limiting disease. When diagnosed in the emergency department, ABCs must always be prioritized. Often, no significant interventions are required. While the course of treatment is not standardized, admission is generally recommended along with cardiothoracic or general surgery consultation. This is because of the need to rule out secondary

causes that may require operative washout or repair of the aerodigestive tract. Bed rest and analgesia are often all the patient needs for recovery, with prophylactic antibiotics as a debated subject in the treatment algorithm.³

Complications are rare, and these patients often have an uneventful recovery course.

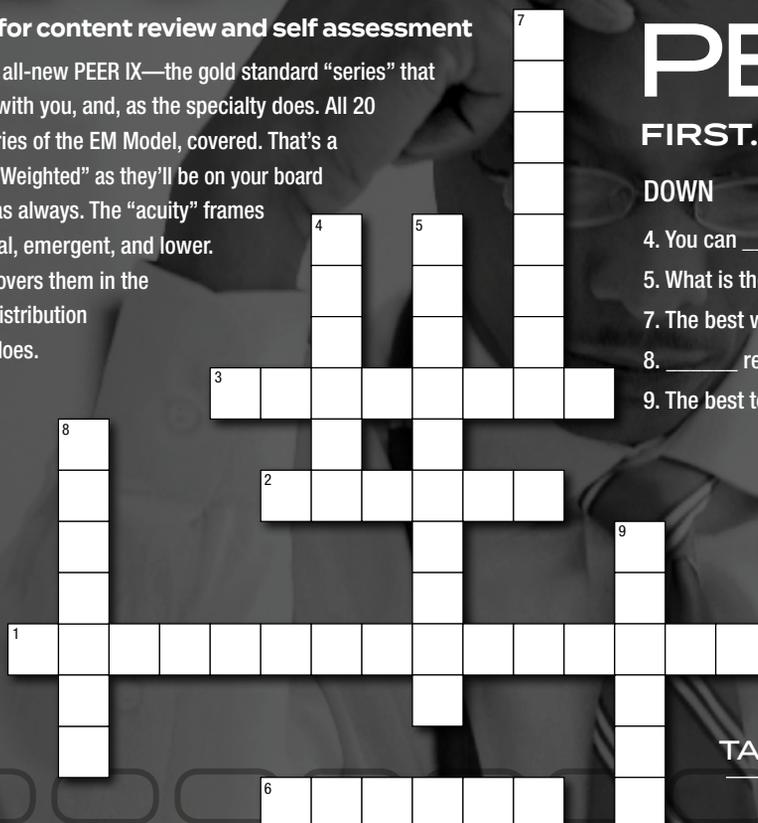
Case Resolution

The patient was admitted to the general medicine team with cardiothoracic surgery consulting. An esophagogram was obtained and was normal. The patient improved with supportive care and was discharged on hospital day three in good condition.

In conclusion, while SPM is a rare disorder, it is worth considering on the differential for a young patient presenting to the emergency department with chest pain or shortness of breath. Treatment is often supportive, but life-threatening causes and complications must be ruled out. Proper imaging is essential for diagnosis, and consultation with surgery is generally recommended. ★

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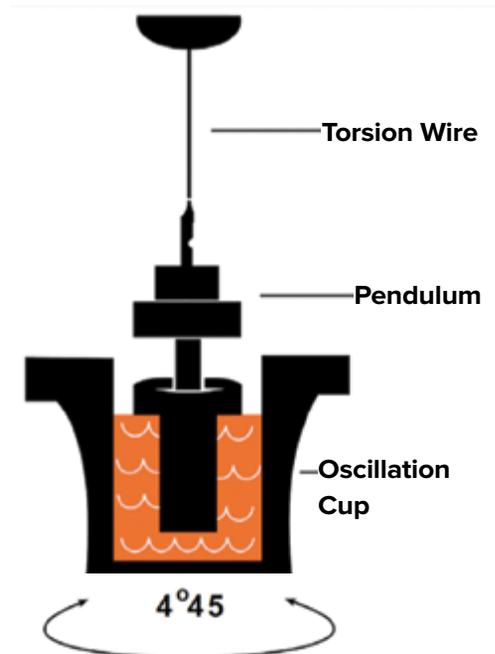
By measuring the clotting ability of a patient's whole blood sample in real time, the TEG is able to provide a more comprehensive representation of hemostatic integrity.

The initial management of shock in patients with severe trauma is most often directed by emergency physicians. Recent adoption of damage control resuscitation has resulted in an increase in the amount of blood products given to these patients. As a result, the development of goal-directed blood component therapy has been promising for reducing blood product wastage and cost, while improving mortality.^{1,2} This review serves to provide basic familiarity with thromboelastographic blood-directed therapy, which has only recently been recognized in the field of emergency medicine and trauma.

Background

The current standard of care for damage control resuscitation and hemorrhagic shock is to replicate whole blood using a 1:1:1 ratio of packed red blood cells, fresh frozen plasma, and platelets.⁷ Traditional algorithms relying on data from PT/INR, PTT, platelet count, and fibrinogen levels have been shown to provide limited information on coagulopathy in the time sensitive setting of trauma.³⁻⁸ Therefore, resuscitation with goal-directed blood component therapy using whole blood visco-elastic tests (VETs) has been promising.

FIGURE 1. TEG Mechanics



References available online.

Thromboelastography (TEG) and Rotational Thromboelastometry (ROTEM) are the two most commonly used VETs. In the United States, the TEG has predominantly been utilized to guide resuscitation, whereas in Europe ROTEM is more widely used. Although TEG-guided management has long been established in cardiac surgery and liver transplantation, it is only recently being used for trauma resuscitation worldwide.⁷⁻¹²

Advantages of TEG-guided resuscitation include the ability to provide real-time assessment of coagulability while limiting the use of blood products, thereby reducing cost and the potential for transfusion-induced organ injury.^{7,13}

How it Works

By measuring the clotting ability of a patient's whole blood sample in real time, the TEG is able to provide a more comprehensive representation of hemostatic integrity, especially during massive transfusion.^{2,5-9} The TEG accurately reflects the lifespan of a clot through its four stages: initiation, amplification, propagation, and termination by fibrinolysis.

The mechanics of the TEG rely on a pin attached to a pressure transducer which is suspended into a cup of small volume. As the cup rotates around the pin, the pin and the cup are gradually joined by the formation of the fibrin and platelet mesh (Figure 1). The resultant

TABLE 1. Therapeutic Interventions for Abnormal TEG Values

Parameter	Value	Intervention
Prolonged r-value	>7 minutes	Plasma and/or prothrombin complex concentrate
Low or flat α angle	<45 degrees	Cryoprecipitate
Narrow MA	<48 mm	Platelets +/- DDAVP +/- Cryoprecipitate
Increased LY30	>7.5%	Anti-fibrinolytic agent

movement of the pin is then plotted as a change in tension that provides graphical representation of each stage of the clot's life.

Interpretation

The four key parameters of a TEG tracing are as follows: r-value, alpha angle (α -angle), maximum amplitude (MA), and LY30 (Figure 2).⁴ The r-value is similar to PT/INR and PTT in that it measures the reaction time to clot formation. The α -angle determines the fibrin and fibrinogen activity by measuring the rate of clot formation. The MA represents the maximum strength of a clot by showing fibrin cross-linking activity. Finally, LY30 shows the percent clot lysis after 30 minutes. Additionally, TEG provides a Platelet Mapping™ assay for assessment of platelet inhibition for patients who are on antiplatelet therapy. TEG has also recently been shown useful in managing patients who are on novel oral anticoagulants.¹⁴

TEG values guide blood component therapy using specific therapeutic

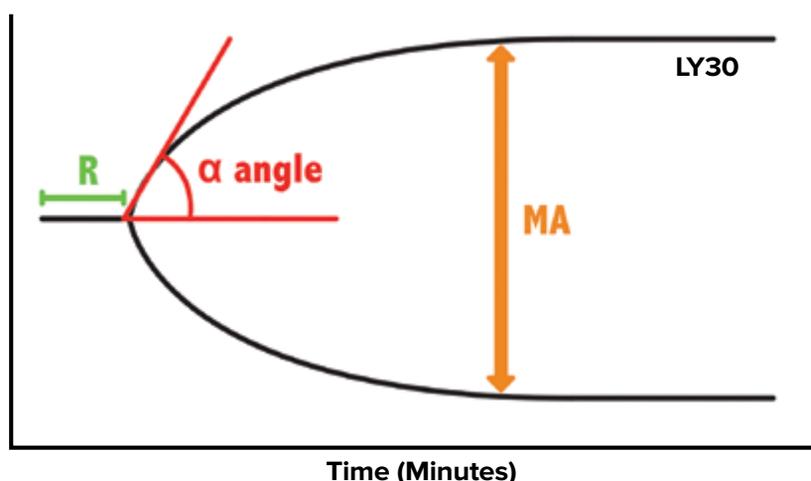
interventions based on values in each of the four parameters. Clinical decision making using TEG data can be achieved using the algorithm shown in Table 1.^{2,6}

The r-value is a measure of time to formation of the clot, reflecting clotting factor activation. A prolonged r-value represents a deficiency of clotting factors, thus indicating the need for a transfusion of fresh frozen plasma or clotting factor complex concentrates. A low or flat alpha angle is a measure of the rate of thrombin generation, leading to the conversion of fibrinogen to fibrin. This indicates the need for cryoprecipitate, which contains fibrinogen, VWF, factor VII, VIII, and fibronectin. A narrow MA indicates low strength of fibrin-platelet crosslinking, indicating the need for platelets, cryoprecipitate, and/or DDAVP, which enhances levels of factor VIII, VWF, and platelet adhesion. Increased LY30 indicates the effect of fibrinolysis, pointing towards the need for an anti-fibrinolytic such as tranexamic acid.

The Future

While recent evidence suggests that thromboelastographic blood-directed therapy may improve mortality and blood product waste during trauma resuscitation, limitations do exist. One major limitation is the availability of TEG trained lab technicians during trauma resuscitations. Another limitation is the emergency physician's ability and time to interpret the TEG tracing. Therefore, the continued adoption of this promising technology will require collaboration between emergency physicians, trauma surgeons, anesthesiologists, laboratory personnel, and perfusionists in order to develop simple algorithms to guide trauma resuscitation in real time. ★

FIGURE 2. Four Key Parameters of a TEG Tracing





Pimping 101



Sara Paradise, MD

Banner University Medical Center-Tucson
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Maximizing Medical Student Teaching on Shift

We've all been there.....you wake up late, arriving to your shift just in the nick of time. You log on to the computer and notice the waiting room is full and you have 5 new patients on the board. A bright-eyed, eager-appearing medical student comes up and introduces herself as your student for the day. You are tired and stressed, but you also want to be able to provide your student with a valuable experience during her time in the emergency department. You sigh and admit to yourself that you really do not know HOW to teach medical students because you were never taught yourself.

Luckily, there are a few simple steps you can follow to maintain your efficiency while giving your medical student a great emergency department experience.

Introduction	A brief introduction and welcome goes a long way. Where is the student from? How far into the rotation are they? A student on Day 1 will need a lot more orienting than a student who is completing the month. Are they only considering emergency medicine? Or another specialty, too?
Focus on the Student	Start the encounter by asking if there is a specific thing the student would like to focus on today. They haven't sutured enough? Plenty to go around! Never seen an intubation? At the very least, you can run them through the steps to a successful intubation, such as the SOAP ME mnemonic. Would they like feedback on their notes? You've written plenty.
Set Expectations	It is important that you define your expectations with the student. Would you like them to write notes on every patient? How do you want them to go about seeing patients? Will they be presenting to you, or to the attending? Do not expect the student to know what you want unless you explicitly tell them.
Create Teaching Pearls	<p>Now it's time for teaching! Remember, each encounter has <i>something</i> you can teach. However, it is important that you structure the learning. Depending on the presentation, decide on ONE specific thing you'd like the student to take away from that encounter.</p> <p>Try the "BDA" (Before, During, After) framework as a simple way to provide reflective teaching for your student.</p> <p>BEFORE the patient encounter, gauge their knowledge on the topic. Ask the learner to...</p> <ul style="list-style-type: none"> — Indicate what she or he knows about the particular medical knowledge relevant to this patient. — Look up relevant paper, scoring system, etc. — Watch a video of a procedure to prepare for the encounter. <p>DURING the experience, guide their learning. Ask the learner to...</p> <ul style="list-style-type: none"> — Obtain specific information from the patient. — Observe for particular symptoms with a specific purpose in mind. <p>AFTER the experience, summarize what you've taught, answering any questions and directing future learning. Ask the learner to...</p> <ul style="list-style-type: none"> — Think about whether their anticipated findings matched what they discovered. — Identify and articulate reasoning for appropriate next steps, e.g. follow-up questions or testing. — Assess their performance to help them identify skills, attitudes, or behaviors for improvement. — Establish goals for future learning.
Provide Constructive Feedback	You've had a great shift and you're hungry. Time for a feedback sandwich! After the student gives you their own self-assessment, provide them with something they did particularly well, or even exemplary. Then, mention something the student could work on, using specific examples in a non-judgmental tone. Lastly, provide reassurance and tips for next time. Honest, constructive feedback will help the student. It is NOT helpful to give the student great feedback, then give them a poor written evaluation. In the same token, do not give a student feedback regarding a personal trait or behavior they cannot change.

Now that you've mastered the art of teaching on shift, have fun, and stay positive! ★

EXAMPLE

You are assigned to a 45-year-old female, previously healthy, chief complaint of chest pain. Vital signs are normal. EKG is in the chart already from triage, and you note (but do not tell the student) that it is normal. You decide to use this patient to teach the student about the HEART score, including typical vs. atypical features of acute coronary syndrome to determine risk stratification.

BEFORE.

Ask the student, "Are you familiar with the HEART score?"

- If yes: Can you tell me the elements? At this juncture, you may decide to change your teaching objective if the student already has mastered this skill.
- If no: I'd like you to use it to assess this patient's risk. Can you please look it up and we will go through it together?

DURING.

Calculate the HEART score with your student, explaining the elements.

- Ensure the student asks the patient the appropriate questions to assess their HEART score.
- Obtain a full and accurate cardiac history, including pertinent negatives and atypical features.

AFTER.

Emphasize the importance of the HEART score as a diagnostic tool.

- Recommend they use it on future cardiac patients.
- Give them feedback on their performance.
- For historical learning, you may also refer them to the TIMI and why we no longer use this as standard of care.

To Cuff or Not to Cuff



Kaia Knutson, MD
Emergency Medicine and
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Indianapolis, IN



THAT IS THE QUESTION

You are working a busy shift in the emergency department when you answer the EMS radio: “10-month-old, active compressions, GCS 3, be there in 2!” As you whip out the Broselow tape and get the trauma bay set up, you turn to the airway cart. Cuffed vs. uncuffed... does the choice between endotracheal tubes (ETT) make your head spin?

Why All the Fuss?

The old adage is that kids are not just little adults. One notable anatomic difference is that the cricoid cartilage is the narrowest part of the airway, as opposed to the glottis in adults.¹ For many years, this information translated into the recommendation to use uncuffed tubes for patients younger than 8 years old.² It was feared that cuffed ETTs would injure the subglottic tissue, leading to tracheal damage, mucosal ischemia, and complications such as post-extubation stridor or tracheal stenosis.³ Another assumed benefit of uncuffed ETTs was maximizing airway diameter in the already tiny pediatric airway, which would improve ventilation and the ability to suction secretions.⁴

What Made Us Change the Tune?

A lot of the cuffed vs. uncuffed “urban legends” are rooted in a time when specialized airway equipment simply did

not exist for the pediatric population. Many doctors used the formula [(Age/4) + 4] to estimate the correct uncuffed ETT size.⁵ However, it has been shown that up to 30% of intubations with uncuffed ETTs need reintubation for size adjustment, as not all children fit the standard formula.^{4,6} Thankfully, we now have an array of pediatric specific cuffed ETTs that have high-volume, low-pressure seals to help combat this anatomic variation and minimize ETT exchanges.⁴

Furthermore, a lot of data now support the use of cuffed ETTs in the

pediatric population. There appears to be no difference in tracheal injury between cuffed and uncuffed tubes.^{7,8} Cuffed ETTs can optimize oxygenation and ventilation by diminishing by air leak, which can help in patients with poor compliance or high resistance.⁹ Newth et al. looked at rates of post-extubation stridor and found no difference between cuffed and uncuffed ETTs, even in the subgroup of prolonged intubation (>21 days). Further, data showed improved end tidal gas monitoring and decreased rates of pneumonia with cuffed ETTs.²

What’s the Recommendation?

The American Heart Association updated their pediatric guidelines in 2010, stating that it is OK to use both uncuffed and cuffed tubes in infants and children.^{3,9} Cuffed ETTs seem to be the preferred choice by pediatric emergency medicine physicians for many reasons: pediatric specific designs, improved ventilation, minimal airway trauma, and decreased need for ETT exchange.¹ When faced with an ETT dilemma in the emergency department, “to cuff” seems to be the answer. ★



CONSULT CORNER OB-GYN

Victoria Fitz, MD
OB/GYN Resident
University of North Carolina
Chapel Hill, NC



EMR: What is the most effective way to present an OB/GYN consult over the phone?

CC: The goal should be to concisely present the information and clinical question in a way that allows the consulting provider to triage the urgency of the consult and advise any immediate intervention. Key points to convey vary depending on the clinical scenario. In general, this should include age, whether the patient is pregnant, presenting complaint, hemodynamic status, and the SPECIFIC clinical question.

For example: "This is a consult for possible ectopic pregnancy with hemodynamic instability. JR is a 26-year-old female approximately 6 weeks pregnant with a history of two prior ectopic pregnancies who presents with acute onset RLQ pain, tachycardia, and hypotension. She has a positive FAST scan." That clearly communicates the emergent nature of the consult and the need for immediate evaluation and intervention.

Another example: "This is a consult for pregnancy of undetermined location. LM is a 37-year-old female approximately 6 weeks pregnant by LMP with a history of two prior miscarriages who presents with light vaginal bleeding for 2 days. She has normal vital signs and minimal bleeding on pelvic exam. Her cervical os is closed. Her hematocrit is 39% and she is Rh positive. Her serum beta hCG is 1500 mIU/mL. Her ultrasound shows no definitive intrauterine pregnancy. Her adnexa appear normal. We would like for you to confirm the findings and assist her with close follow-up."

(Please note that while Gs and Ps are important, I do not consider them an absolutely crucial part of the initial consult, particularly because the numbers can be confusing. Others may feel differently.)

EMR: What basic workup do you prefer to be completed prior to seeing a consult?

CC: A pelvic exam and a urine pregnancy test are generally a must. If the patient is pregnant and has vaginal bleeding, a type and screen, Rh, and complete blood count are necessary. If the patient is stable, is presenting with a newly diagnosed pregnancy without a prior ultrasound, and is complaining of abdominal pain or vaginal bleeding, an ultrasound should be completed prior to consultation.

EMR: What do you consider to be urgent or emergent consultations?

CC: Emergent consultations include ruptured ectopic pregnancy and ovarian torsion. If you have a suspicion for either of these, the gynecology team should be contacted immediately; proceeding expediently to the operating room is paramount.

Urgent consults include concern for ectopic pregnancy in a hemodynamically stable patient, heavy (>1 pad per hour) vaginal bleeding, and sepsis.

EMR: What are some common OB/GYN complaints or procedures an EM resident should feel comfortable managing in the community setting?

CC: EM residents should feel comfortable managing uncomplicated pelvic inflammatory disease, particularly those who are afebrile, not in severe pain, tolerating fluids, have no evidence of tubo-ovarian abscess, and are able to follow up as an outpatient. You should also feel comfortable counseling a stable patient regarding expectant management of an uncomplicated first-trimester miscarriage.

Common procedures that an EM resident should feel comfortable performing include pelvic examination and basic ultrasound to confirm viability

and location of pregnancy, as well as incision and drainage of a Bartholin's cyst/abscess.

EMR: Top 3 ED pet peeves?

- CC:**
1. Calling a consult before performing a pelvic exam. Even though we will likely repeat the exam, your initial impression with regard to amount of bleeding or any abnormal findings is important for triage and initial stabilization. Often, patients with minimal to moderate bleeding can be evaluated as an outpatient.
 2. Not ordering a type and screen on a pregnant patient with vaginal bleeding.
 3. Not having an up-to-date set of vital signs available on a patient at the time of consultation.

EMR: Other pearls for emergency medicine residents?

CC: Providers in the community may not have immediate access to an obstetrician and will encounter many presentations of incomplete or missed abortions. Familiarity with how to counsel a patient for medical management (eg, cytotec) when appropriate are important in this setting. We are always happy to have an EM resident come with us to counsel a patient on management options. ★



Seeing Past the Present



Katie Rebillot, DO

EMRA Wellness Committee
Maimonides Medical Center
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@krebillot

She was constantly in the emergency department for alcohol and drug intoxication. Staff dreaded her because she was usually inebriated and asking for pain medication. She came alone without friends or family, so it was unknown if this woman had a support network. She didn't appear homeless or disheveled, but frequently smelled of rum and usually had empty Percocet bottles with her. You could see the elated feeling of sweet release from reality on her face as she drifted off to dreams after getting her intravenous morphine. This charade continued for 2 years, and every time she arrived, there was whispered gossip speculating on how much alcohol and pills she had taken that time.

We have all seen this patient. The frequent-flying, drug-seeking, seemingly hopeless patient who we assume has created her own demise and is on the express train down a track littered with disaster. This woman represents many patients who incite compassion fatigue among physicians, as we see them repeatedly for non-emergent complaints, asking for food, a warm bed, and pain medications. We like to hypothesize about their present addiction and absent future, but what about their past?

Compassion fatigue is the development of indifference and emotional stress that occurs in physicians from caring for certain patients. It lends itself to dissociation from the emotional aspect of patient care, creating a more sterile patient-physician



RECOGNIZING Compassion Fatigue

Take steps to combat this and other threats to your well-being during the second annual Emergency Medicine Wellness Week, Jan. 22-28.

relationship lacking empathy and compassion, and ultimately protecting the emotional state of the physician.

I went into medicine to make a difference in the lives of my patients, and I found that my experience with these types of patients challenged my ability to treat and educate them in a meaningful and influential way. I wanted to help them in the acute environment and counsel them about changes they could make to augment their health. Instead, I found myself slowly succumbing to the disenchanting idea that I would never have a sustained influence on their situation and thus should just give them a hot meal and let them sleep through the night.

This terrified me.

After a night of sleeping and becoming sober, one of the nurses decided to sit down and talk to this patient about her addiction. Through conversation, the nurse discovered the patient dealt with chronic back pain, was overwhelmed by stressful work and family issues, and eventually turned to Percocet and alcohol. The nurse referred

her to a rehabilitation program and encouraged her to call her family. When they showed up at her bedside, their look of hopelessness was heart-wrenching. They knew she had a serious problem but had chosen to ignore it.

This patient was my family member. She was also my inspiration to go into emergency medicine. So, when she called to tell me she had admitted herself for drug and alcohol addiction, I was breathless. How could my former idol, my own family member, be an addict?

During the first 3 months of rehabilitation, she battled headaches, withdrawal symptoms, depression, anxiety, and self-hatred. As she slowly began to heal from within, she realized what she had been missing in life. Throughout her 6-month stay at the rehabilitation facility and for the following year, she grew into a person who was more motivating and inspirational than I had ever remembered. Even though she had taught me a lot throughout my childhood and along my path to becoming a physician, the most important lesson she

gave me was through her own struggle with addiction.

Through her rehabilitation and healing process, I started to look at my intoxicated patients differently. Where did they come from and what were their lives like before their addiction? Surely they had jobs, families, and unique interests before their addiction took over their lives.

As emergency medicine physicians, we have higher rates of burnout than any other field, which means we also have high rates of compassion fatigue. It is easy to label, judge, dismiss, and forget these many patients who frequent the emergency department with the same complaints time and time again, but we have to remember they are all people who had meaningful lives at some point. They have families who care about them and are entrusting us to treat them in their absence.

Sometimes, the best thing for these patients is a little kindness and empathy without judgment to help them on their way to recovery. ★

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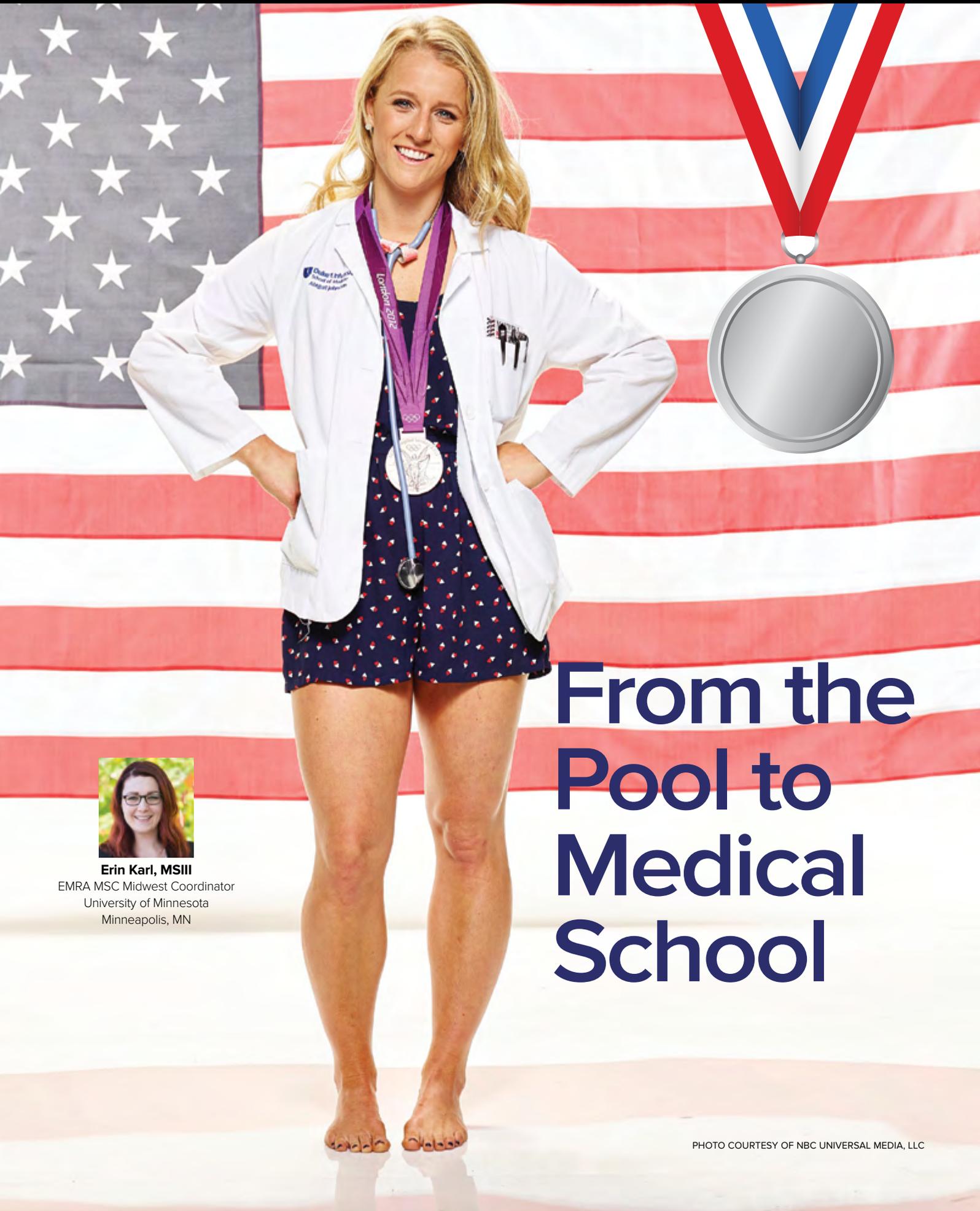


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From the Pool to Medical School



Erin Karl, MSIII
EMRA MSC Midwest Coordinator
University of Minnesota
Minneapolis, MN

AN INTERVIEW

Abby Johnston

Olympic Diver and Medical Student



Medical students often set aside other pursuits to focus entirely on coursework, exams, etc. But Olympic diver **Abby Johnston**, a silver medalist in 2012 and a member of Team USA again in 2016, has refused to sacrifice her passions. While in her third year of medical school at Duke University School of Medicine, Johnston trained for and competed in the Rio Olympics.

As she looks forward to pursuing emergency medicine, how will Johnston continue to balance her passions?

When did you start diving, and what do you enjoy most about it?

I started when I was 13. I was a gymnast for many years but had to stop due to a back injury. Diving felt like a close substitution because I was able to flip and twist but it wasn't as tough on my body to land in water.

Did you know coming into medical school that you wanted to try to return to diving at the Olympic level?

After the 2012 Olympic Games, my motivation to return to the sport was a roller coaster ride. Initially, I was dying to go back for another Games. However, I didn't want to put off medical school in order to train. Then I had shoulder surgery and thought maybe I'd become a washed-up has-been. During my gap year, I started training again and thought, "Would it be insane if I did medical school while I train for Rio?" And the answer in hindsight is that yes, it was absolutely insane, but I don't regret any of the sacrifices I made or one minute of the time I spent training.

How were you able to train for the Olympics while attending medical school?

I trained twice a day, 6 days a week. I'd practice from 6:30-8 am, go to lab/class, return to practice for another 2 hours in the afternoon, go home to study, and then wake up and repeat. When pressed for time, it's incredible how productive one can be. I watched lectures on the treadmill, answered conference calls about research while I was out of the country for a competition, and flipped through pharm flashcards while walking between the pool and the medical school. I wasn't a total robot, though; I made time for the other things in my life that I love, like watching my fiance coach at Duke football games, drinking wine with friends, and talking to my crazy family every day.

What interests you most about emergency medicine?

I like high-pressure situations (shocker, right?). I love that every day in the emergency department is something different and the profound impact you can have on very sick patients. Also, wearing scrubs is like wearing comfy workout clothes, and who wouldn't want to wear that every day?

What advice would you give to other medical students who want to balance medical school studies with extracurricular activities?

You need something that's a break from medicine to keep your sanity. For me, being an athlete makes me a better student and being a student makes me a better athlete. Make time for things you love and you'll be a happier, more rounded person. Also, never press snooze.

Now that you have retired from diving, what do you hope to do with your newfound "free time?"

I haven't officially retired, but I'm taking a long hiatus to focus on my clinical rotations. I finally have more time to take weekend trips, plan my wedding, and watch reality TV. One of my favorite things to do is what I like to call "sloth Sunday," where I virtually only move from the couch to the kitchen all day and binge-watch TV. I finally have more time to indulge in this way.

You say you haven't officially retired, so I have to ask — are you considering returning to the 2020 Summer Olympics?

Possibly. I'm planning to reevaluate my interest in returning at the end of this year. Diving has been such a huge part of my life, and I'm not sure what life without it will be like. So, I'm giving myself the chance to explore that this year, with the possibility of returning for Tokyo 2020. ★



empower

Sharing our Stories

Your Time, Your Legacy

John J. Rogers, MD, CPE, FACS, FACEP ACEP Chairman of the Board

Medical school: University of Iowa

Residency: Medical Center of Central Georgia

Current Position: Co-ED Medical Director and Immediate Past President of the Medical Staff, Coliseum Northside Hospital, Macon, Georgia

Newly elected ACEP Chairman of the Board John Rogers, who recently completed a term as the ACEP Board liaison to EMRA, is known for his calm demeanor, tendency to listen more than speak, and affinity for thinking several steps ahead. We invite you to learn more about this EM leader.

Last non-textbook you read?

Edith Hamilton's *The Greek Way* from 1930. Hamilton was the headmistress at Bryn Mawr for 25 years. She provides a glimpse at the many gifts the ancient Greeks gave us. She opens the world of Homer, Herodotus, Aeschylus, Sophocles, and more. Not only explaining the difference between Eastern and Western thought, and Greek religion as opposed to myth, but how we in the West view the world today. Within its pages you will begin to understand how physicians are inherently Greek in their philosophy and outlook on life.

What experiences have impacted you most as a physician?

There are four. Three are examples of sudden tragedy that profoundly affected the lives of patients as well as their families. First there was the 16-year-old who after an MVC arrived to the ED in two different EMS units, she in one and her right lower extremity in the other. The phone call to her parents at midnight was exceedingly difficult as was her subsequent adjustment to her new reality. Then there was the woman with multiple fractures after being run over multiple times and beaten with a crowbar by her husband. Who despite her injuries and severe pain said, "*At least I know he loves me.*" And the 7-year-old who on Halloween was struck in the abdomen by an errant bullet fired by a partygoer. She died on the operating table, with my hands around her liver and aorta. She was still partially clothed in her princess costume. I still remember the profound weeping of the OR nurses and will never forget her mother's silent sobbing. Finally is the story that I tried to tell to the EMRA Board but have difficulty every time I try to tell it. Suffice it to say, sometimes patients do not need our technology, our procedural skill, or unique knowledge; what they need is our compassion and our kindness. They need the small moments when one human heart connects with another.

How will EM change during the next decade?

EM physicians will become the primary source of all unscheduled care, supported by the various specialties. Those in private offices or other outpatient settings will focus upon chronic care and prevention. Technology will continue to be leveraged, and advances in our science will continue to compel changes in our practice. However, the major



shift in medicine will be a movement toward what has been termed *precision population health*. Applying data to make targeted changes to the environment or other factors that affect large populations to address health issues specific to them.

How do you get exercise?

Learned how to swim before the age of 3 and found water to be a natural environment. Was a competitive swimmer from an early age and through college. Continue to swim as much as possible, not only for the exercise but for the quiet time it provides. The solitude allows one to retreat into one's own mind and thoughts. It is a respite from the noise, interruptions, and chaos of our daily lives.

Family and pets?

Live with my wife Jan, who has her Master's in Nursing Administration as well as an MBA. She is the Director of Quality at my hospital, which often leads to interesting conversations at home. She keeps me grounded and is far smarter than I would ever hope to be. On our 6 acres we have a small creek that leads to a small lake that we share with 2 horses and 3 dogs. Frequent visits from a flock of geese, a heron, beaver, turtles, and the occasional deer round out the neighborhood. Teddy, a miniature pinscher, is the newest member of the family and has become my constant companion. Our 4 am walks are now a routine that he enjoys, and I have come to look forward to as well.

Who gave you the most useful advice and what was it?

The best advice was in a way a time management tip. It came from Sir William Osler. He gave an address to Yale medical students in April of 1913. It has been preserved in a book titled *The Way of Life*, a copy of which I keep in my personal library. The Titanic disaster of April 1912 was still fresh in their minds. He referenced the lack of *watertight* doors on the Titanic, to the *way of life* he espoused. Osler recommended that we keep *day-tight compartments* – that we not only complete what needs to be done but also leave the problems of the day in that day alone and not let them spill over into another day. Each day is sufficient to itself.



What is the best way to avoid burnout?

Nurture your inner life as much as you do your outer life. It is not what happens outside of us that causes the frustration and stress, but how we react internally to the stresses and strains of our life, and of our work. Being at peace within yourself is the magic for avoiding the burnout too many of us suffer. For me, my heart is kept at peace by doing something intentionally for myself, for someone else, and for my career, each and every day. My refuge lies in books, and daily I read something that will make me a better person, even if only a paragraph. By paying attention I am often able to recognize opportunities to do something for someone else, no matter how small. And to improve myself as physician, I cling to the attitude of a resident by constantly learning. Daily I encounter things I do not know or do not understand well and take advantage of these recognitions to learn something new, no matter how little.

What are the 3 most important traits of a successful emergency physician?

1. Compassion and kindness despite the behavior or words of others
2. Calm leadership in the midst of chaos
3. Commitment to increasing one's skill and knowledge, advancing our craft, and improving the lives of those who practice it ★

CORD Congratulates CPC Finalists and Competitors

The following individuals and their programs contributed hard work and valuable time to make the CORD 2016 CPC Final Competition a success, and CORD thanks them.

Best Resident Presenter: Guy Carmelli, MD, SUNY Downstate Kings County

Best Faculty Discussant: Chen He, MD, Mount Sinai St. Luke's-Roosevelt

Resident Presenter Runner-Up: Graham Brant-Zawadzki, MD, MA, Alameda County — Highland Hospital

Faculty Discussant Runner-Up (tie): Bryant Allen, MD, Carolinas Medical Center

Faculty Discussant Runner-Up (tie): Alisha Brown, MD, University of Washington

CORD also recognizes the 2016 CPC Final Judges: Amy Church, MD, FACEP; Jonathan Jones, MD; Thomas Nguyen, MD; Antonia Quinn, DO, FACEP; Stephanie Stokes Buzzelli; and Katrin Takenaka, MD, FACEP. ★

Submit an Abstract to *Annals of Emergency Medicine*

All EM residents and fellows are invited to **submit an abstract** to the Residents' Perspective section in *Annals of Emergency Medicine*. Authors of promising abstracts will be invited to submit a full manuscript for peer review. Themes of particular interest this year are:

- **Emergency Medicine Education**
- **Emergency Medicine in Society**
- **Technology in Emergency Medicine**
- **The Administration of Emergency Medicine**



Submit your abstract at editorialmanager.com/annemergmed (select the "Residents' Perspective" article type). More information for authors can be found at annemergmed.com/content/categories#residentperspective. ★

Online ITE Update

The 2017 In-training Examination (ITE) will be administered online on a single day: Feb. 22, 2017. In 2017 only, programs that believe they cannot adequately prepare for an online administration can administer a paper examination. Full implementation of the online testing format administered over a 3-day period will begin with the 2018 ITE administration. ★

visit www.cordem.org for details

CORD
EM

Academic Assembly
Thursday, April 27 - Sunday, April 30

CPC Semi-Final Competition
Electronic poster session,
and many more "Don't Miss Events"!

Fort Lauderdale

Marriott Harbor Beach Resort & Spa

UPCOMING EVENTS

- Jan. 15 **EMRA Spring Awards Nominations Due**
- Feb. 15 **EMRA Committee & Division Vice Chair Applications Due**
EMRA Medical Student Council Applications Due
- Feb. 22 **In-Training Exam**
- March 4 **Emergency Medicine Residents' Appreciation Day**
- March 12-15 **ACEP Leadership & Advocacy Conference**
- May 16-19 **SAEM Annual Conference**
- 5th of month even-numbered **EM Resident articles deadline**
- EMRA Hangout**
First Thursday of every month
- EMRA•Cast**
Listen at your convenience



NEWS FROM ABEM

Single Accreditation System Update: Training Requirements

Credit Allowed for Transfers

Residents who transfer from an AOA-approved Emergency Medicine (EM) residency program to a separate and distinct ACGME-accredited EM residency program can receive partial credit for their AOA-approved EM training. Program directors can grant partial credit to residents who have completed at least 12 months of training in an AOA-approved program. The maximum amount of credit allowed is 12 months for 24 months of AOA-approved training. Transfers do not require ABEM pre-approval; however, ABEM is available to discuss transfers and should always be notified when a transfer has occurred. For details, check the ABEM Policy on Resident Transfer online.

Training Requirements for Osteopathic Programs that Change Format

As of September, 13 osteopathic EM programs had become newly ACGME-accredited. At the time they seek ACGME accreditation, some programs are switching from a PGY 1-4 to a PGY 1-3 format. Because certification by ABEM is grounded on training completed in an ACGME-accredited program, residents in such programs should note the amount and type of training required for ABEM certification. When a residency program changes its format in this situation, the total amount of training required depends on how much training a resident has already completed. Two basic principles apply:

1. A resident must successfully complete at least four years in the same program, a combination of AOA-approved EM training and ACGME-accredited EM training.
OR
2. A resident must successfully complete at least 24 months under the new ACGME-accredited, three-year format.

Training must be completed as follows:

1. A physician in the **fourth year** of training on the program's initial ACGME accreditation effective date must complete the current level of training (4 years of total training).
2. A physician in the **third year** of training on the program's initial ACGME accreditation effective date must complete training at that level under the new ACGME-accredited, 3-year format, and must also complete at least 12 additional months of training under the new ACGME-accredited, 3-year format in the same program (at least 4 years of total training).
3. A physician in the **second year** of training on the program's initial ACGME accreditation effective date must complete training at that level under the new ACGME-accredited, 3-year format, and must also complete at least 24 additional months of training under the new ACGME-accredited, 3-year format (at least four years of total training).
4. A physician in the **first year** of training on the program's initial ACGME accreditation effective date must complete training at that level under the new ACGME-accredited, 3-year format, and must also complete at least 24 additional months of training under the new ACGME-accredited, 3-year format (at least 3 years of total training).

Additional information is included in the *Policy on Emergency Medicine Residency Training Requirements*, available at abem.org/training-policies. Contact ABEM at training@abem.org or 517-332-4800, ext. 388. ★

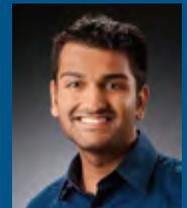
New Resident Fellows Announced

Tricia A. Smith, MBBS, (MD) MPH, of the University of Connecticut, and

Tarak K. Trivedi, MD, of Alameda County Medical Center, have

been selected as the new *Annals of Emergency Medicine* Editorial Board Resident Fellows. Dr. Smith

received her MBBS from University of the West Indies, Kingston, Jamaica; Dr. Trivedi received his MD from the University of Chicago. You can reach them at annalsfellow@acep.org. ★



Raise Your Profile by Getting Involved!

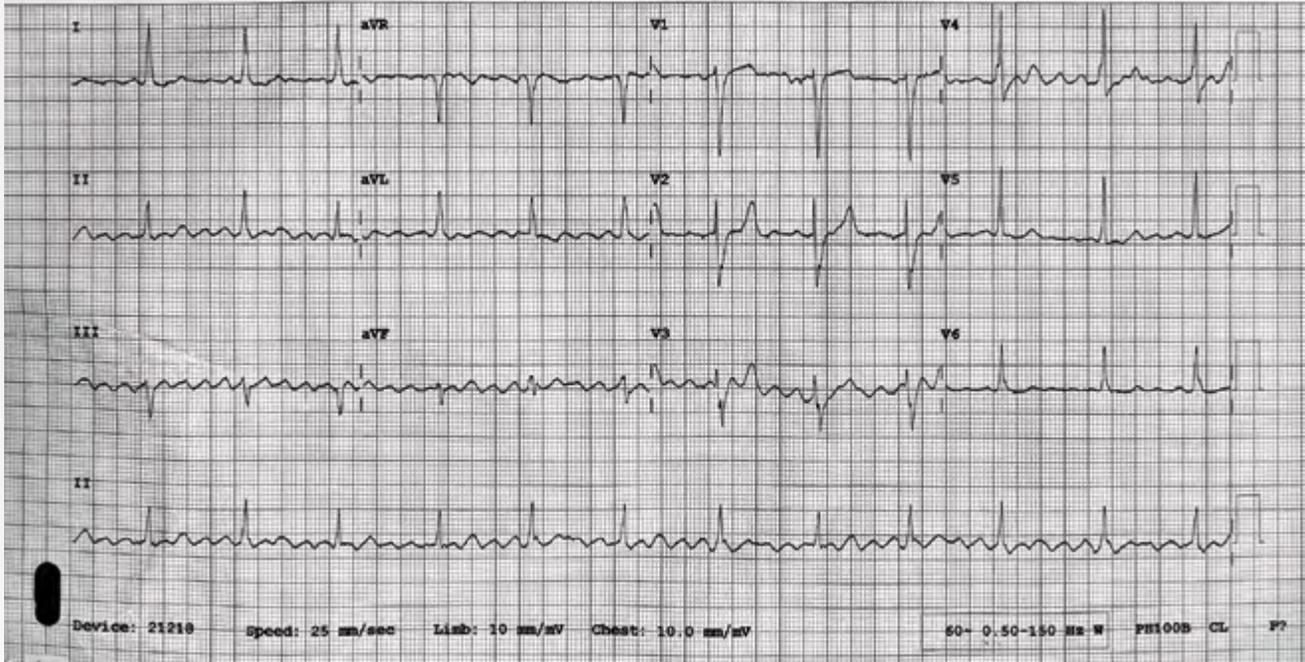
EMRA offers a variety of ways to raise your professional profile – but none more exciting than by becoming an EMRA leader. And now's your chance. Apply to be a committee or division vice-chair, or ask to serve on the EMRA Medical Student Council. **All applications are due Feb. 15.**

Committee and division vice-chair positions begin in May and span 2 years, with automatic succession to chair in the second year. Apply at emra.org/committees-divisions/EMRA-Committee-and-Division-Application.

Medical Student Council members serve 1-year appointments, beginning April 1 and ending April 30 the following year. Apply at emra.org/students/leadership/Join-the-EMRA-Medical-Student-Council. ★

ECG Challenge

CASE. A 79-year-old male with a medical history of “some heart problems” presents to the emergency department with 3 days of fatigue and shortness of breath. This ECG is obtained in triage



In reviewing this ECG, you can see the rate is normal, the QRS complex is narrow, and there are prominent repeating p-waves creating a sawtooth pattern in multiple leads. This is most consistent with atrial flutter.

Atrial flutter is a supraventricular tachycardia in which there is a reentry circuit within the right atrium. The anatomy is such that atrial flutter generally produces an atrial rate of 300 beats per minute. The ventricular rate, however, is determined by the AV node, which generally suppresses the rapid atrial rate at a ratio of 2:1, 3:1 or 4:1, thereby generating a ventricular rate of 150, 100, or 75 beats per minute respectively.

This ECG demonstrates a calculated rate of 73 beats per minute, which reflects a 4:1 AV nodal blocking ratio. As there are multiple p-waves, a PR interval cannot be calculated. In the presence of a 1:1 ratio (and a ventricular rate of approximately 300), you should expect to see significant changes in hemodynamics and prominent symptoms. Though the term AV block is commonly used, a well-functioning AV node *should* suppress an atrial rate of 300; therefore, the AV block is normal in this case. AV nodal blocking agents can further suppress the rapid atrial rate and are often the cause of a 4:1 or greater AV block, as was the case with this patient. The flutter waves can usually be seen best in leads II, III, and aVF, and are defined as inverted in these leads. The p-waves in V1 are defined as positive and may look like normal p waves. The opposite pattern can also rarely be seen. Though a specific unchanging blocking ratio often exists, it is important to remember that a variable block can occur. In these instances, there should still be an alternating pattern of 2:1, 3:1 and 4:1 block.



Zachary S. Wilson, MD
ECG Section Editor
Icahn SOM at Mt Sinai
New York, NY

LEARNING POINTS

1. Atrial flutter is a supraventricular tachycardia resulting from a re-entry circuit within the right atrium.
2. The atrial rate is generally 300 (though can vary between 200-400) and conduction through the AV node is blocked at a predictable ratio of 2:1, 3:1 or 4:1, producing heart rates of 150, 100, and 75.
3. The most common finding of atrial flutter is the sawtooth pattern of the p-waves seen best in leads II, III, and aVF. ★

Diagnose this Condition



PHOTO COURTESY OF 1LUCKYGAMBLE

The Patient

A 35-year-old-male presents to the emergency department complaining of throat swelling and difficulty swallowing. He has no past medical history and his vital signs are all within normal limits. An examination of his oropharynx follows.

What is the diagnosis?

See the **DIAGNOSIS** on page 42



Maryam Arshad, MD
Emergency Medicine Resident
Emory University
Atlanta, GA

The Diagnosis

Uvulitis

The image shows diffuse swelling of the uvula. Uvulitis, or inflammation of the uvula, is associated with marked edema and erythema. A swollen uvula can produce a gagging sensation and patients may have difficulty swallowing their secretions. Patients may also present with fever, sore throat, and in extreme cases, respiratory distress.

Bacterial infection with Group A strep is the most common cause, almost always in association with pharyngitis. Noninfectious causes include angioedema, acid reflux, trauma (for instance during intubation, orogastric tube placement, or suctioning), and exposure to chemical irritants.

Diagnosis is mostly clinical, however if infectious causes are suspected, appropriate cultures should be sent. Blood tests are generally unnecessary. In patients with uvulitis without pharyngitis, plain films of the neck can be ordered to evaluate the epiglottitis. If patients cannot open their mouth completely or there is any concern for underlying abscess, consider CT scan with IV contrast.

Treatment is aimed at the underlying cause. In general, a single IM or IV dose of dexamethasone will help reduce swelling. For infectious cases, empiric use of antibiotics such as penicillin or macrolides is recommended. Noninfectious uvulitis is generally self-limited and will resolve spontaneously. Patients with signs of airway obstruction or distress should be admitted for observation and airway management.



PHOTO CREDIT: LAWRENCE STACK, MD

BY LE'SHANN SCOTT, MD,
AND THE EMRA
RESEARCH COMMITTEE

STUDY TYPES

Case-Control ("What happened?")

Compares a group with a disease to a group without disease. This study can calculate an odds ratio.

Advantages: many exposures can be studied and is useful for rare disorders.

Disadvantages: confounding factors and the potential for recall/selection bias.

Cohort ("What will happen?")

Compares a group with an exposure/risk factor to a group without exposure. This study can calculate a relative risk.

Advantages: ethically safe, timing and directionality of events can be established

Disadvantages: blinding is difficult; no randomization; controls may be difficult to identify



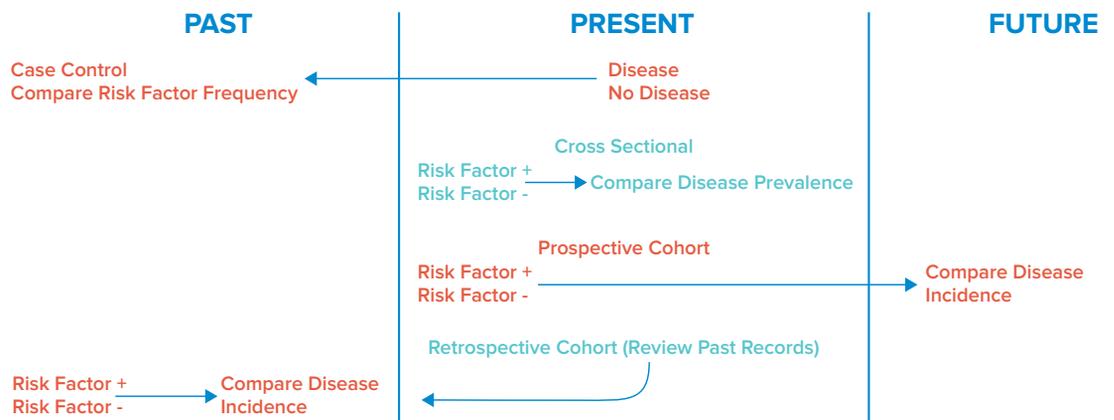
Rapid Research Review

Cross-Sectional Study ("What is happening?")

Collects data from a group of people to assess frequency of disease and related risk factors at a particular point in time. This study can help calculate disease prevalence.

Advantages: ethically safe

Disadvantages: potential recall or Neyman bias; association can be established but not causality



Board Review

QUESTIONS



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

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

- In pediatric patients, which of the following anatomic locations of lymphadenopathy is most likely to be associated with a serious underlying pathology?
 - Axillary
 - Inguinal
 - Jugulodigastric
 - Supraclavicular
- Which of the following agents is most appropriate to treat convulsions associated with a tricyclic antidepressant poisoning?
 - Flumazenil
 - Lorazepam
 - Physostigmine
 - Sodium bicarbonate
- Which of the following agents is contraindicated in the management of hypertension from acute cocaine intoxication?
 - Benzodiazepines
 - Metoprolol
 - Nitroglycerin
 - Phentolamine
- Which of the following statements regarding escharotomy is correct?
 - Escharotomy typically involves significant blood loss when properly performed
 - Muscle compartments in extremities with circumferential burns should be decompressed as soon as compartment pressures exceed 10 mm Hg
 - No anesthesia is needed for local pain control with full-thickness burns
 - Peripheral pulses are reliably absent when escharotomy of an extremity is needed
- A 22-year-old man presents with spasms in his neck and tongue. When his head is turned to the right, his tongue is noted to be deviated to the right. He is able to voluntarily move his tongue and neck to midline, but the contortions recur. He appears anxious. Which of the following medications is most likely to cause this side effect?
 - Clozapine
 - Ephedrine
 - Sumatriptan
 - Tramadol

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

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ARIZONA



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NORTHERN CALIFORNIA, Placerville, Marshall Medical Center: Equity partnership position with stable, democratic group at modern community hospital seeing 31,000 emergency pts./yr. New 24 bed ED opened in 2013. Desirable area proximate to the amenities of the Bay Area, Sacramento, Napa Valley, Lake Tahoe and Yosemite. US Acute Care Solutions (USACS) was founded by EMP and other like-minded groups that share an ironclad commitment to a physician-led and majority-owned, democratic business model. As a USACS physician, you'll have an equal voice as an owner, and unparalleled access to personal and professional growth resources. Our incredible benefits package includes excellent compensation, the best medical malpractice, an industry leading company-funded 401(k), exceptional healthcare and the camaraderie that is exclusive to a physician led and majority owned group. At USACS, we control our careers and love our lives! Visit us at www.usacs.com. Ownership matters! Contact Bernhard Beltran directly at 800-359-9117 or email bbeltran@usacs.com.

SAN FRANCISCO: Chinese Hospital — Located in the heart of San Francisco's Chinatown, Chinese Hospital has served the diverse healthcare needs of this community since 1924. Although the volume of emergency patient visits is low (6,500 per year), the acuity is high with a wide spectrum of interesting and complex medical cases. A brand new state of the art ED opened in 2016. The supportive medical staff of approximately 250 represents most major specialties. ED shifts are 12 hours in length and provide for a high quality of life through a manageable work schedule. US Acute Care Solutions (USACS) was founded by EMP and other like-minded groups that share an ironclad commitment to a physician-led and majority-owned, democratic business model. As a USACS physician, you'll have an equal voice as an owner and unparalleled access to personal and professional growth resources. Our incredible benefits package includes excellent compensation, the best medical malpractice, an industry leading company-funded 401(k), exceptional healthcare and the camaraderie that is exclusive to a physician led and majority owned group. At USACS, we control our careers and love our lives! Visit us at www.usacs.com. Ownership matters! Contact Bernhard Beltran directly at 800-359-9117 or email bbeltran@usacs.com.

COLORADO

Denver: Unique opportunities with newly formed, physician-owned and managed organization in the Denver region. New positions will be available in 2017 at several new free-standing emergency departments combined with shifts at larger community hospital EDs. US Acute Care Solutions (USACS) was founded by like-minded groups that share a strong commitment to a physician-led and majority-owned, democratic business model. As a USACS physician, you'll have an equal voice as an owner, and unparalleled access to personal and professional growth resources. Our outstanding benefits package includes excellent compensation, student loan refinancing as low as 2.99%, strong malpractice, industry-leading company-funded retirement plan, family healthcare and the camaraderie that is exclusive to a physician-led and majority-owned group. At USACS, we control our careers and love our lives! Visit us at www.usacs.com. Contact Darrin Grella, Vice President of Recruiting: careers@usacs.com or (800) 828-0898.

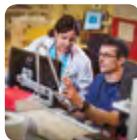
CONNECTICUT

Bristol: Bristol Hospital features a full-service ED and a four-bed Express Care Unit and is ranked as one of the best hospitals in Connecticut for patient satisfaction. Situated in one of Hartford's most desirable suburbs, the facility provides care for more than 41,000 emergency patients annually. US Acute Care Solutions (USACS) was founded by like-minded groups that share a strong commitment to a physician-led and owned, democratic business model. As a USACS physician, you'll have an equal voice as an owner, and unparalleled access to personal and professional growth resources. Our outstanding benefits package includes groundbreaking 100% paid parental leave, student/med. school loan refinancing as low as 2.99%, excellent compensation, the best medical malpractice (occurrence - includes tail), industry leading company-funded retirement plan, family healthcare and the camaraderie that is exclusive to a physician-led and owned group. At USACS, we control our careers and love our lives! Visit us at www.usacs.com. Contact Sandra Lee, Senior Recruiter: careers@usacs.com, (301) 944-0049.

Meriden, New London and Stamford: MidState Medical Center is a modern community hospital situated between Hartford and New Haven, seeing 53,000 EM pts./yr. Lawrence & Memorial is a Level II Trauma Center on the coast near Mystic seeing 52,000 pts./yr. The Stamford Hospital will be a brand new facility in 2016 with Level II Trauma Center designation seeing 49,000 ED pts./yr., located 35 miles from New York City near excellent residential areas. US Acute Care Solutions (USACS) was founded by like-minded groups that share a strong commitment to a physician-led and owned, democratic business model. As a USACS physician, you'll have an equal voice as an owner, and unparalleled access to personal and professional growth resources. Our outstanding benefits package includes groundbreaking 100% paid parental leave, student/med. school loan refinancing as low as 2.99%, excellent compensation, the best medical malpractice (occurrence - includes tail), industry leading company-funded retirement plan, family healthcare and the camaraderie that is exclusive to a physician-led and owned group. At USACS, we control our careers and love our lives! Visit us at www.usacs.com. Contact Darrin Grella, Vice President of Recruiting: careers@usacs.com or (800) 828-0898.

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GEORGIA

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HAWAII

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ILLINOIS

Chicago: US Acute Care Solutions is pleased to announce our newest hospital partner – Norwegian American Hospital. Situated just northwest of downtown, this highly regarded hospital represents most major services and treats 31,000 emergency pts./yr. with a full-range of pathology. US Acute Care Solutions (USACS) was founded by like-minded groups that share a strong commitment to a physician-led and majority-owned, democratic business model. As a USACS physician, you'll have an equal voice as an owner, and unparalleled access to personal and professional growth resources. Our outstanding benefits package includes groundbreaking 100% paid parental leave, student/med. school loan refinancing as low as 2.99%, excellent compensation, the best medical malpractice (occurrence – includes tail), industry leading company-funded retirement plan, family healthcare and the camaraderie that is exclusive to a physician-led and owned group. At USACS, we control our careers and love our lives! Visit us at www.usacs.com. Contact Darrin Grella, Vice President of Recruiting: careers@usacs.com or (800) 828-0898.

Chicago-Blue Island: Signing bonus available! MetroSouth Medical Center is located in the southern end of Chicago 18 miles from downtown. This respected acute care facility treats 50,000 emergency pts./yr. A modern ED and fast track see a broad mix of pathology and admit approximately 14%. US Acute Care Solutions (USACS) was founded by like-minded groups that share a strong commitment to a physician-led and majority-owned, democratic business model. As a USACS physician, you'll have an equal voice as an owner, and unparalleled access to personal and professional growth resources. Our outstanding benefits package includes groundbreaking 100% paid parental leave, student/med. school loan refinancing as low as 2.99%, excellent compensation, the best medical malpractice (occurrence – includes tail), industry leading company-funded retirement plan, family healthcare and the camaraderie that is exclusive to a physician-led and owned group. At USACS, we control our careers and love our lives! Visit us at www.usacs.com. Contact Darrin Grella, Vice President of Recruiting: careers@usacs.com or (800) 828-0898.

Chicago Heights/Olympia Fields: Signing Bonus Available! Franciscan St. James Health (2 campuses seeing 38,000 and 37,000 pts./yr.) is affiliated with Midwestern University's emergency medicine residency program. Situated just 30 miles south of Chicago, the location makes for easy access to a variety of desirable residential areas. US Acute Care Solutions (USACS) was founded by like-minded groups that share a strong commitment to a physician-led and owned, democratic business model. As a USACS physician, you'll have an equal voice as an owner, and unparalleled access to personal and professional growth resources. Our outstanding benefits package includes groundbreaking 100% paid parental leave, student/med. school loan refinancing as low as 2.99%, excellent compensation, the best medical malpractice (occurrence – includes tail), industry leading company-funded retirement plan, family healthcare and the camaraderie that is exclusive to a physician-led and owned group. At USACS, we control our careers and love our lives! Visit us at www.usacs.com. Contact Darrin Grella, Vice President of Recruiting: careers@usacs.com or (800) 828-0898.

Chicago-Joliet: Signing bonus available! Presence Saint Joseph Medical Center (64,000 pts./yr.) is a respected hospital SW of Chicago proximate to the Hinsdale and Naperville suburbs. Comprehensive services include a dedicated pediatric ED. Outstanding opportunity to join a dynamic director and supportive staff. US Acute Care Solutions (USACS) was founded by like-minded groups that share a strong commitment to a physician-led and owned, democratic business model. As a USACS physician, you'll have an equal voice as an owner, and unparalleled access to personal and professional growth resources. Our outstanding benefits package includes groundbreaking 100% paid parental leave, student/med. school loan refinancing as low as 2.99%, excellent compensation, the best medical malpractice (occurrence – includes tail), industry leading company-funded retirement plan, family healthcare and the camaraderie that is exclusive to a physician-led and owned group. At USACS, we control our careers and love our lives! Visit us at www.usacs.com. Contact Darrin Grella, Vice President of Recruiting: careers@usacs.com or (800) 828-0898.

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

INDIANA

South Bend: Memorial Hospital. Very stable, Democratic, single hospital, 22 member group seeks additional Emergency Physicians. 60K visits, Level II Trauma Center, double, triple and quad physician coverage. Equal pay, schedule and vote from day one. Over 375K total package with qualified retirement plan; group health and disability insurance; medical, dental and CME reimbursement, etc. Very favorable Indiana malpractice environment. University town, low cost of living, good schools, 90 minutes to Chicago, 40 minutes to Lake Michigan. Teaching opportunities at four year medical school and with FP residency program. Contact Michael Blakesley MD FAAEM at 574.299.1945 or send CV to Blakesley.1@ND.edu.

KANSAS

Garden City: St. Catherine Hospital is the regional healthcare hub for western Kansas with 132 beds and uses the latest innovations to care for all of western Kansas, Eastern Colorado and the Oklahoma pan handle. Newly renovated ED sees 18,000 emergency pts./yr. US Acute Care Solutions (USACS) was founded by like-minded groups that share a strong commitment to a physician-led and majority-owned, democratic business model. As a USACS physician, you'll have an equal voice as an owner, and unparalleled access to personal and professional growth resources. Our outstanding benefits package includes excellent compensation, strong malpractice, industry leading company-funded retirement plan, exceptional healthcare and the camaraderie that is exclusive to a physician-led and majority-owned group. At USACS, we control our careers and love our lives! Visit us at www.usacs.com. Contact Darrin Grella, Vice President of Recruiting: careers@usacs.com or (800) 828-0898.

MARYLAND

Hagerstown: Meritus Medical Center is a 265-bed regional facility serving patients from western Maryland, southern Pennsylvania and the panhandle of West Virginia. Opened in 2010, the ED treats 78,000 patients annually. Hagerstown offers small-town living within reach of Washington, DC and Baltimore, MD, and is situated between the Blue Ridge and Alleghany Mountains. (USACS) was founded by like-minded groups that share a strong commitment to a physician-led and owned, democratic business model. As a USACS physician, you'll have an equal voice as an owner, and unparalleled access to personal and professional growth resources. Our outstanding benefits package includes groundbreaking 100% paid parental



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Leonardtown: Medstar St. Mary's Hospital is a 114-bed, full-service facility seeing 52,000 emergency patients annually. Situated in a beautiful waterfront community, the area also boasts excellent schools, housing, dining options and more. US Acute Care Solutions (USACS) was founded by like-minded groups that share a strong commitment to a physician-led and owned, democratic business model. As a USACS physician, you'll have an equal voice as an owner, and unparalleled access to personal and professional growth resources. Our outstanding benefits package includes groundbreaking 100% paid parental leave, student/med. school loan refinancing as low as 2.99%, excellent compensation, the best medical malpractice (occurrence – includes tail), industry leading company-funded retirement plan, family healthcare and the camaraderie that is exclusive to a physician-led and owned group. At USACS, we control our careers and love our lives! Visit us at www.usacs.com. Contact Sandra Lee, Senior Recruiter: careers@usacs.com or (301) 944-0049.

WASHINGTON DC area: Shady Grove Medical Center and Germantown Emergency Center offer a main ED, a Fast Track ED, a pediatric ED, and a psychiatric ED. An 18-bed Observation Unit created exclusively for ED patients opened in November 2012. Annual patient census is over 70,000 at SGAH and about 37,000 at GEC. Rockville is just minutes from Washington, DC and a short drive to Baltimore. US Acute Care Solutions (USACS) was founded by like-minded groups that share a strong commitment to a physician-led and owned, democratic business model. As a USACS physician, you'll have an equal voice as an owner, and unparalleled access to personal and professional growth resources. Our outstanding benefits package includes groundbreaking 100% paid parental leave, student/med. school loan refinancing as low as 2.99%, excellent compensation, the best medical malpractice (occurrence – includes tail), industry leading company-funded retirement plan, family healthcare and the camaraderie that is exclusive to a physician-led and owned group. At USACS, we control our careers and love our lives! Visit us at www.usacs.com. Contact Sandra Lee, Senior Recruiter at careers@usacs.com or (800) 828-0898.

MASSACHUSETTS

Framingham and Natick: MetroWest Boston – Established, democratic, physician managed group has open position for a BC/BE emergency physician. MetroWest Emergency Physicians provides staffing for the Emergency Department of MetroWest Medical Center, located in the western suburbs of Boston. We have campuses in Framingham and Natick, MA with a combined annual volume of 70,000 visits. MetroWest Medical Center is a Stroke Center, Point of Entry

for STEMI patients, staffs 12 hours of pediatric ER coverage 7 days a week, and staffs 24 hours of pediatric hospitalist coverage. We offer flexible scheduling, comfortable work environment, excellent salary and benefits package. Please submit inquiries to: Maureen Galaid, MetroWest Emergency Physicians, 115 Lincoln Street, Framingham, MA 01702, 508-383-1104, maureen.galaid@mwmc.com.

MICHIGAN

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

Port Huron: Physician HealthCare Network's Emergency Medicine Department is offering a career opportunity that provides the option to work in a diverse practice environment, seeing a higher level of acuity and treating a more rural patient population at McLaren Port Huron Emergency Center. Physician HealthCare Network, PC, is a Multi-Specialty Group based in Port Huron, MI that is physician owned, offering a wide variety of services to the community. McLaren Port Huron Hospital is a 186 bed not-for-profit facility treating nearly 42,000 emergency room patient visits a year. You will have the opportunity of a partnership track position with excellent compensation and bonus potential, a robust profit sharing/401k participation, comprehensive benefits, pleasing work environment with outstanding staff and physician assistant support, a variety of shift options and strong collaboration with your partners. Please contact: Kelly Hargrove 314-236-4454 khargrove@cejkasearch.com.

NEVADA

LAS VEGAS: Full time opportunities for Pediatric Emergency Medicine Physicians. Children's Hospital of Nevada at UMC is the main teaching hospital of the University of Nevada School of Medicine and serves as the region's only Pediatric Trauma Center and Burn Center. Our 20-bed department cares for 30,000 pediatric patients annually.

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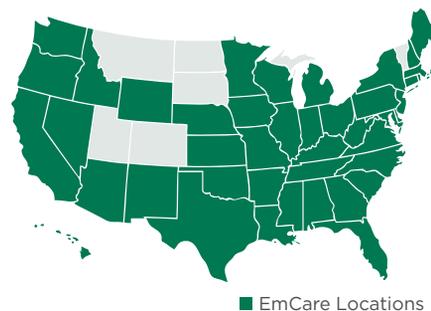
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NEW YORK

Albany area: Signing Bonus Available! Albany Memorial Hospital has a newer ED that sees 43,000 pts/yr. and hosts EM resident rotations. Samaritan Hospital in Troy is a respected community hospital situated minutes from Albany and treats 42,000 ED pts/yr. US Acute Care Solutions (USACS) was founded by like-minded groups that share a strong commitment to a physician-led and owned, democratic business model. As a USACS physician, you'll have an equal voice as an owner, and unparalleled access to personal and professional growth resources. Our outstanding benefits package includes groundbreaking 100% paid parental leave, student/med. school loan refinancing as low as 2.99%, excellent compensation, the best medical malpractice (occurrence – includes tail), industry leading company-funded retirement plan, family healthcare and the camaraderie that is exclusive to a physician-led and owned group. At USACS, we control our careers and love our lives! Visit us at www.usacs.com. Contact Darrin Grella, Vice President of Recruiting: careers@usacs.com or (800) 828-0898.

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

Cortland: Signing bonus available at Cortland Regional Medical Center. This modern, full-service facility is situated in the Finger Lakes Region between Syracuse and Ithaca. A broad mix of pathology makes up 33,000 ED pts/yr., and there is strong support from medical staff and administration. US Acute Care Solutions (USACS) was founded by like-minded groups that share a strong commitment to a physician-led and owned, democratic business model. As a USACS physician, you'll have an equal voice as an owner, and unparalleled access to personal and professional growth resources. Our outstanding benefits package includes groundbreaking 100% paid parental leave, student/med. school loan refinancing as low as 2.99%, excellent compensation, the best medical malpractice (occurrence – includes tail), industry leading company-funded retirement

plan, family healthcare and the camaraderie that is exclusive to a physician-led and owned group. At USACS, we control our careers and love our lives! Visit us at www.usacs.com. Contact Darrin Grella, Vice President of Recruiting: careers@usacs.com or (800) 828-0898.



Lake Champlain Region: Emergency Medicine Opportunities: The University of Vermont Health Network-Champlain Valley Physicians Hospital (www.UVMHealth.org/CVPH) seeks BC/BP EM Physicians to join its Emergency Department (50,000 annual visits). Schedule has 60 hrs/day of physician coverage. Enjoy working in our newly renovated ER which includes a new EMR system. Incoming physicians may either be hospital employed with a comprehensive benefit package or be independent contractors. **Community** (www.NorthCountryGoodLife.com) offers a rich family lifestyle on Lake Champlain at the foothills of the Adirondack Mountains. Enjoy close proximity to the Lake Placid Olympic Region, Montreal and Burlington, VT. Practice in a university affiliated hospital and live where others vacation! For info: Becky Larkin, 518-314-3025, rlarkin@cvph.org.

Port Jefferson: John T. Mather Memorial Hospital is situated in a quaint coastal town on Long Island's north shore and sees 43,000 emergency patients per year. Pathology is broad with moderate acuity, and most services are represented. Enjoy a variety of residential options, outdoor recreation and shopping and access to NYC. US Acute Care Solutions (USACS) was founded by like-minded groups that share a strong commitment to a physician-led and majority-owned, democratic business model. As a USACS physician, you'll have an equal voice as an owner, and unparalleled access to personal and professional growth resources. Our outstanding benefits package includes groundbreaking 100% paid parental leave, student/med. school loan refinancing as low as 2.99%, excellent compensation, the best medical malpractice (occurrence – includes tail), industry leading company-funded retirement plan, family healthcare and the camaraderie that is exclusive to a physician-led and owned group. At USACS, we control our careers and love our lives! Visit us at www.usacs.com. Contact Darrin Grella, Vice President of Recruiting: careers@usacs.com or (800) 828-0898.

NORTH CAROLINA

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

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

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For additional information, please contact:

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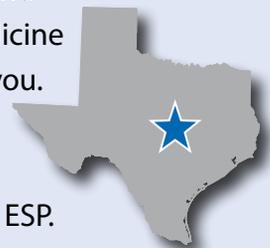
Morehead City: Modern community hospital on the Atlantic coast minutes from Atlantic Beach and Emerald Isle! This 135-bed facility sees 38,000 emergency pts./yr., is active in EMS, and has a supportive medical staff and administration. US Acute Care Solutions (USACS) was founded by like-minded groups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

New Bern: CarolinaEast Medical Center is a respected 313-bed regional medical center located at the intersection of the Trent and Neuse Rivers just off the central coast. 71,000 ED pts./yr. are seen in the ED. Beautiful small city setting offers great quality of life. US Acute Care Solutions (USACS) was founded by like-minded groups that share a strong commitment to a physician-led and owned, democratic business model. As a USACS physician, you'll have an equal voice as an owner, and unparalleled access to personal and professional growth resources. Our outstanding benefits package includes groundbreaking 100% paid parental leave, student/med. school loan refinancing as low as 2.99%, excellent compensation, the best medical malpractice (occurrence – includes tail), industry leading company-funded retirement plan, family healthcare and the camaraderie that is exclusive to a physician-led and owned group. At USACS, we control our careers and love our lives! Visit us at www.usacs.com. Contact Darrin Grella, Vice President of Recruiting: careers@usacs.com or (800) 828-0898.

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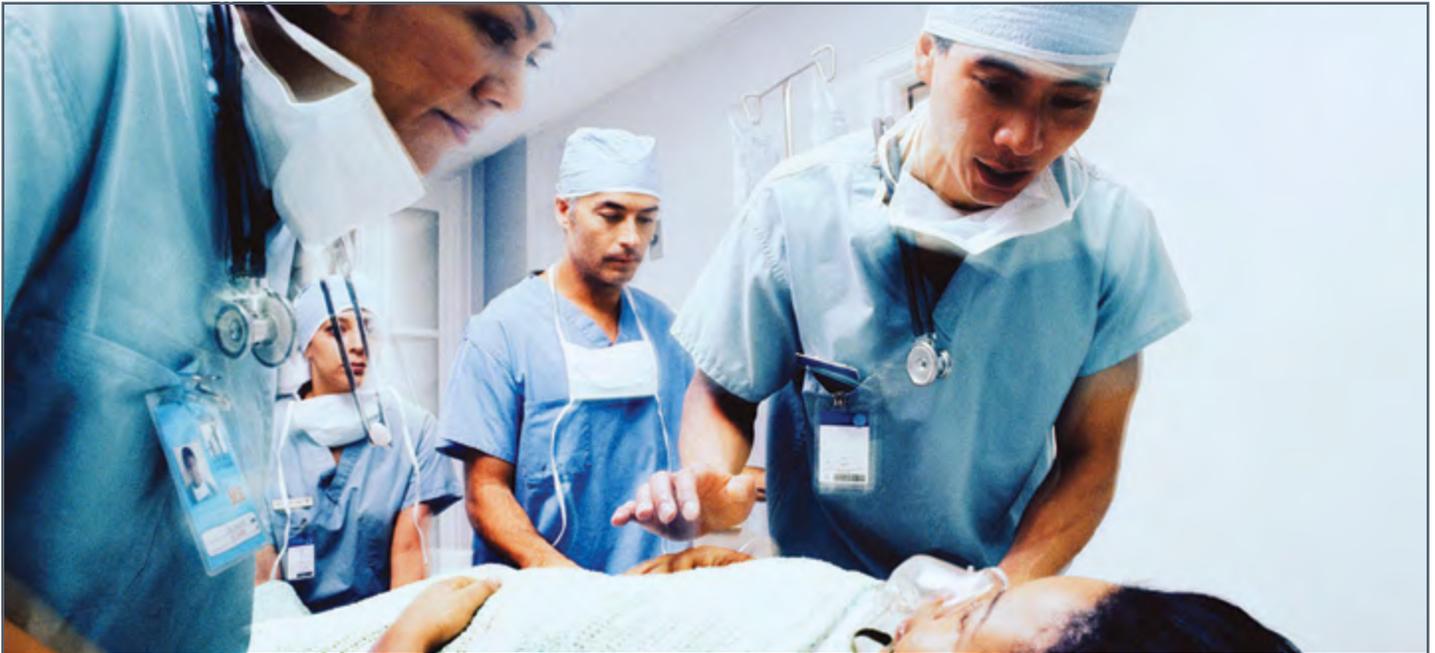
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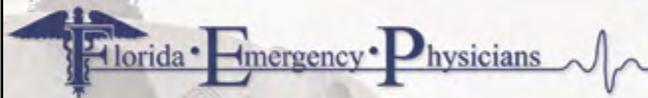
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hours of PA/NP coverage daily across all facilities. Pinehurst is a world-renowned resort centrally located in the Sandhills of North Carolina. Our physicians and families enjoy a short drive to the ocean, mountains, and several highly acclaimed universities. We are also home to the 1999, 2005, 2014 and future 2024 US Open Golf Championships. The majority of our physicians start and finish their career in this family-oriented community which also boasts equestrian activities, trails, lakes, and other outdoor sports activities. Become a part of FirstHealth Moore Regional Hospital, named one of the nation's 100 top hospitals in a recent industry study conducted by Truven Health Analytics. We are looking for residency trained EM physicians seeking a partnership opportunity. Residency trained ABEM/ABOEM BE/BC physicians may apply. The offer encompasses fair and equitable scheduling from day 1 in a democratic group with a 2-year partnership track. SEP offers funded retirement plus the usual health, malpractice, CME, vision/dental allowance, etc. We annually treat a combined 125K+ patients and utilize an integrated EMR. Hospitalists handle most admissions. Competitive sign-on bonus. For more information or inquiries, please contact Peter A. Tuchic at madju@nc.rr.com or (910) 692-8224.

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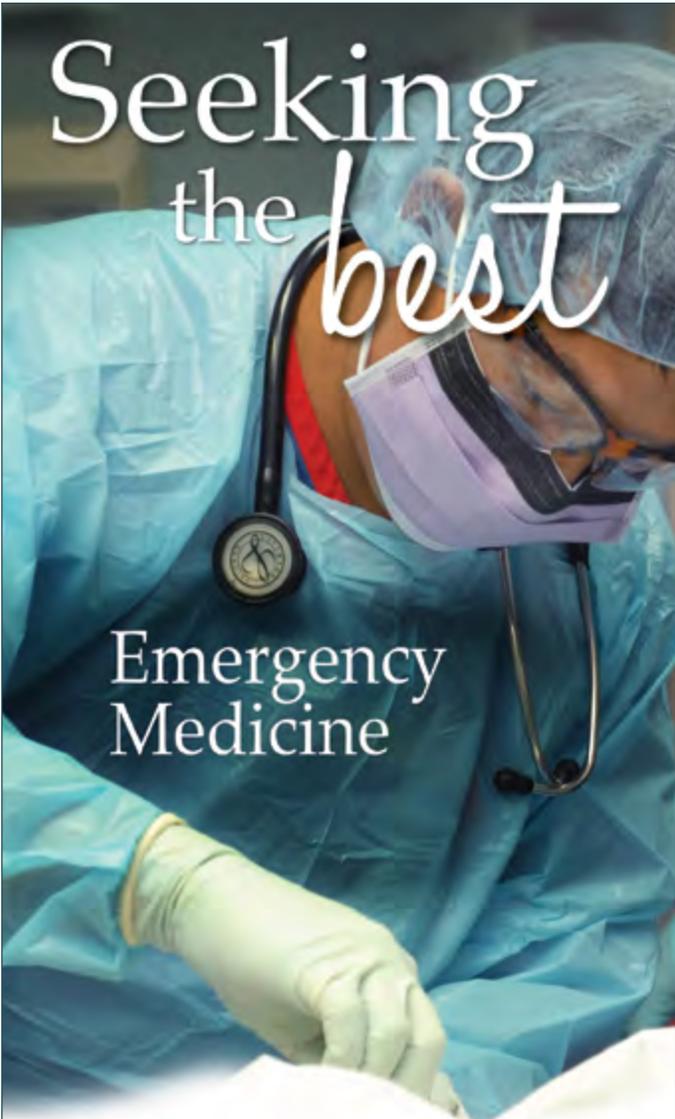
Cincinnati Region: Signing bonus available! The Mercy Health System in eastern and western Cincinnati includes nine respected community hospitals seeing 14,000-60,000 emergency pts./yr. Locations are proximate to desirable residential areas. US Acute Care Solutions (USACS) was founded by like-minded groups that share a strong commitment to a physician-led and owned, democratic business model. As a USACS physician, you'll have an equal voice as an owner, and unparalleled access to personal and professional growth resources. Our outstanding benefits package includes groundbreaking 100% paid parental leave, student/med. school loan refinancing as low as 2.99%, excellent compensation, the best medical malpractice (occurrence - includes tail), industry leading company-funded retirement plan, family healthcare and the camaraderie that is exclusive to a physician-led and owned group. At USACS, we control our careers and love our lives! Visit us at www.usacs.com. Contact Darrin Grella, Vice President of Recruiting: careers@usacs.com or (800) 828-0898.

Concord, Madison and Willoughby: New increased compensation and signing bonus! Lake Health is situated in the eastern Cleveland Suburbs. TriPoint Medical Center was built in 2009 and treats 27,000 emergency pts./yr. The Madison Medical Campus hosts a freestanding ED seeing 12,000 pts./yr. West Medical Center is a state-of-the-art acute care hospital serving 35,000 ED pts./yr. US Acute Care Solutions (USACS) was founded by like-minded groups that share a strong commitment to a physician-led and owned, democratic business model. As a USACS physician, you'll have an equal voice as an owner, and unparalleled access to personal and professional growth resources. Our outstanding benefits package includes groundbreaking 100% paid parental leave, student/med. school loan refinancing as low as 2.99%, excellent compensation, the best medical malpractice (occurrence - includes tail), industry leading company-funded retirement plan, family healthcare and the camaraderie that is exclusive to a physician-led and owned group. At USACS, we control our careers and love our lives! Visit us at www.usacs.com. Contact Darrin Grella, Vice President of Recruiting: careers@usacs.com or (800) 828-0898.

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

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

Urbana: Mercy Memorial Hospital services the SW Ohio region's residents in Champaign County; the facility treats approximately 16,000 emergency pts./yr. Desirable residential areas in Dayton are easily accessible. US Acute Care Solutions (USACS) was founded by like-minded groups that share a strong commitment to a physician-led and owned, democratic business model. As a USACS physician, you'll have an equal voice as an owner, and unparalleled access to personal and professional growth resources. Our outstanding benefits package includes groundbreaking 100% paid parental leave, student/



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Paula Johnson, director of
Physician Recruitment
1-800-869-4201



Goldsboro, North Carolina

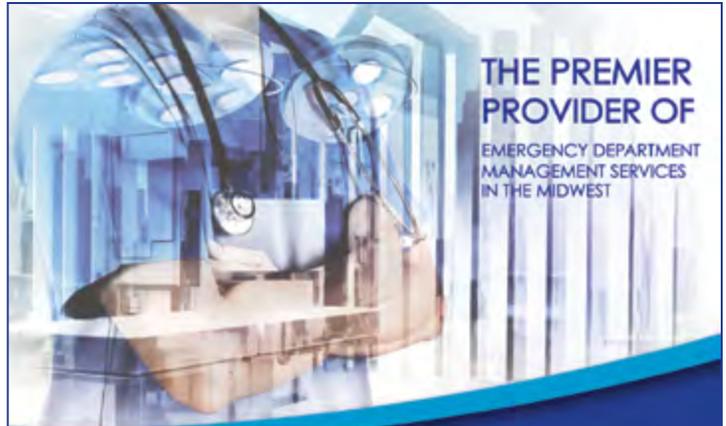
Goldsboro Emergency Medical Specialists, Inc. is seeking a full-time BC/BE Emergency Medicine Physician to join its private practice.

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

Enjoy an outstanding quality of life in this family oriented community located in the heart of Eastern North Carolina. Location is close to local beaches and the mountains. Low cost of living and desirable climate.

- Top tier income, annual bonus, partnership after one year of satisfactory performance.
- Total benefit package includes 401K, Health Insurance, HSA employer contributions, and Malpractice Insurance with tail coverage
- Flexible scheduling offering 24/7 coverage of emergency room with 8, 9 and 10 hour rotating shifts

Email CV to: donna@immediatecarenc.com.



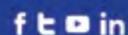
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Infinity HealthCare seeks clinicians who aspire bigger and better things as they advance through their careers. Infinity offers an enticing range of career advancement opportunities and practice locations across Wisconsin and Northern Illinois. Whether seeking a position in a metropolitan area with high volume and acuity, or a quieter, rural setting, opportunities are available through Infinity HealthCare.

All Infinity clinicians share a common ethic, expectation and intent to prosper. Infinity strives to ensure that each new healthcare provider who joins its team is not only an ideal fit for Infinity, but that Infinity is an ideal fit for the clinician as well. Infinity doesn't simply offer physician jobs in the Midwest. It offers rewarding careers and stimulating lifestyles.



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OKLAHOMA

Tulsa: Brand new, state-of-the-art, 85-room ED opened in Fall 2014. Saint Francis Hospital is a modern 971-bed regional tertiary care center seeing 99,000 ED patients per year, with broad pathology, high acuity, modern facilities and supportive environment. US Acute Care Solutions (USACS) was founded by like-minded groups that share a strong commitment to a physician-led and owned, democratic business model. As a USACS physician, you'll have an equal voice as an owner, and unparalleled access to personal and professional growth resources. Our outstanding benefits package includes groundbreaking 100% paid parental leave, student/med. school loan refinancing as low as 2.99%, excellent compensation, the best medical malpractice (occurrence – includes tail), industry leading company-funded retirement plan, family healthcare and the camaraderie that is exclusive to a physician-led and owned group. At USACS, we control our careers and love our lives! Visit us at www.usacs.com. Contact Darrin Grella, Vice President of Recruiting: careers@usacs.com or (800) 828-0898.

PENNSYLVANIA

Indiana: Signing bonus! New scribe and hospitalist programs! Indiana Regional Medical Center is a full-service community hospital in a college town located 50 miles northeast of Pittsburgh. IRMC sees 45,000 ED pts./yr. and has a dynamic, supportive ED director. Excellent local schools, reasonable housing costs, and easy access to metropolitan and outdoor recreation make for a high quality of life. Allegheny Health Network Emergency Medicine Management (AHNEMM) has a strong commitment to a physician-led and owned, democratic business model. As an AHNEMM physician, you'll have an equal voice as an owner, and unparalleled access to personal and professional growth resources. Our outstanding benefits package includes groundbreaking 100% paid parental leave, student/med. school loan refinancing as low as 2.99%, excellent compensation, the best medical malpractice (occurrence – includes tail), industry leading company-funded retirement plan, family healthcare and the camaraderie that is exclusive to a physician-led and owned group. At USACS, we control our careers and love our lives! Visit us at www.usacs.com. Contact Jim Nicholas (jnicholas@usacs.com) or call (800) 828-0898.



Berkshire
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Big City Medicine, Hometown Feel!

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

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

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

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

Please apply online at our website
berkshirehealthsystems.org.

Advocate Health Care

Emergency Medicine Opportunities

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

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

Details:

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

Why choose Advocate?

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

Locations currently recruiting:

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

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

Sarah Smith, Physician Recruiter at Sarah.Smith5@advocatehealth.com



Bakersfield, California

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

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

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

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

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

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

Income in top 5-10% nationwide

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

Contact: Les Burson, DO, Medical Director phogku@aol.com 661-332-1064 or

Dr. Kian Azimian, MD, Assistant Medical Director kianazimian@yahoo.com 661-616-8930

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Pittsburgh: Allegheny General Hospital is a highly regarded quaternary care center with Level I trauma designation and an international reputation for excellence. A full-range of medical and surgical specialties supports residency programs in 22 specialties including EM and EM/IM, plus fellowships in EMS and EM Ultrasound. 55,000 ED patients are treated annually. Allegheny Health Network Emergency Medicine Management (AHNEMM) has a strong commitment to a physician-led and owned, democratic business model. As an AHNEMM physician, you'll have an equal voice as an owner, and unparalleled access to personal and professional growth resources. Our outstanding benefits package includes groundbreaking 100% paid parental leave, student/med. school loan refinancing as low as 2.99%, excellent compensation, the best medical malpractice (occurrence – includes tail), industry leading company-funded retirement plan, family healthcare and the camaraderie that is exclusive to a physician-led and owned group. At USACS, we control our careers and love our lives! Visit us at www.usacs.com. Contact Jim Nicholas (jnicholas@usacs.com) or call (800) 828-0898.

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

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



Assistant/Associate Residency Program Director

Emergency Medicine Core Faculty

Pediatric Emergency Medicine Faculty

Community-Based Site Opportunity

For additional information, please contact:
Susan B. Promes, Professor and Chair, Department of Emergency Medicine, c/o Heather Peffley, Physician Recruiter, Penn State Hershey Medical Center, Mail Code A590, P.O. Box 850, 90 Hope Drive, Hershey PA 17033-0850, Email: hpeffley@hmc.psu.edu

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

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

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

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



PennState Health
Milton S. Hershey Medical Center

The Penn State Health Milton S. Hershey Medical Center is committed to affirmative action, equal opportunity and the diversity of its workforce. Equal Opportunity Employer – Minorities/Women/Protected Veterans/Disabled.

Health System

PHYSICIANS NEEDED for Emergency Department Coverage

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

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

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

**For further information, please contact Kimberly Salvail
at (256) 265-7073 or physicianrecruitment@hhsys.org**



huntsvillehospital.org

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Exciting Academic Emergency Medicine Opportunities

The Baylor College of Medicine, a top medical school, is looking for academic leaders to join us in the world's largest medical center, located in Houston, Texas. We offer a highly competitive academic salary and benefits. The program is based out of Ben Taub General Hospital, the largest Level 1 trauma center in southeast Texas with certified stroke and STEMI programs that has more than 100,000 emergency visits per year. BCM is affiliated with eight world-class hospitals and clinics in the Texas Medical Center. These affiliations, along with the medical school's preeminence in education and research, help to create one of the strongest emergency medicine experiences in the country. We are currently seeking applicants who have demonstrated a strong interest and background in medical education, simulation, ultrasound, or research. Clinical opportunities are also available at our affiliated hospitals. Our very competitive PGY 1-3 residency program currently has 14 residents per year.

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

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leading company-funded retirement plan, family healthcare and the camaraderie that is exclusive to a physician-led and owned group. At USACS, we control our careers and love our lives! Visit us at www.usacs.com. Contact Jim Nicholas (jnicholas@usacs.com) or call (800) 828-0898.

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

Sharon: Signing bonus available at Sharon Regional Health System. Join an extremely supportive director/administration/medical staff, newer ED, and full-service capabilities making this a great place to work with 37,000 patients treated annually. Small city setting offers beautiful housing and abundant recreation less than an hour from Pittsburgh and Cleveland. Allegheny Health Network Emergency Medicine Management is part of US Acute Care Solutions (USACS) which was founded by EMP and other like-minded groups that share a strong commitment to a physician-led and owned, democratic business model. As an AHNEMM physician, you'll have an equal voice as an owner, and unparalleled access to personal and professional growth resources. Our outstanding benefits package includes groundbreaking 100% paid parental leave, student/med. school loan refinancing as low as 2.99%, excellent compensation, the best medical malpractice (occurrence – includes tail), industry leading company-funded retirement plan, family healthcare and the camaraderie that is exclusive to a physician-led and owned group. At USACS, we control our careers and love our lives! Visit us at www.usacs.com. Contact Jim Nicholas (jnicholas@usacs.com) or call (800) 828-0898.

Somerset: Somerset Hospital is a respected, 110-bed facility located in western Pennsylvania's Laurel Highlands. Easy access is afforded to the mountains and great ski resorts, biking/hiking and a number of rivers and lakes, as well as the metropolitan amenities of Pittsburgh which are just an hour away. A brand new ED sees 18,000 patients/year and a broad mix of pathology. An integrated hospitalist program provides for more efficient care. The facility hosts close-knit



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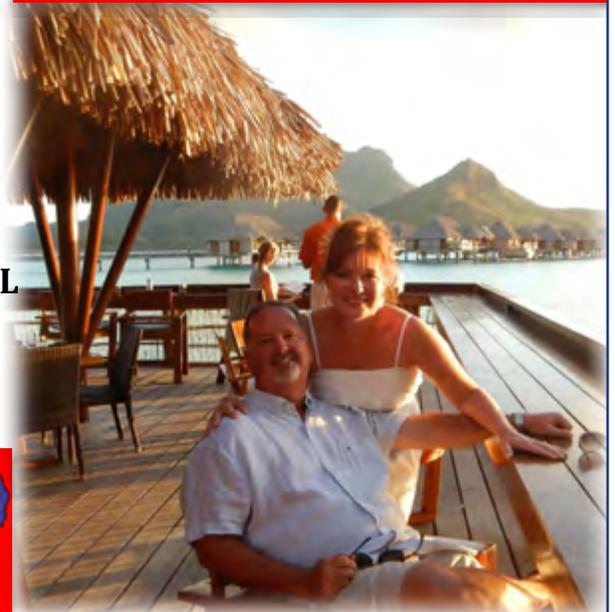
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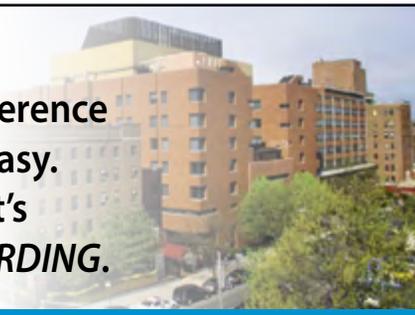
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New York Methodist Hospital, a voluntary, acute care teaching facility, has long been one of Brooklyn's most respected institutions, with outstanding team members known for their excellence in patient care delivery and a history that spans over 135 years. As a proud member of the New York Presbyterian Healthcare System, which provides access to top-ranking physicians and comprehensive resources, including some of the best thought leaders in the medical field, we are affiliated with Weill Cornell Medicine – an Ivy League medical school that is among the nation's best in medical education and research.

EMERGENCY MEDICINE PHYSICIAN

Park Slope, Brooklyn * Full Time

We are currently seeking a board certified/eligible physician with outstanding clinical skills and a desire to work in an academic environment, to join our high volume Emergency Department, which handles nearly 110,000 visits each year and offers a newly accredited ACS level II Trauma Center.

As a faculty member in our Department of Emergency Medicine, you will join an enthusiastic group of emergency physicians, advanced practice providers, and emergency medicine residents committed to creating the premiere emergency medicine residency program and academic department in the State of New York. There are additional opportunities for candidates with fellowship experience.

We offer a competitive salary and a comprehensive benefit package. Academic appointment and salary will be commensurate with experience. **For immediate consideration, please visit us at: www.nym.org/careers, email: gcc9003@nyp.org, or send your CV to: Gerardo Chiricolo, MD, FACEP, Vice Chairman of Emergency Medicine, New York Methodist Hospital, Department of Emergency Medicine, 506 Sixth Street, Brooklyn, NY 11215.**

Member
New York Presbyterian Healthcare System
Affiliate: Weill Cornell Medical College



New York Methodist Hospital is an equal opportunity employer.

THE GEORGE WASHINGTON UNIVERSITY

WASHINGTON, DC

Faculty Positions - Emergency Medicine

DISTRICT OF COLUMBIA - The Department of Emergency Medicine of the George Washington University is seeking physicians for our academic practice. Physicians are employed by Medical Faculty Associates, a University-affiliated, not-for-profit multispecialty physician group, and receive regular faculty appointments at the University. The Department provides staffing for the emergency units of George Washington University Hospital, the Walter Reed National Military Medical Center, and the DC Veterans' Administration Medical Center. The Department (<http://smhs.gwu.edu/emed/>) offers educational programs including a four-year residency, ten fellowships programs, and numerous student programs.

We are seeking physicians who will participate in our clinical and educational programs and contribute to the Department's research and consulting activities. Rank and salary are commensurate with experience.

Basic Qualifications: Physicians must be ABEM or AOEM certified, or have completed an ACGME or AOA certified Emergency Medicine residency, prior to the date of employment.

Application Procedure: Complete the online faculty application at <http://www.gwu.jobs/postings/37357> and upload a CV and cover letter. Review of applications will be ongoing beginning November 1, 2016 until positions are filled. Only complete applications will be considered. Contact department chair Robert Shesser M.D. at rshesser@mfa.gwu.edu with questions about the position.

Employment offers are contingent on the satisfactory outcome of a standard background screening.

The George Washington University and the George Washington University Medical Faculty Associates are an Equal Employment Opportunity/Affirmative Action employer that does not unlawfully discriminate in any of its programs or activities on the basis of race, color, religion, sex, national origin, age, disability, veteran status, sexual orientation, gender identity or expression, or on any other basis prohibited by applicable law.

EOE

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EMA, an established sixteen-hospital, regional, democratic, physician-managed group seeks full and part-time BC or BP Emergency physicians to practice in Maryland, Northern Virginia, Washington, D.C. and West Virginia. Since 1971, EMA has offered our physicians an unmatched quality-of-life with the security of our 100% contract stability!

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By Washington Post

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- Democratic partnership structure
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- Full benefits package for physicians and family

Send CV: Emergency Medicine Associates, P.A., P.C.
Phone: 1-800-942-3363
Fax: 240-686-2334
Email: Recruitment@EMAonline.com
www.EMAonline.com

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- Abigail Adams, MD
Assistant Medical Director
& EMPros Partner



Live & Work
Where **MOST**
Vacation!

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- ◆ Health, Life, 401K, Disability & CME Account
- ◆ Partnership opportunity in 18 months



ArnotHealth

Arnot Medical Services

Arnot Ogden Medical Center is seeking an ABEM-Certified Emergency Medicine Physician to join our Emergency Department. A fully equipped ER with 24-hour angioplasty, anesthesia, double physician coverage and dedicated Fast Track will create the environment for you to blend your talents and skills in a progressive and financially sound health system that serves over 47,000 emergency medicine visits annually.

Our multispecialty practice group and DO residency program with a truly collegial staff provide excellent support and contribute to the rewards of a balanced professional and personal lifestyle. The Southern Finger Lakes and Pennsylvania Grand Canyon and the cities and suburbs of Elmira and Corning offer a truly exceptional lifestyle. Excellent schools, convenient shopping, low crime rates, and high air and water quality combine to foster a superior environment with very affordable housing. The region is a mecca for outdoor enthusiasts offering an abundance of activities in all seasons. The region is centrally located within an easy 4-5 hour drive to major cities in the Northeast.

The successful candidates will receive competitive compensation with a newly enhanced initiative and benefit package including loan forgiveness, residency stipend and relocation. Arnot is an osteopathic training facility with an accredited EM residency program. Core faculty positions are available.

EEO Employer

For confidential consideration, please contact:
Francis DiBari, Director Medical Staff Recruitment,
Arnot Health, 600 Ivy Street, Suite 105, Elmira, NY 14905
Phone: (607) 735-4620; Fax: (607) 737-7700;
Email: fdibari@arnothealth.org

or visit our web-site at: <https://www.arnothealth.org/careers>

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and supportive EM and administrative staffs which provide for a great work environment. Allegheny Health Network Emergency Medicine Management is part of US Acute Care Solutions (USACS) which was founded by EMP and other like-minded groups that share a strong commitment to a physician-led and owned, democratic business model. As an AHNEMM physician, you'll have an equal voice as an owner, and unparalleled access to personal and professional growth resources. Our outstanding benefits package includes groundbreaking 100% paid parental leave, student/med. school loan refinancing as low as 2.99%, excellent compensation, the best medical malpractice (occurrence – includes tail), industry leading company-funded retirement plan, family healthcare and the camaraderie that is exclusive to a physician-led and owned group. At USACS, we control our careers and love our lives! Visit us at www.usacs.com. Contact Jim Nicholas (jnicholas@usacs.com) or call (800) 828-0898.

RHODE ISLAND

Westerly: The Westerly Hospital is a 125-bed community hospital situated in a beautiful beach community in SE RI, 45 minutes from Providence and 1.5 hours from Boston. Modern, well-equipped ED sees 21,000 pts./yr. US Acute Care Solutions (USACS) was founded by like-minded groups that share a strong commitment to a physician-led and owned, democratic business model. As a USACS physician, you'll have an equal voice as an owner, and unparalleled access to personal and professional growth resources. Our outstanding benefits package includes groundbreaking 100% paid parental leave, student/med. school loan refinancing as low as 2.99%, excellent compensation, the best medical malpractice (occurrence – includes tail), industry leading company-funded retirement plan, family healthcare and the camaraderie that is exclusive to a physician-led and owned group. At USACS, we control our careers and love our lives! Visit us at www.usacs.com. Contact Darrin Grella, Vice President of Recruiting: careers@usacs.com or (800) 828-0898.

SOUTH CAROLINA

Upstate: Emergency Medicine Physicians. Independent, democratic group offering partnership for BC/BE emergency physicians with equal pay and scheduling from day one. Competitive compensation, group health insurance, pension plan and occurrence malpractice insurance. Level II Trauma Center and area referral center; emergency department and adjacent fast track facility have combined volume of 85k patient visits/year. Affordable, lakefront property on beautiful Lake Hartwell; an outdoor enthusiast's dream! Short drive to mountains and beaches; equi-distant of Atlanta and Charlotte. Contact: Brandy Vaughn at brandy.vaughn@anmedhealth.org or (864) 512-3897.

TEXAS



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

WEST VIRGINIA

Wheeling: EM residency faculty and clinical positions available at Ohio Valley Medical Center, a 250-bed community teaching hospital with an AOA approved Osteopathic EM and EM/IM residency program. Enjoy full-specialty back up, active EMS, and two campuses seeing 30,000 and 20,000 pts./yr. US Acute Care Solutions (USACS) was founded by like-minded groups that share a strong commitment to a physician-led and owned, democratic business model. As a USACS physician, you'll have an equal voice as an owner, and unparalleled access to personal and professional growth resources. Our outstanding benefits package includes groundbreaking 100% paid parental leave, student/med. school loan refinancing as low as 2.99%, excellent compensation, the best medical malpractice (occurrence – includes tail), industry leading company-funded retirement plan, family healthcare and the camaraderie that is exclusive to a physician-led and owned group. At USACS, we control our careers and love our lives! Visit us at www.usacs.com. Contact Jim Nicholas (jnicholas@usacs.com) or call (800) 828-0898.

WISCONSIN

MILWAUKEE: Emergency Medicine Specialists (EMS) is a Physician-owned, democratic EM group of 30 EM Physicians based in Milwaukee, WI. We are seeking full time and/or part time BC/BP Emergency Physicians to join our well-established practice. Our group staffs four EDs in the Milwaukee area. Partnership tracks are available. Excellent work environment, benefits, compensation! We pride ourselves on being fair, equitable, and democratic. Interested Physicians please contact Matthew Deluhery, matthew.deluhery@ems-wi.com, 414.877.5350.

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